



Acct#: _____

Today's Date: _____ Email: _____ Gender: M F
 Name: _____ Date of Birth: _____ Age: _____
 Your Address: _____ City: _____
 State: _____ Zip: _____ SS# _____ Hm#: _____
 Name of Employer: _____ Wk#: _____
 Marital Status: S M W D Referred by: _____ Cell# _____
 How Many Children Do You Have? _____ What Are Their Ages? _____
 Emergency Contact: _____ Phone#: _____
 Who is Responsible For Your Bill? Self Spouse Worker's Compensation Medicaid
Medicare Auto Insurance Personal Health Insurance Other: _____
 Purpose or Reason For Today's Appointment: _____
 How Often Do You Drink Alcoholic Beverages? _____
 Do You Smoke? Yes No How Much? _____
 Do You Exercise? Yes No How Much? _____ Type? _____
 Do You Have Any Allergies? Yes No Specify: _____

Have You Ever Suffered From or Been Diagnosed As Having: (check yes or no for each)

Y	N	Condition	Y	N	Condition	Y	N	Condition
		Broken Bone			Diabetes Type I or II*			Osteoarthritis
		Circulation Problems			Epilepsy			HIV Positive
		Rheumatoid Arthritis			Pacemaker			Gall Bladder
		Seizures/Convulsions			Strokes			Head Problems*
		Congenital Disease			Cancer/Tumors*			Depression
		Excessive Bleeding			Ulcers			Headaches
		High/Low Blood Pressure			Coughing Blood			Fatigue
		Stress			Fibromyalgia			Edema
		Blood Clots			Hepatitis			Alcohol/Drug

*Explain: _____

Medication List

Drug	Vitamin/Supplement	Date Started	Date Stopped

Doctor's Notes:

HT: _____ WT: _____ B/P: _____ BPM: _____ RESP: _____

Date: _____ Patient Name: _____ Account# _____

PATIENT HISTORY

Complaint #1: _____ When did it start? _____

Circle the current pain level of your complaint: Mild Moderate Severe

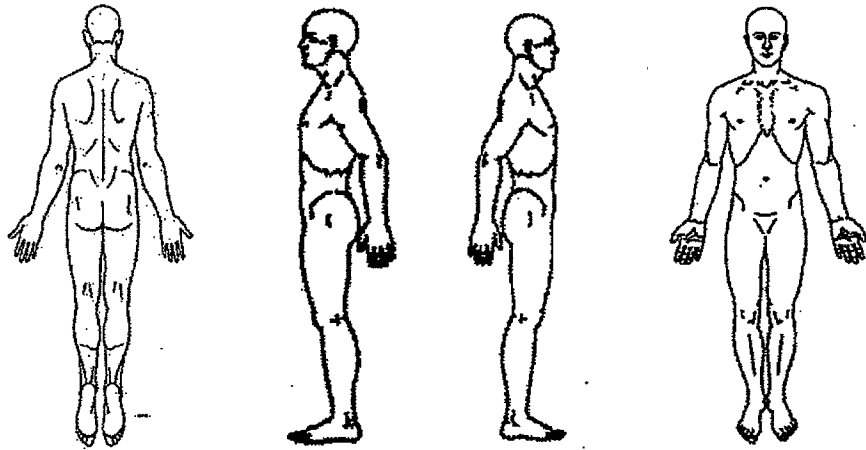
Circle the percentage of time you experience the complaint: 0 10 20 30 40 50 60 70 80 90 100 %
Occasional Intermittent Frequent Constant

When do you feel it most? ? AM ? PM When present, how long does the complaint last? _____ min _____ Hrs

What makes you feel better? _____ What make if feel worse? _____

Using the letters below, please show where you are experiencing all of your complaints on the diagram.

- A. Ache
- B. Burning
- C. Cramping
- D. Dull Pain
- F. Stiffness
- N. Numbness
- R. Throbbing
- S. Soreness
- T. Tingling
- X. Sharp Pain



Do you currently have pain and/or difficulty performing any of the following activities? (Circle Y or N)			
Walking	? Y ? N	Bending	? Y ? N
Sleeping	? Y ? N	Kneeling	? Y ? N
Sitting	? Y ? N	Lifting Children	? Y ? N
Personal Grooming	? Y ? N	Lifting Objects	? Y ? N
Standing	? Y ? N	Running	? Y ? N
Driving	? Y ? N	Exercising	? Y ? N
Housework	? Y ? N		

1. Have you ever had the condition(s) in the past? ? Yes ? No If yes, please indicate if any treatment was received and what type of treatment: ? Hospitalization ? Chiropractic care ? Medical doctor / specialty provider ? None
2. Have you ever lost time from work due to your condition(s)? ? Yes ? No If Yes, dates? _____
3. Are you pregnant? ? Yes ? No
4. What was the first day of your last menstrual cycle? _____
5. Number of pregnancies? _____ Number of miscarriages? _____

Patient Signature _____ Date: _____ Physician Initials: _____



1715 SE-28th Loop. Ocala, FL 34471 (352)861-0566 ph (352)402-0565 fax

Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name: _____ Last Name: _____

Email address: _____ @ _____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: ___/___/___ Gender (Circle one): Male / Female Preferred Language: _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White
(Caucasian) Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

I choose to decline receipt of my clinical summary after every visit (These summaries are often blank as a result of the nature and frequency of chiropractic care.)

Patient Signature: _____ Date: _____

For office use only:

Height: _____ Weight: _____ Blood Pressure: _____ / _____

Respirations: _____ Pulse: _____



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INFORMED CONSENT TO CHIROPRACTIC TREATMENT

Medical doctors, chiropractic doctors, osteopath and physical therapists that perform manipulation are required by law to obtain your informed consent before starting treatment.

I, _____, do hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/adjustments involving movement of the joints and soft tissues. Physical therapy, exercises, Graston, traction and other therapeutic modalities may also be used.

Although spinal manipulations/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows:

Soreness: I am aware that, like exercise, it is common to experience muscle soreness in the first few treatments.

Dizziness: Temporary symptoms like dizziness and nausea can occur but are relatively rare.

Fractures/Joint Injury: I further understand that in isolated cases underlying physical defects, deformities or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disc or other abnormality is detected, this office will proceed with extra caution.

Stroke: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage including stroke is reported to occur once in one million to once in ten million treatments.

TREATMENT RESULTS

I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits. I agree to the performance of these procedures by my doctor and such other person of the doctor's choosing.

ALTERNATIVE TREATMENTS AVAILABLE

Reasonable alternatives to these procedures have been explained to me including rest, home applications of therapy, prescription or over-the-counter medications, exercises and possible surgery.

I have read or have read to me the above explanation of chiropractic treatment. Any questions I had regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely.

To attest to my consent to these procedures, I hereby affix my signature to this authorization for treatment.

Date

Patient Signature

Date

Witness of Patient Signature

Office Policies and Authorizations

1. **Insurance and Billing:** I, _____ (Print Name), hereby authorize For Your Health LLC, d/b/a Chiropractic USA to bill my insurance _____ (Print Insurance), appeal any decisions made by my insurance, and represent me regarding any appeals. I understand that should something be returned as disputed/ unpaid and remains unresolved, that I will be responsible for the charges. *If you have any questions, please see the front desk to review your verification of benefits.*
2. **Massage Cancellation:** I understand that massage is a service with limited availability. I understand that the massage therapist relies on knowing their booked schedule in advance, and I will cancel my appointment as soon as possible should I be unable to keep my appointment for any reason.
3. **Information Use:** I authorize Chiropractic USA to use my information given to contact me regarding appointment reminders, missed appointments, information regarding treatments and alternatives, as well as other health related information that may arise.
4. **Right to Revoke:** I understand I have the right to revoke the above authorization of my information in writing at any time. The statement may be mailed or delivered in person and must include the following: name, SSN, DOB, the intent to revoke the authorization, the date of your request, and signature.
5. **HIPPA:** I understand that should I have any questions regarding the HIPPA (Health Insurance Portability and Accountability Act) I may ask for a copy of the practice's documents for my own records or viewing. *Should you wish to see or obtain a copy please ask the front desk.*
6. **Shareable Parties:** I authorize Chiropractic USA to share my health information with following:
 - _____ (Name) _____ (Phone)
 - _____ (Name) _____ (Phone)
 - _____ (Name) _____ (Phone)

Print

Sign

Date





ChiropracticUSA™

Amber A. Plante, D.C. Mark H. Chen, D.C. Kaycie Hartley, D.C.

Date: _____

RELEASE OF PATIENT RECORDS AUTHORIZATION

I HEREBY AUTHORIZE _____ (name of practice) to release a copy of my records and/or x-rays containing protected health information to

_____. This authorization is given pursuant to Florida Statute 456.057 and HIPAA regulations. I understand that Florida Statute 456.057 (10) makes clear that any third party to whom records are disclosed is prohibited from further disclosing any information in the medical records without the expressed written consent of the patient or the patient's legal representatives.

Patient's Name (Print)

Patient's Date of Birth

Patient's or Legal Representative's Signature

Patient's Social Security Number

Specific description of information to be disclosed:

