POSITIVE CHIROPRACTIC SOLUTIONS

Case History/Patient Information

Reactivation

Date: _____ Patient #: _____ Doctor: _____

Name: _____

Street: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Occupation: _____ Employer: _____

Marital Status: (M S) Spouse: _____ Children (ages): _____

Medical Doctor: _____

Previous Chiropractic Care: _____

Medical History - *since your last visit only*

□ Headaches	□ Weakness in Extremities	□ Broken Bones	□ Hepatitis
□ Neck Pain	□ Hand Numbness/Tingling	□ Eye/Vision Problems	□ HIV Positive
□ Mid Back Pain	□ Foot Numbness/Tingling	□ Hearing Problems	□ Osteoporosis
□ Low Back Pain	□ High Blood Pressure	□ Ringing/Buzzing in Ears	□ Loss of Memory
□ Arm Pain/Numbness/Tingling	□ Diabetes	□ Breathing Problems	□ Fatigue
□ Leg Pain/Numbness/Tingling	□ Stroke/Heart Attack	□ Chest Pain/Tightness	□ Stomach Problems
□ Muscle Spasm	□ Cancer	□ Pacemaker	□ Circulation Problems
□ Joint Stiffness	□ Arthritis	□ Menstrual Difficulties	□ Ulcers
□ Stiff Neck	□ Difficulty urinating	□ Depression/Other disorders	□ Fever
□ Sleeping Problems	□ Unusual Bowel Patterns	□ Tension/Irritability	□ Heart Disease
□ Dizziness/Loss of Balance	□ Epilepsy/Seizures	□ Alcoholism	□ Neurological Disorder
□ Fainting	□ Significant Weight Change	□ Drug Addiction	□ Prostate Problems
□ Foot/Ankle/Knee/Hip Pain	□ Hand/Wrist/Elbow Pain	□ Shoulder Pain	□ Spinal Cord Injury

List and describe any other medical history not listed above:

_____

_____

Operations/Surgeries – *since your last visit only* - (include date if applicable):

□ Appendix	□ Neurological	□ Elbow: R or L	□ Cervical Spine/ Disc
□ Chest	□ Ears/Nose/Throat	□ Shoulder: R or L	□ Thoracic Spine/Disc
□ Gallbladder	□ Brain/Tumor	□ Foot/Ankle: R or L	□ Lumbar Spine/Disc
□ Hernia	□ Heart Bypass	□ Knee: R or L	□ Neck
□ Heart	□ Podiatric	□ Hip Replacement: R or L	□ Back
□ Obstetrical	□ Hand/Wrist: R or L	□ Knee Replacement: R or L	□ Cosmetic
□ Gastrointestinal	□ Other:		

Patient Name: _____ *Patient #:* _____ *Date:* _____

Please list any Medications and/or supplements you are currently taking:

_____

_____

Traumas/Accidents – *since your last visit only*

Please describe, give dates, injuries, broken bones, treatment if applicable:

- Automobile: _____
- Occupational: _____
- Recreational: _____
- Childhood: _____
- Other: _____

Have you been hospitalized since your last visit with us? _____ Yes _____ No

If yes, please describe the reason(s): _____

Have you had a physical exam/bloodwork since your last visit with us? _____

Have you had any x-ray/CT/MRI/Ultrasound tests done in the past year? _____ Yes _____ No

If yes, date and type of imaging performed: _____

Location/Doctor who performed the above imaging: _____

Women: Are you pregnant? _____ # of Weeks: _____

Newly Developed Allergies - *since your last visit only* - (please check all applicable):

□ Animals	□ Pain Medication	□ Shellfish/Iodine	□ Chocolates/Sweets
□ Dairy	□ Penicillin	□ Bee Stings	□ Wheat
□ Molds	□ Other Medication	□ Eggs	□ Soaps
□ Seasonal Allergies	□ Latex	□ Peanuts	□ Polyester
□ Dust	□ Rubber	□ Other:	

I certify the information provided is accurate to the best of my knowledge:

Print Patient's Name: _____

Signature of Patient/Legal Guardian: _____ Date: _____

Patient Name: _____ *Patient #:* _____ *Date:* _____

What is your MAIN complaint? _____ Date problem began: _____

How did this problem begin (falling, lifting, etc.)? _____

How is your condition changing? □ GETTING BETTER □ GETTING WORSE □ NOT CHANGING

Have you had this condition in the past? □ YES □ NO If yes, when was your last episode of this pain? _____

How often do you experience your symptoms?

□ Intermittently (0-25% of the day) □ Occasionally (26-50% of the day)

□ Frequently (51-75% of the day) □ Constantly (76-100% of the day)

Describe the nature of your symptoms:

□ Sharp □ Dull □ Numb □ Burning □ Shooting □ Tingling □ Radiating Pain □ Tightness

□ Stabbing □ Throbbing □ Other: _____

Please rate your pain on a scale of 1 to 10 (0 = NO PAIN and 10 = EXCRUCIATING PAIN)

□ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

Does your pain radiate? □ YES □ NO If yes, where does it radiate to? _____

What activities make your condition WORSE (working, exercise, sitting, etc.)? _____

What activities make your condition BETTER (ice, heat, medication, etc.)? _____

How do your symptoms affect your ability to perform daily activities such as working or driving?

No problem 0 1 2 3 4 5 6 7 8 9 10 Cannot perform activities

What is your SECOND complaint? _____ Date problem began: _____

How did this problem begin (falling, lifting, etc.)? _____

How is your condition changing? □ GETTING BETTER □ GETTING WORSE □ NOT CHANGING

Have you had this condition in the past? □ YES □ NO If yes, when was your last episode of this pain? _____

How often do you experience your symptoms?

□ Intermittently (0-25% of the day) □ Occasionally (26-50% of the day)

□ Frequently (51-75% of the day) □ Constantly (76-100% of the day)

Describe the nature of your symptoms:

□ Sharp □ Dull □ Numb □ Burning □ Shooting □ Tingling □ Radiating Pain □ Tightness

□ Stabbing □ Throbbing □ Other: _____

Please rate your pain on a scale of 1 to 10 (0 = NO PAIN and 10 = EXCRUCIATING PAIN)

□ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

Does your pain radiate? □ YES □ NO If yes, where does it radiate to? _____

What activities make your condition WORSE (working, exercise, sitting, etc.)? _____

What activities make your condition BETTER (ice, heat, medication, etc.)? _____

How do your symptoms affect your ability to perform daily activities such as working or driving?

No problem 0 1 2 3 4 5 6 7 8 9 10 Cannot perform activities

Patient Name: _____ *Patient #:* _____ *Date:* _____

What is your THIRD complaint? _____ Date problem began: _____

How did this problem begin (falling, lifting, etc.)? _____

How is your condition changing? □ GETTING BETTER □ GETTING WORSE □ NOT CHANGING

Have you had this condition in the past? □ YES □ NO If yes, when was your last episode of this pain? _____

How often do you experience your symptoms?

□ Intermittently (0-25% of the day) □ Occasionally (26-50% of the day)

□ Frequently (51-75% of the day) □ Constantly (76-100% of the day)

Describe the nature of your symptoms:

□ Sharp □ Dull □ Numb □ Burning □ Shooting □ Tingling □ Radiating Pain □ Tightness

□ Stabbing □ Throbbing □ Other: _____

Please rate your pain on a scale of 1 to 10 (0 = NO PAIN and 10 = EXCRUCIATING PAIN)

□ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

Does your pain radiate? □ YES □ NO If yes, where does it radiate to? _____

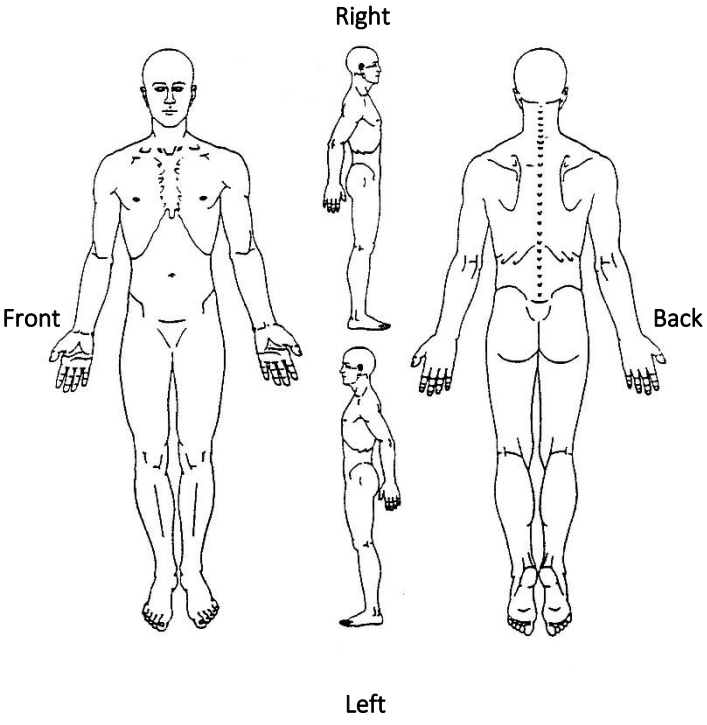
What activities make your condition WORSE (working, exercise, sitting, etc.)? _____

What activities make your condition BETTER (ice, heat, medication, etc.)? _____

How do your symptoms affect your ability to perform daily activities such as working or driving?

No problem 0 1 2 3 4 5 6 7 8 9 10 Cannot perform activities

PLEASE MARK YOUR AREAS OF PAIN ON THE DIAGRAM BELOW:



Main Reason for Consulting This Office:

- □ Become Pain Free
- □ Reduce Symptoms
- □ Resume normal activity level
- □ Explanation of my condition
- □ Learn how to care for my condition
- □ Second Opinion on my condition
- □ Wellness/Maintenance Care

Insurance:

Please check any and all insurance coverage that may be applicable in this case:

□ Major Medical □ Worker's Compensation □ Medicaid □ Medicare □ Auto Accident
□ Medical Savings Account & Flex Plans □ Other

Name of Primary Insurance Company:_____

Name of Secondary Insurance Company (if any):_____

By signing below, I understand and agree to allow this chiropractic office to use my Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

Print Patient's Name:_____

Signature of Patient or Legal Guardian:_____ Date:_____

HIPAA Notice of Privacy Practices:

By signing below, I acknowledge receipt, understanding, and agreement to the HIPAA Notice of Privacy Practices of Positive Chiropractic Solutions. In addition, I understand and agree to allow this chiropractic office to use my Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. You have the right to know how your Patient Health Information is going to be used in this office and your rights concerning those records. A copy of our HIPAA Notice of Privacy Practices is available to you online and in our office. If you have questions regarding our Privacy Practices, please contact our Privacy Officer, Dr. Amanda M. Williams, D.C. at (850) 939-2200.

The following entity(ies) / person(s) have my permission to receive my personal health information:

Name / Relationship / Phone: _____

Name / Relationship / Phone: _____

Name / Relationship / Phone: _____

Print Patient's Name:_____

Signature of Patient or Legal Guardian:_____ Date:_____

Patient Name: _____ *Patient #:* _____ *Date:* _____

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic.

I have had the opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures.

I understand and I am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts known, is my best interest.

I have read, and or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Print Patient's Name:_____

Signature of Patient or Legal Guardian:_____ Date:_____

Name and address of clinic/office:
Positive Chiropractic Solutions
9200 Navarre Parkway, Suite E
Navarre, FL 32566

Print name(s) /doctor(s) treating this patient:
Dr. Amanda M. Williams, D.C.