MIAMI CHIROPRACTIC & MOVEMENT

Date _____

Personal History Form

The following is a confidential questionnaire which will help us determine the best possible course of treatment for you. Please take your time and complete the information accurately. Thank you!

Name _____

Address _____ City _____ State _____ Zip _____

Home phone _____ Business phone _____

Cell phone _____ e-mail address _____

Gender: Male Female Birth Date _____ Age _____

Employer _____ Occupation _____

Employment address _____

In case of emergency contact _____ Phone _____

Referred by _____ Have you ever been treated by a chiropractor before? Yes No

How would you describe your chief complaint at this time?

_____

_____

When did it start? _____
(Include month and year, day if known)

What makes the pain worse? _____

What makes the pain better? _____

How would you describe your pain? _____

At what time of the day or week is your pain worse? _____

The pain is: Intermittent Constant

Have you had this problem in the past? _____ If so, how often? _____

Is your pain the result of a motor vehicle accident? _____

Have you filed a legal suit? _____

Is your pain the result of a work related injury? _____

If so, have you filed a worker's compensation claim? _____

Name _____ **Date**_____

My Chief Complaint is _____ **My Secondary Complaint is** _____

I) CURRENT STATUS -

1. Since my most recent episode of pain, my overall status is:

□ Very Much (80%) better

□ Much (50%) better

□ Minimally (20%) better

□ No Change

□ Minimally (20%) Worse

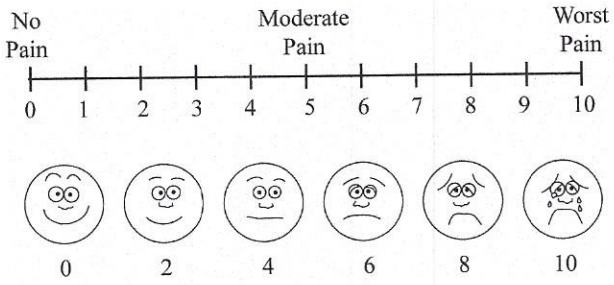
□ Much (50%) Worse

□ Very Much (80%) Worse

II) PAIN -

2. Please indicate your usual level of pain & worst pain during the past week:

No pain 0 1 2 3 4 5 6 7 8 9 10 Worst possible pain



3a. Are you taking any MEDICATION (PAIN KILLERS) for your symptoms? (pick ONE)

□ Never □ Rarely □ Sometimes □ Every day

SKIP 3b. if the answer to 3a. was Never

3b. If you are taking any MEDICATION (PAIN KILLERS) pick ONE:

□ I have ⬇ them □ I am taking about the SAME amount □ I have ⬆ them

4. If you had to spend the rest of your life with your <u>condition as it is right now</u>, how would you feel about it?

Delighted 0 1 2 3 4 5 6 7 8 9 10 Terrible

III) ACTIVITY TOLERANCE -

5. On a scale of 0 to 10, how certain (confident) are you that you will be doing normal activities or working in <u>six months</u>?

Very certain 0 1 2 3 4 5 6 7 8 9 10 Not certain at all

6. How confident are you that you are moving in the right direction?

Very confident 0 1 2 3 4 5 6 7 8 9 10 Not confident at all

7. Physical activity (in general) makes my pain worse?

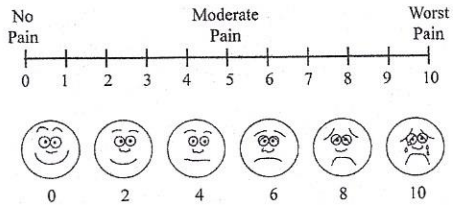
Completely disagree 0 1 2 3 4 5 6 7 8 9 10 Completely agree

8. What specific daily tasks give you the most problems, & rate the pain (0-10) of each?

1:_____ Pain:_____

2:_____ Pain:_____

3:_____ Pain:_____



IV) FITNESS -

9. List your 3 most strenuous weekly activities or workouts - time (min), level of exertion (RPE), frequency/week

Activity 1:_____

Avg. Duration of Activity:_____ Min.

RPE:_____Days/week _____

Activity 2:_____

Avg. Duration of Activity:_____ Min.

RPE:_____Days/week _____

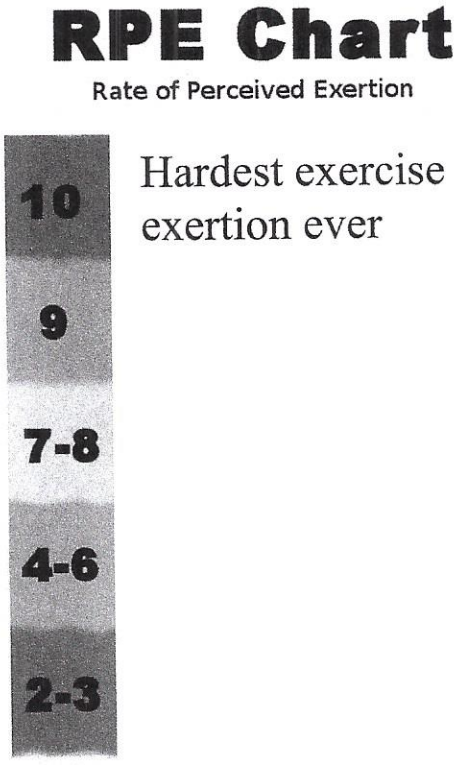
Activity 3:_____

Avg. Duration of Activity:_____ Min.

RPE:_____Days/week _____

_____

Signature

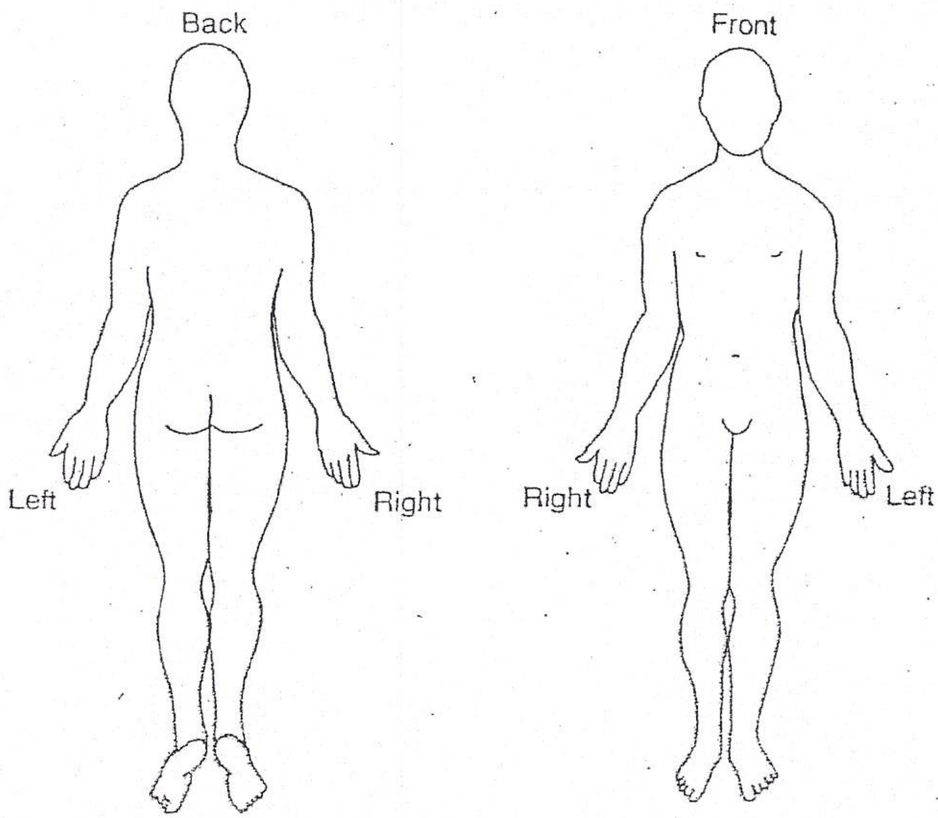


Pain Drawing

Date: ______________________ Name: ________________________________

Draw location of your pain on body outlines

Ache	Burning	Numbness	Pins and Needles	Stabbing	Other
ΛΛΛΛ	= = = =	ꝏꝏ	. . . .	////////	XXXXX
ΛΛ	= = = =	ꝏ	. . . .	////	XXX



Please list accidents, injuries, surgeries, and hospitalizations you have had.

_____ Date or Age _____

_____ Date or Age _____

_____ Date or Age _____

Do you or other family members have a history of any of the following?

Arthritis	Self	Family member _____
Asthma	Self	Family member _____
Cancer	Self	Family member _____
Diabetes	Self	Family member _____
Heart Disease	Self	Family member _____
Hypertension	Self	Family member _____
Hypoglycemia	Self	Family member _____
Kidney Disease	Self	Family member _____
Depression	Self	Family member _____
Mental Illness	Self	Family member _____

Do you drink coffee or black tea? _____ If so, how much per day? _____

Do you smoke tobacco? _____ If so, how much per day? _____

Do you drink alcohol? _____ If so, how often? _____

What medications, vitamins, supplements, herbs do you take?

Name	**Reason**
_____	_____
_____	_____
_____	_____
_____	_____

Please list any allergies that you have.

_____

MIAMI CHIROPRACTIC & MOVEMENT

Financial Agreement

Please remember that insurance is considered a method of reimbursing the patient for fees put to the doctor and is NOT A SUBSTITUTE FOR PAYMENT. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance.

IN ORDER TO CONTROL YOUR OUTSTANDING BALANCE, IT IS OUR POLICY TO COLLECT CO-PAYS, CO-INSURANCE AND DEDUCTIBLE AT TIME OF SERVICE.

If this account is assigned to an attorney/outside agency for collection and/or suit, Flex Chiropractic shall be entitled to reasonable attorney's fees and for cost of collection.

I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim.

_____ _____

PATIENT'S / GUARDIAN'S SIGNATURE INSURED'S SIGNATURE

_____

DATE

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to Flex Chiropractic all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

_____ _____

PATIENT'S / GUARDIAN'S SIGNATURE DATE

MIAMI CHIROPRACTIC & MOVEMENT

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date:

Parent or Guardian: _____ Signature: _____ Date:

Witness Name: _____ Signature: _____ Date:

HIPAA Consent

1. How Chiropractic & Medical Information About You May Be Used and Disclosed

2. How You Can Get Access to This Information and;

3. Our "Open Adjustment" Environment.

PLEASE READ CAREFULLY

In the course of your care as a patient at Miami Chiropractic & Movement we may use or disclose personal and health related information about you in the following ways:

1. Your personal health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.

2. Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or may become responsible for the payment of your services.

3. Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.

If you are not at home to receive an appointment reminder, a message may be left on your answering machine. Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provided to you or the reimbursement avenues associated with your care.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

1. If we are provided health care services to you based on the orders of another health care provider.

2. If we provide health care services to you in an emergency.

3. If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.

4. If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.

5. If we are ordered by the courts or another appropriate agency.

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization. We normally provide information about your health to you in person at the time your receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home, or, if you would like the information at an address other than your home or, if you would like the information in a different from please advise us in writing as you your preferences.

You have the right to inspect and/ or copy your health information for seven years from the date that record was created or as long as the information remains in or files. In addition you have right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files. Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

If you would like further information about our privacy policies and practices please or have a concern regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your inquiry or concern to the clinic staff.

This office may use an "open-care" environment for ongoing patient care. "Open-care" involves several patients receiving treatment in the same are at the same time. Patients are within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and this is NOT the environment used for taking patient histories, provided examinations or presenting report of findings. These procedures are completed in a private, confidential setting. The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. If you choose not to receive treatment in an open-care environment other arrangements will be made for you. Your signature below indicates your authorization of this activity. This notice is effective immediately. This notice, and any alterations or amendments made hereto, will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the practice's office will prepare any necessary reports and forms to file such insurance on my behalf. However, I clearly understand and agree that all services rendered me are charged directly to me and I am ultimately personally responsible for payment.

I hereby authorize the practice to treat my condition as it deems appropriate. If I do not agree to a treatment, I must notify the practice ahead of time.

Patient Signature:

_____

Date: _____

Parent/Guardian Signature for Minor:

_____

Date: _____