College Parkway Health Center

6371 Presidential Ct. Suite 4
Fort Myers, FL 33919

APPLICATION FOR TREATMENT

Date:_____

Patient Title: *(check one)* ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ Dr. ❑ Prof. ❑ Rev.

Name: _____ Nickname: _____

Address: _____

City:_____ State: _____ Zip: _____

If you are a seasonal resident please check here ❑ Local Address:_____

City_____ State_____Zip _____

SSN: _____ Age: _____ DOB: _____ Sex: _____

Martial Status: ❑*Single* ❑ *Married* ❑*Divorced* ❑*Widow* ❑*Other* _____Name of Spouse:_____

Phone #: (*H*)_____ (*Cell*)_____ (*W*)_____

Home email _____
By providing my email address, I authorize my doctor to contact me via the email address(es) provided.

Contact method: ❑*Home phone* ❑*Work phone* ❑*Cell phone* ❑*Home email*

Employment status: ❑ Employed ❑Retired ❑Other

Occupation: _____ Employer: _____

Student: ❑*Yes* ❑*No* ❑*Full Time* ❑*Part Time* Name of School: _____

How did you find our office: ❑Internet ❑Walk by ❑Other:_____ ❑Referral from friend/family

WHO can we thank for referring you to our office?_____

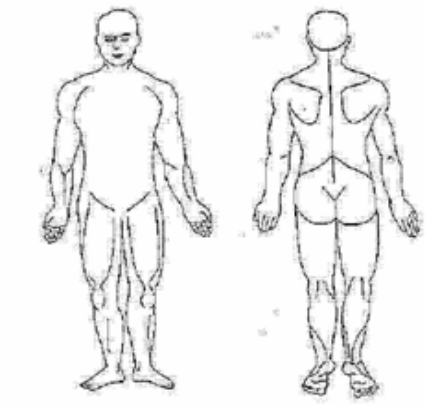
EMERGENCY CONTACT INFORMATION:

Name:_____

Phone:_____Relation to patient:_____

DESCRIBE YOUR MAJOR COMPLAINTS:

(please mark exact location of pain on diagram)



_____

_____

_____

Have you ever been to a chiropractor? ❑Yes ❑No

Name(s) & Location_____

Is there any possibility of pregnancy at this time? ❑Yes ❑No

Do you have a pacemaker? ❑Yes ❑No

What do you hope to achieve with Chiropractic Care? ❑Relief of symptoms only ❑Total corrective care/Optimal Health

Height:_____ Weight:_____ BP:_____Pulse:_____ Temp:_____

CHECK SYMPTOMS YOU HAVE NOTICED

❑ Headache	❑ Irritability	❑ Shortness of breath	❑ Face Flushed	❑ Neck Pain
❑Balance changes	❑ Fatigue	❑ Diarrhea	❑ Loss of smell	❑ Chest Pain
❑ Sleep Problems	❑ Pins & Needles in arms	❑ Depression	❑ Fainting	❑ Balance
❑ Head seems heavy	❑ Pins & Needles in legs	❑ Light bothers eyes	❑ Constipated	❑ Hands Cold
❑ Nervousness	❑ Numbness in fingers	❑ Loss of memory	❑ Loss of taste	❑ Back Pain
❑ Tension	❑ Numbness in toes	❑ Ringing in ear(s)	❑ Upset stomach	❑ Fever
❑ Feet Cold	❑ Cold sweats			

WHEN and HOW did your CURRENT condition develop?_____

Quality of the complaint:❑Dull❑aching❑sharp❑shooting❑burning❑throbbing❑deep❑nagging ❑other:_____

Does this complaint radiate or travel(shoot) to any areas of your body? Where?_____

Do you have any numbness or tingling in your body? Yes/ NO Where?_____

Grade intensity/severity: ❑ (none) ❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑9 ❑10(worst pain/complaint imaginable)

How frequent is the complaint present, how long does it last?_____

Does anything aggravate the complaint?_____

Does anything make the complaint better?_____

Have you ever had this or a similar problem before? if yes, when, where, what were the results_____

_____

Has your condition been getting better, worse, or staying the same?:_____

How has this affected your home life:_____

LIFESTYLE Rest & Sleep (#hours/position): _____ Hrs; Position: ❑*right side* ❑*left side* ❑*stomach* ❑*back*

Exercise/Recreation Activities: ❑*run* ❑*walk* ❑*lift weights* ❑*stretches* ❑*golf* ❑*tennis* ❑*swim* ❑*other:*_____

Diet: ❑*controlled* ❑*out of control* ❑*vegetarian* ❑*vegan* ❑*no red meat* ❑*gluten free* ❑*diabetic*

Allergies/restrictions_____ ❑*personal* ❑*medical necessity*

Alcohol: ❑*none* ❑*social* ❑*light* ❑*moderate* ❑*heavy;* Caffeine: ❑*none* ❑*1 cup/day* ❑*2-4 cups/day* ❑*5+ cups/day*
Cigarettes: ❑*none* ❑*light* ❑*moderate* ❑*heavy;* IF NONE: ❑*Never smoked* ❑*Quit:* _____ *ago*
Medications/supplements/vitamins/recreational drugs(provide a separate list if need be)*:*_____

_____

Any auto accidents: ❑*yes* ❑*no* Date*:*_____ Any Falls: ❑*yes* ❑*no* Date:_____

Explain:_____

Have you had ANY surgeries:_____

ANY hospitalizations?_____

PERSONAL HISTORY Do YOU have/had: ❑high blood pressure ❑low blood pressure ❑ Any heart problems
❑Aneurysms ❑Phlebitis ❑HIV ❑Diabetes ❑ Cancer ❑ Other _____
If YES to any, explain:_____

FAMILY HISTORY

Has anyone in your immediate family had ❑high blood pressure ❑low blood pressure ❑ Any heart problems
❑Aneurysms ❑Phlebitis ❑HIV ❑Diabetes ❑ Cancer ❑ Other _____
Explain: (who/what) _____

Fees are payable at time of examination and treatment are received unless other arrangements are made in advance.
Records remain the property of this clinic.

SIGNATURE:_____DATE:_____

Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may affect the restoration and preservation of health. Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

_____ _____ _____

Print Name Signature Date

Consent to evaluate and adjust a minor child:

I, _____ being the parent or legal guardian of _____ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

Doctor's Signature _____

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an X-ray evaluation. I have been advised that X-rays can be hazardous to an unborn child.

Date of last menstrual cycle:_____

_____ _____ _____

Print Name Signature Date

Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

Verification Question *(choose only one question by circling the question, then give the answer to that question)*

❑ What is the name of your favorite pet? ❑ In what city were you born? ❑ What high school did you attend?
❑ What is your favorite movie? ❑ What is your mother's maiden name? ❑ On what street did you grow up?
❑ What was the make of your first car? ❑ When is your anniversary? ❑ What is your favorite color?

Verification Answer to the Chosen question: _____

Do you currently smoke tobacco of any kind? ❑ Yes ❑ Former smoker ❑ Never been a smoker

If yes, how often do you smoke: ❑ Current every day smoker ❑ Current sometimes smoker

If yes, what is your level of interest in quitting smoking?

❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10
No interest *Very Interested*

Race *(check one)* ❑ Asian ❑ Asian Indian ❑ Chinese ❑ Filipino
❑ White ❑ Black/African American ❑ Hispanic ❑ American Indian/Alaskan Native
❑ Japanese ❑ Korean ❑ Vietnamese ❑ Native Hawaiian or other Pacific Island
❑Samoan ❑ Guamanian or Chamorro ❑Other_____ ❑ I choose not to specify

Multi-Racial *(check one)* ❑Yes ❑No ❑ Unknown

Ethnicity *(check one)* ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ I choose not to specify

Are you currently taking any medications?(Please include regularly used over the counter medications)If none check here: ❑

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

Do you have any medication ALLERGIES? If none check here: ❑

Medication Name	Reaction	Onset Date	Additional Comments

Briefly list your main health problems: _____

Has any doctor diagnosed you with Hypertension presently? ❑ Yes ❑ No If yes, describe: _____

Has any doctor diagnosed you with Diabetes presently?❑ Yes ❑ No If yes, what kind? ❑ Type I ❑ Type II

If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%? ❑ Yes ❑ No ❑ Not Sure

If yes, other comments regarding Diabetes: _____

Have you had an X-ray or CT scan or MRI of your low back spine in the past 28 days? ❑ Yes ❑ No

PATIENT PRIVACY CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer. You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name:_____ Signature _____ Date_____

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

To Our Valued Patient:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule." We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate use of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

Thank you for being one of our highly valued patients.

COLLEGE PARKWAY HEALTH CENTER

Authorization for Release of Information

Patient Name:_____ Date of Birth:_____

Many of our patients allow friends or family members such as their spouse, parents or others to call and request medical and billing information. Under the requirements of HIPAA, we are not allowed to give this information to anyone without the patient's consent.

If you wish to have your medical or billing information released to someone, you must sign this form. Signing this form will only give information to the people listed below. Keep in mind individuals not listed will have **NO** information given to them in regards to your status at the office, appointment details and whereabouts.

Check here if you do not wish to share your information with anyone❑

I authorize College Parkway Health Center to release my medical and/or billing information to the following individual(s):

Name_____ Relation to the patient:_____

Name _____ Relation to the patient:_____

Name _____ Relation to the patient:_____

Name _____ Relation to the patient:_____

Patient information

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed.

I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to re-disclosure by the above recipient.

You have the right to revoke this consent in writing.

Print Name:_____

Signature:_____ Date:_____

Modality Contraindications

PLEASE READ THE FOLLOWING INFORMATION REGARDING CONTRAINDICATIONS AND NOTIFY THE DOCTOR IF **ANY** OF THESE CONDITIONS APPLY TO YOU **OR IF YOU ARE UNSURE, PLEASE ASK!!!**

Please Circle any Contraindications that you have.

A **contraindication** is a condition or factor that serves as a reason to withhold a certain medical treatment due to the harm that it could cause the patient.

The use of these machines is for symptomatic relief of chronic, intractable pain, muscle spasm and joint contractures.

Electrical Stimulation Contraindications

*Demand type cardiac pacemakers

*Use over cancerous lesions

Laser Therapy Contraindications

*Over abdomen during pregnancy

*Over pacemakers

*Over cancerous lesions

*Use on patients who are taking drugs that have heat or light sensitive contraindications (i.e. Steroids)

*Over epiphyseal plates in children

I,_____ have read the above statement and to the best of my knowledge, do not have any of the above listed contraindications to the use of electrical stimulation and Laser therapy.

❑I do have a contraindication to one or more of the therapies listed above and have circled it to inform my doctor.

_____ _____

Signature Date