STEVENS CHIROPRACTIC & WELLNESS CENTER

CONFIDENTIAL HEALTH INFORMATION

Please allow our staff to photocopy your driver's license.
All information you supply is confidential. We comply with all federal privacy standards.
Please print clearly.

Today's Date (MM/DD/YYYY)

Have you consulted a chiropractor before? ○ No ○ Yes **When?**

Whom may we thank for referring you?

If so, whom?

Your Last Name

Birth Date (MM/DD/YYYY) **Age**

Your First Name **Your Middle Name (or Initial)**

Gender ○ Male ○ Female **Nickname**

Address of Permanent Residence

Marital Status ○ Married ○ Single ○ Divorced ○ Widowed ○ Separated **Ethnicity**

City **State/Province** **ZIP/Postal Code**

Seasonal Address

Spouse's Name

City **State/Province** **ZIP/Postal Code**

Children's names and Ages

Home Phone **Cell Phone**

Are you Medicare eligible? ☐ Yes ☐ No

Email Address

If Yes, please present your Medicare card at the front desk, and please read our Special Notice to Medicare Patients. (Medicare replacement policies are not the same as Medicare)

Emergency Contact **Emergency Contact's Phone**

Your Occupation

Your Employer

Work Phone

Address

May we contact you at work? ○ Yes ○ No

City **State/Province** **ZIP/Postal Code**

Preferred method of contact? ○ Home Phone ○ Cell Phone ○ Work Phone ○ Email

Primary Care Provider's Name

Request for Confidential Communication and Use of Email

Our office uses text messaging, as well as email to contact our patients regarding care, appointment reminders, holiday closures, or other announcements pertinent to our office.

Please read and complete the required areas to the right advising how you would prefer we disclose detailed and/or potentially sensitive information to you in the event we must contact you.

You may..

contact me via home and/or cell phone	☐ Yes	No
leave a detailed message on my home answering	Yes	No
machine leave a detailed message on my cell phone	Yes	No
contact me via text message	Yes	No
mail correspondence to my home address	Yes	No
leave a detailed message with someone I trust	Yes	No

If yes, who: _____ Relationship: _____ Phone #: _____

CONFIDENTIAL HEALTH INFORMATION

1. The symptom(s) that have prompted me to seek care today include: _____

_____

2. And are the result of (darken circle): ◯ An accident or injury

◯ Work ◯ Auto ◯ Other _____

◯ A worsening long-term problem

◯ An interest in: ◯ Wellness ◯ Other _____

3. Onset (When did you first notice your current symptoms?)

_____

4. Intensity (How extreme are your current symptoms?)

0 ◯◯◯◯◯◯◯◯◯◯ 10

Absent Uncomfortable Agonizing

5. Duration and Timing (When did it start and how often do you feel it?)

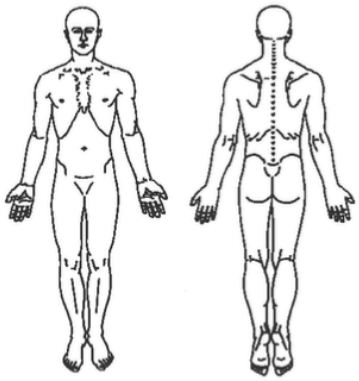
◯ Constant ◯ Comes and goes. How Often? _____

_____

6. Quality of symptoms (What does it feel like?)

◯ Numbness
◯ Tingling
◯ Stiffness
◯ Dull
◯ Aching
◯ Cramps
◯ Nagging
◯ Sharp
◯ Burning
◯ Shooting
◯ Throbbing
◯ Stabbing
◯ Other _____

7. Location (Where does it hurt?) Circle the area(s) on the illustration.
"0" for current condition
"X" for conditions experienced in the past



8. Radiation (Does it affect other areas of your body? To what areas does the pain radiate, shoot or travel.)

_____

9. Aggravating or relieving factors (What makes it better or worse, such as time of day, movements, certain activities, etc.)

What tends to worsen the problem? _____

What tends to lessen the problem? _____

10. Prior interventions (What have you done to relieve the symptoms?)

◯ Prescription medication ◯ Surgery ◯ Ice
◯ Over-the-counter drugs ◯ Acupuncture ◯ Heat
◯ Homeopathic remedies ◯ Chiropractic Other _____
◯ Physical therapy ◯ Massage _____

11. What else should we know about your current condition? _____

_____

12. How does your current condition interfere with your:

Work or career: _____

Recreational activities: _____

Household responsibilities: _____

Personal relationships: _____

13. Review of Systems

Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please darken the circle beside any condition that you've **Had** or currently **Have** and initial to the right.

a. Musculoskeletal

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
◯	◯	Osteoporosis	◯	◯	Arthritis	◯	◯	Scoliosis	◯	◯	Neck pain	◯	◯	Back problems	◯	◯	Hip disorders
◯	◯	Knee injuries	◯	◯	Foot/ankle pain	◯	◯	Shoulder problems	◯	◯	Elbow/wrist pain	◯	◯	TMJ issues	◯	◯	Poor posture

NONE ◯ Initials ____

b. Neurological

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
◯	◯	Anxiety	◯	◯	Depression	◯	◯	Headache	◯	◯	Dizziness	◯	◯	Pins and needles	◯	◯	Numbness

NONE ◯ Initials ____

c. Cardiovascular

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
◯	◯	High blood pressure	◯	◯	Low blood pressure	◯	◯	High cholesterol	◯	◯	Poor circulation	◯	◯	Angina	◯	◯	Excessive bruising

NONE ◯ Initials ____

d. Respiratory

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
◯	◯	Asthma	◯	◯	Apnea	◯	◯	Emphysema	◯	◯	Hay fever	◯	◯	Shortness of breath	◯	◯	Pneumonia

NONE ◯ Initials ____

e. Digestive

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
◯	◯	Anorexia/bulimia	◯	◯	Ulcer	◯	◯	Food sensitivities	◯	◯	Heartburn	◯	◯	Constipation	◯	◯	Diarrhea

NONE ◯ Initials ____

f. Sensory

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
◯	◯	Blurred vision	◯	◯	Ringing in ears	◯	◯	Hearing loss	◯	◯	Chronic ear infection	◯	◯	Loss of smell	◯	◯	Loss of taste

NONE ◯ Initials ____

g. Skin

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
◯	◯	Skin cancer	◯	◯	Psoriasis	◯	◯	Eczema	◯	◯	Acne	◯	◯	Hair loss	◯	◯	Rash

NONE ◯ Initials ____

(Continued from previous page)

h. Endocrine

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE ○
○	○	Thyroid issues	○	○	Immune disorders	○	○	Hypoglycemia	○	○	Frequent infection	○	○	Swollen glands	○	○	Low energy	Initials ____

i. Genitourinary

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE ○
○	○	Kidney stones	○	○	Infertility	○	○	Bedwetting	○	○	Prostate issues	○	○	Erectile dysfunction	○	○	PMS symptoms	Initials ____

j. Constitutional

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE ○
○	○	Fainting	○	○	Low libido	○	○	Poor appetite	○	○	Fatigue	○	○	Sudden weight gain/loss (circle one)	○	○	Weakness	Initials ____

Past Personal, Family and Social History

Please identify your past health history, including accidents, injuries, illnesses and treatments. Please complete each section fully.

PERSONAL

14. Illnesses

Check the illnesses you have **Had** in the past or **Have** now.

Had	Have		Had	Have	
○	○	AIDS	○	○	Tuberculosis
○	○	Alcoholism	○	○	Typhoid fever
○	○	Allergies	○	○	Ulcer
○	○	Arteriosclerosis	○	○	Other: _____
○	○	Cancer			
○	○	Chicken pox			
○	○	Diabetes			
○	○	Epilepsy			
○	○	Glaucoma			
○	○	Goiter			
○	○	Gout			
○	○	Heart disease			
○	○	Hepatitis			
○	○	HIV Positive			
○	○	Malaria			
○	○	Measles			
○	○	Multiple Sclerosis			
○	○	Mumps			
○	○	Polio			
○	○	Rheumatic fever			
○	○	Scarlet fever			
○	○	Sexually transmitted disease			
○	○	Stroke			

17. Allergies

Are you allergic to any medications?

Yes ○ No ○ If Yes please list: _____

15. Operations

Surgical interventions, which may or may not have included hospitalization.

- ○ Appendix removal
- ○ Bypass surgery
- ○ Cancer
- ○ Cosmetic surgery
- ○ Elective surgery: _____
- ○ Eye surgery
- ○ Hysterectomy
- ○ Pacemaker
- ○ Spine _____
- ○ Tonsillectomy
- ○ Vasectomy
- ○ Other: _____

16. Treatments

Check the ones you've received in the **Past** or are receiving **Currently**.

Past	Currently	
○	○	Acupuncture
○	○	Antibiotics
○	○	Birth control pills
○	○	Blood transfusions
○	○	Chemotherapy
○	○	Chiropractic care
○	○	Dialysis
○	○	Herbs
○	○	Homeopathy
○	○	Hormone replacement
○	○	Inhaler
○	○	Massage therapy
○	○	Physical therapy
○	○	Medications

(Please list below all prescription, over-the-counter, natural supplements, enzymes, vitamins and minerals): _____

18. Injuries

Have you ever...

- ○ Had a fractured or broken bone
- ○ Had a spine or nerve disorder
- ○ Been knocked unconscious
- ○ Been injured in an accident
- ○ Used a crutch or other support
- ○ Used neck or back bracing
- ○ Received a tattoo
- ○ Had a body piercing

FAMILY

19. Family History

Some health issues are hereditary. Tell us about the health of your immediate family members.

Relative	Age (If living)	State of health Good	Poor	Illnesses	Age at death	Cause of death Natural	Illness
Mother		○	○			○	○
Father		○	○			○	○
Sister 1		○	○			○	○
Sister 2		○	○			○	○
Brother 1		○	○			○	○
Brother 2		○	○			○	○
_____		○	○			○	○

20. Are there any other hereditary health issues that you know about? _____

SOCIAL

21. Social History

Tell us about your health habits and stress levels.

Alcohol use	○ Daily	○ Weekly	How much? _____	Prayer or meditation?	○ Yes ○ No
Coffee use	○ Daily	○ Weekly	How much? _____	Job pressure/stress?	○ Yes ○ No
Tobacco use	○ Daily	○ Weekly	How much? _____	Financial peace?	○ Yes ○ No
Exercising	○ Daily	○ Weekly	How much? _____	Vaccinated?	○ Yes ○ No
Pain relievers	○ Daily	○ Weekly	How much? _____	Mercury fillings?	○ Yes ○ No
Soft drinks	○ Daily	○ Weekly	How much? _____	Recreational drugs?	○ Yes ○ No
Water intake	○ Daily	○ Weekly	How much? _____		

Hobbies: _____

22. Activities of Daily Living

How does this condition currently interfere with your life and ability to function?

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	○	○	○	○
Rising out of chair	○	○	○	○
Standing	○	○	○	○
Walking	○	○	○	○
Lying down	○	○	○	○
Bending over	○	○	○	○
Climbing stairs	○	○	○	○
Using a computer	○	○	○	○
Getting in/out of car	○	○	○	○
Driving a car	○	○	○	○
Looking over shoulder	○	○	○	○
Caring for family	○	○	○	○

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Grocery shopping	○	○	○	○
Household chores	○	○	○	○
Lifting objects	○	○	○	○
Reaching overhead	○	○	○	○
Showering or bathing	○	○	○	○
Dressing myself	○	○	○	○
Love life	○	○	○	○
Getting to sleep	○	○	○	○
Staying asleep	○	○	○	○
Concentrating	○	○	○	○
Exercising	○	○	○	○
Yard work	○	○	○	○

23. What is the major stressor in your life? _____

24. How much sleep do you average per night? _____ **Hours**

25. What is the type and approximate age of your mattress and pillow? _____

26. What is your preferred sleeping position? _____

27. Describe your typical eating habits: ○ Skip breakfast ○ Two meals a day ○ Three meals a day ○ Snacking between meals

28. What would be the most significant thing that you could do to improve your health? _____

_____

29. In addition to the main reason for your visit today, what additional health goals do you have? _____

_____

Acknowledgements

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initials ____ **I instruct the chiropractor to deliver the care that, in his or her professional judgement, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.**

Initials ____ **I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.**

Initials ____ **I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY):** _____

Initials ____ **I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.**

Initials ____ **To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.**

If the patient is a minor child, print child's full name: _____

_____ _____

Signature Date (MM/DD/YYYY)

Patient Name: _____

Injury History (General):

Was the crash on the job? ☐ Yes ☐ No
You were: ☐ Driver ☐Front seat passenger ☐Rear seat passenger
☐ Motorcycle operator ☐ Motorcycle passenger ☐ Other: _____
Vehicle driven by: _____
Your vehicle (year, make, model) : _____
Estimated speed at moment of crash: _____ ☐Stopped ☐ Slowing ☐ Accelerating
Other vehicle (year, make, model):_____
Time of day: ☐ Daylight ☐ Dawn ☐ Dusk ☐ Dark
Road conditions: ☐ Dry ☐ Damp ☐ Wet ☐ Snow ☐ Ice ☐ Other: _____
Head restraints: ☐ None ☐ Integral type ☐ Adjustable type: (☐ UP / ☐ Down)
If adjustable, was the position altered by the crash? ☐ Yes ☐ No
Was the seat back adjusted altered by the crash? ☐ Yes ☐ No
Was the seat broken? ☐ Yes ☐ No
Lap Belt: ☐ Wearing ☐ Not wearing ☐ Not Sure
Shoulder Belt? ☐ None ☐ Wearing ☐ Not wearing ☐ Not Sure
Did the airbag deploy? ☐ Yes ☐ No If yes, were you struck? ☐ Yes ☐ No
Body position: ☐ Good ☐ Forward lean ☐ Other
Head position: ☐ Forward ☐ Left ___° ☐ Right ____° ☐ Up ____° ☐ Down ___°
Hands: ☐ One on wheel ☐ Two on wheel ☐ N/A
Brakes applied: ☐ Yes ☐ No

Crash Description:

_____
_____
_____

Crash Diagram:

Aware of impending crash? ☐ Yes ☐ No

During the crash:

Did you strike any parts of the vehicle? ☐ Yes ☐ No
If yes, describe; _____
Did the vehicle strike any objects after crash? ☐ Yes ☐ No
If yes, describe; _____
Wearing a hat or glasses? ☐ Yes ☐ No
If yes, still on after crash? ☐ Yes ☐ No
Did you lose consciousness? ☐ Yes ☐ No
If yes, for how long; _____

Patient Name: _____

Estimated property damage to your car **$** _____
Estimated damage to other vehicle? ☐ None ☐ Minimal ☐ Moderate ☐ Major
Were the police on the scene? ☐ Yes ☐ No
If yes, was a report made? ☐ Yes ☐ No

After the crash:
Symptoms: ☐ Headache ☐ Dizziness ☐ Nausea
☐ Confusion/disorientation ☐ Paresthesai(s)
If yes, where? _____
☐ Back pain ☐ Extremity pain. If yes, where? _____
When did the symptoms first appear? ☐ Immediately
If so, describe which symptom _____, _____ hr afterward
Where did you go after the crash? ☐ Hospital ☐ Work ☐ Home ☐ Other
Mode of transportation _____
Previous treating doctor: _____

Emergency Department:
Radiographs: ☐ Yes ☐ No
Body parts imaged: _____
What were the results: _____
Lab work: ☐ Yes ☐ No

Treatment History:
1) Dr. (Name & #) _____
Specialty: _____ Date first seen: _____
Referred by: _____ Treatment type: _____
Treatment frequency: _____ Treatment duration: _____
Currently treating: ☐ Yes ☐ No Any Disability: ☐ Yes ☐ No
If yes, describe:_____
Special Tests: _____ Referred to:_____
Did treatment help? ☐ Yes ☐ No
Notes: _____

2) Dr. (Name & #) _____
Specialty: _____ Date first seen: _____
Referred by: _____ Treatment type: _____
Treatment frequency: _____ Treatment duration: _____
Currently treating: ☐ Yes ☐ No Any Disability: ☐ Yes ☐ No
If yes, describe:_____
Special Tests: _____ Referred to:_____
Did treatment help? ☐ Yes ☐ No
Notes: _____

Current chief complaints:
1) **Body part/system:** _____
Onset: _____
Provocative: _____

OFFICE OF INSURANCE REGULATION
Bureau of Property & Casualty Forms and Rates

Standard Disclosure and Acknowledgement Form
Personal Injury Protection - Initial Treatment or Service Provided

The undersigned insured person (or guardian of such person) affirms:

1. The services or treatment set forth below were **actually rendered.** This means that those services have **already been provided.**

_____

_____

2. I have the right and the **duty to confirm** that the services have already been provided.

3. I was **not solicited** by any person to seek any services from the medical provider of the services described above.

4. The medical provider has **explained** the services to me for which payment is being claimed.

5. If I notify the insurer in writing of a billing error, I may be entitled to a portion of any reduction in the amounts paid by my motor vehicle insurer. If entitled, my share would be at least 20% of the amount of the reduction, up to $500.

Insured Person (patient receiving treatment or services) or Guardian of Insured Person:

Name *(PRINT or TYPE)*	Signature	Date

The undersigned licensed medical professional or medical director, if applicable, affirms the statement numbered 1 above and also:

A. I have **not solicited** or caused the insured person, who was involved in a motor vehicle accident, to be solicited to make a claim for Personal Injury Protection benefits.

B. The treatment or services rendered were explained to the insured person, or his or her guardian, **sufficiently** for that person to sign this form with informed consent.

C. The accompanying statement or bill is **properly completed** in all material provisions and all relevant information has been provided therein. This means that each request for information has been responded to **truthfully, accurately**, and in a **substantially complete** manner.

D. The coding of procedures on the accompanying statement or bill is proper. This means that **no service has been upcoded, unbundled**, or constitutes an invalid **or not medically necessary diagnostic test** as defined by Section 627.732(14) and (15), Florida Statutes or Section 627.736(5)(b)6, Florida Statutes.

Licensed Medical Professional Rendering Treatment/Services or Medical Director, if applicable *(Signature by his/ her **own hand**)*:

Name *(PRINT or TYPE)*	Signature	Date

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of Claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree per Section 817.234(1)(b), Florida Statutes.

Note: The **original** of this form must be furnished to the insurer pursuant to Section 627.736(4)(b), Florida Statutes and may **not** be electronically furnished. Failure to furnish this form may result in non-payment of the claim.

OIR-B1-1571
Pub. 1/2004

STEVENS CHIROPRACTIC & WELLNESS CENTER

Assignment and Authorization

You are hereby authorized to disclose and/or furnish my attorney(s)/insurance company with any and all medical information, bills, and/or records in your possession which they request in reference to any illnesses and injuries which I have suffered.

I further, irrevocably assign to you, and authorize and direct said attorneys/insurance company to pay from the proceeds of any recovery/claim in my case all reasonable fees for services provided by you, including fees for preparation and testimony, as a result of the injury or condition heretofore mentioned. I understand that this in no way relieves me of my personal primary obligation to pay for such services and that the signing of this form does not prohibit customary billing to you. All bills shall be paid promptly in the usual manner. This specifically includes but is not limited to any and all PIP, Med-Pay, or Med Expense payments.

It is further understood that the statute of limitations in this State is three (3) years from the time said services were last performed and I further understand that because of long delays in trial dockets, many cases are not tried or settled until a date which is beyond (3) three years after the last service was performed. In view of this, I hereby agree that the statute of limitations with respect to any claim for services mentioned above will not begin to run until there is a denial in writing by me of any balance claimed to be due and owing to you by me.

Signature: _____

Address: _____

_____

If above Signature is not patient, Relationship to patient: _____

Witness: _____ Date: _____

THE UNDERSIGNED ATTORNEY FOR THE PATIENT REFERRED TO ABOVE HEREBY AGREES TO COMPLY FULLY WITH THE FOREGOING "AUTHORIZATION AND ASSIGNMENT"AND AGREES TO ADVISE THE NAMED ASSIGNEE IN WRITING THE STATUS OF THE CLAIM OF THE PATIENT WITHIN (10) TEN DAYS OF THE REQUEST, AND AGREES TO NOTIFY THE ASSIGNEE IF THE ATTORNEY CEASES TO REPRESENT THIS PATIENT AND/OR IF THE CLAIM IS DROPPED OR DENIED.

_____ Address: _____

Attorney Signature

_____

_____ Telephone: _____

Print Name as Signed Above

Stevens Chiropractic & Wellness Center
14090 Metropolis Ave. Suite 101
Fort Myers, FL 33912
239-489-4100