11401 North 56th St, Suite 18
Temple Terrace, Fl 33617
Phone: (813) 988-8088
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Dr. Michael Major, D.C.
Diplomate In Neurology
www.major-chiro.com

PATIENT INFORMATION

Date: _____

Sex: M____ F ____ **Marital Status:** S____ M ____ W ____ D ____ Minor ____

Name: _____ **DOB:** _____ **SS#** _____

Address: _____ **City**: _____

State: _____ **Zip:** _____

E-mail:_____ **Phone:** _____ **Cell:** _____

Occupation: _____

Patient Employer/School: _____

Employer/School Address: _____ **Phone:** _____

Emergency Contact: _____ **Phone:** _____

Primary Care Doctor (PCP): _____ **Phone**: _____

ACCIDENT INFORMATION

Date of the Accident/Injury: _____

Where Accident/Injury happened: _____

Type of Accident: Auto Accident _____ Slip & Fall _____ Work _____ Home _____ Other_____

Were you the: Driver ____ or Passenger ____ **Were you sitting in the**: Front Seat ____ Back Seat ____

Speed:_____ **Impact was:** Front ____ Behind ____ Left Side ____ Right Side ____

Did you go to the hospital: Yes ____ No ____ Inmediately ____ Same Day ____ Next Day____ Other____

Facility Name: _____

PATIENT CONDITION

Type of pain: Sharp ____ Dull ____ **Is your pain:** Constant ____ Occacional ____, **Worse in** AM ____ PM ____

Does the pain: Radiate into an extremity ____ Stay in one area ____

Does it interfere with your: Work____ Sleep ____ Daily Routine ____ Recreation____

Height:_____ **Weight:**_____

Is there any other injury to your spine, minor or major, that the Doctor should know about?_____

_____

Have you ever consulted a Chiropractor in the past? YES_____ **NO**_____

Dr._____ **When**_____ **Phone**_____

Patient Singnature_____ **Date**_____

REVIEW OF SYSTEMS

Do you currently have or have had any problems with: ***Circle One***

Constitutional

Fever or Chills	Yes / No
Weight Loss or Gain (circle)	Yes / No
Chronis Fatigue	Yes / No
Night Sweats	

Eyes

Wear Glasses or Contacts	Yes / No
Dry Eyes	Yes / No
Double Vision	Yes / No
Blurred Vision	Yes / No
Vision Loss	Yes / No
Glaucoma	Yes / No
Cataracts	Yes / No
Previous Injuries	Yes / No

Ear, Nose, Throat and Mouth

Wearing Hearing Aids	Yes / No
Hearing loss	Yes / No
Balance Disturbance	Yes / No
Speech Difficulties	Yes / No
Post Nasal Drip	Yes / No
Sinus Headaches	Yes / No
Sore Throats	Yes / No
Swallowing Problems	Yes / No

Cardiovascular

Chest Pain or Angina	Yes / No
Date of last EKG: _____	Stress Test: _____
High Blood Pressure	Yes / No
Irregular Heart Rate	Yes / No
History of Heart Murmur	Yes / No
High Cholesterol	Yes / No
Swelling in Ankles/Feet	Yes / No
History of DVT	Yes / No
Cardiac Stents	Yes / No
Cardiac Catheterization	Yes / No
Pacemaker	Yes / No
Shortness of Breath	Yes / No
Chronic Cough	Yes / No
Bloody Sputum	Yes / No
History of Pneumonia	Yes / No
History of pulmonary embolism	Yes / No

Gastrointestinal

Indigestion or Heartburn	Yes / No
Nausea	Yes / No

Vomiting	Yes / No
Abdominal	Yes / No
Diarrhea	Yes / No
Constipation	Yes / No
Blood in Stool	Yes / No

Genitourinary

Frequent Urinary Infections	Yes / No
Blood in Urine	
Difficulty Urinating	Yes / No
Loss of Urine	
Loss of Urine with Cough or Sneeze	Yes / No
Kidney Stone	Yes / No

Musculoskeletal

Neck Pain	Yes / No
Back Pain	Yes / No
Arm Numbness and Tingling	Yes / No
Arm Weakness	Yes / No
Loss of Range of Motion in Arm/Shoulder Joints	Yes / No
Leg Pain	Yes / No
Leg Numbness and Tingling	Yes / No
Leg Weakness	Yes / No
Loss of Range of Motion in Leg Joint	Yes / No
Arm or Leg Length Discrepancy	Yes / No
Joint Pain or Swelling	Yes / No
Osteoporosis	Yes / No
Last Bone Density (DEXA)	Test: _____

Skin (Integumentary)

Skin Disease	Yes / No
Rashes	Yes / No

Neurological

Headaches	Yes / No
Disorientation	Yes / No
Difficulty with Speech	Yes / No
Fainting Spells or "Blacking Out"	Yes / No
Problems with Memory	Yes / No

Psychiatric

Anxiety	Yes / No
Depression	Yes / No
Suicidal Thoughts	Yes / No
Hallucinations	Yes / No
History of Dementia	Yes / No
Other Psychiatric Disorders	Yes / No

Endocrine

Excessive Thirst or Urination Yes / No
Hormone Problems Yes / No

Hematologic/ Lymphatic

Persistent Swollen Glands or
Lymph Nodes Yes / No
Blood Transfusion Yes / No
If Yes, When? _____

Allergic/ Immunologic

Food Allergies Yes / No
Immunologic Disorders Yes / No

Male Reproduction

Difficulty with Erection Yes / No
Diminished Sexual Drive Yes / No
Prostate Enlargement Yes / No

Female Reproduction

Pregnant Yes / No
Menopause Yes / No
Tubal Ligation or
Hysterectomy Yes / No

The above information is accurate to the best of my knowledge:

Print Name **Patient signature** **Date**

I have reviewed the above medical information: _____
Michael Major, D.C., D.I.B.C.N

Patient Pain Drawing

Patient's Name: _____ **Date:** _____

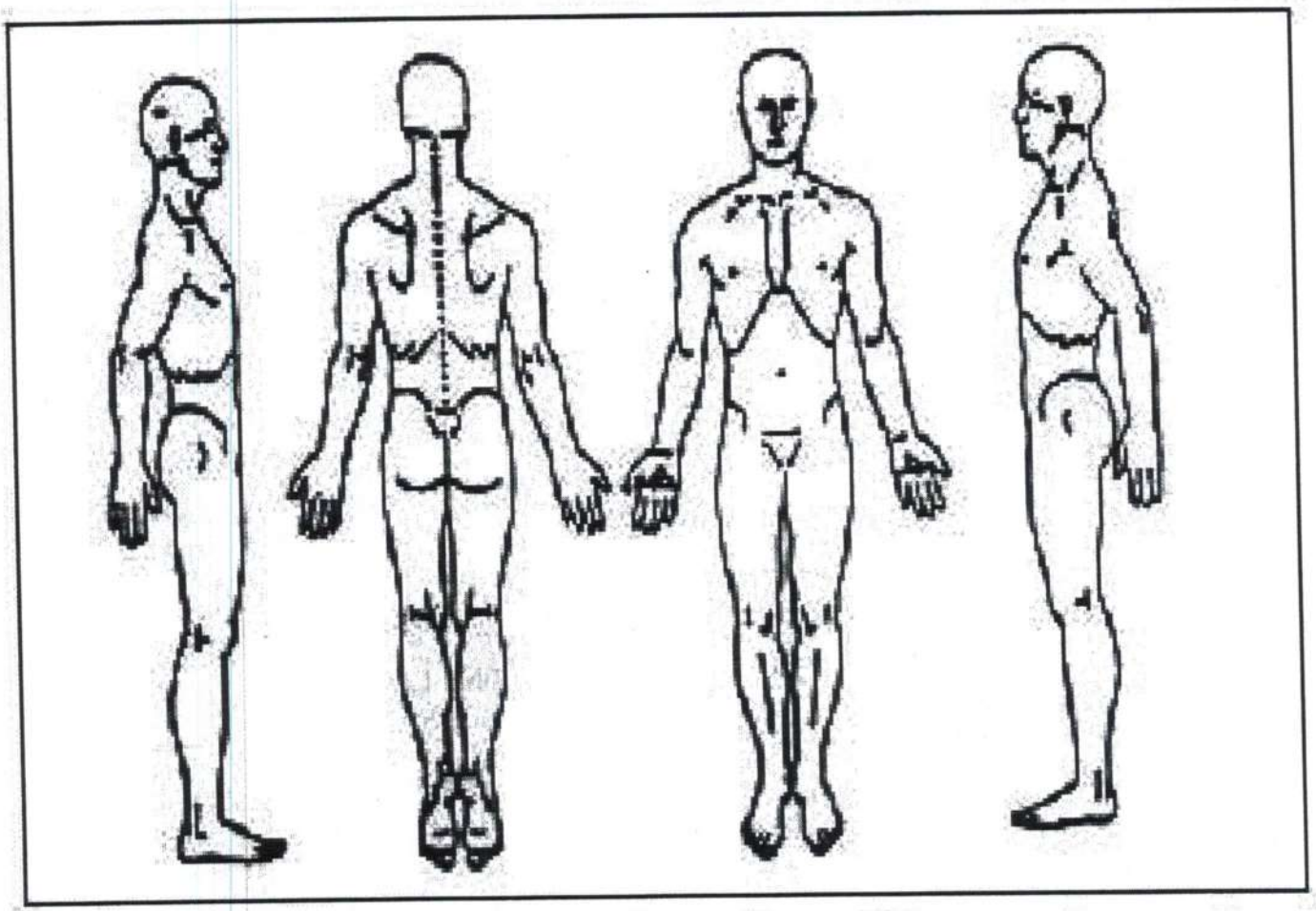
Date of Accident: _____

Directions: Where is your pain? Use the letters to mark on the body drawings where you feel pain or other sentations. Include all affected areas. Once complete, please sign and date this paper in the space provide at the bottom of the page. Please use ink only.

A = Ache
S = Stabbiing

P = Pins & Needles
N = Numbness

B = Burning
O = Other



Patient/Guardian Signature: _____ **Date:** _____

Wesley Chapel
26604 Magnolia Boulevard
Lutz, FL 33559
(813) 907-0770

Temple Terrace
11401 North 56th Street, Suite 18
Temple Terrace, FL 33617
(813) 988-8088

PAYMENT AUTHORIZATION

I herby authorize and direct you, my insurance company and/or my attorney to pay directly to Dr. Michael Major, P.A., ("Assignee") such sums as may be due and owing Assignee for services rendered me, both by reason of accident or illness, and by reason of any other bills that are due Assignee, and to withhold such sums from any disability benefits, medical payment benefits, No-Fault benefits, or any other insurance benefits obligated to reimburse me or from any settlement, judgment or verdict on my behalf as may be necessary to adequately protect said Assignee. I herby further give a lien to said Assignees against any and all insurance benefits named herein and any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of the injuries or illness for which I have been treated by Assignee. This is to act as an assignment of my rights and benefits to the extent of the Assignee's services provided. Further, I hereby instruct the insurance carrier to request that, in the event the subject medical services and / or benefits are disputed for any reason, the amount of benefits being claimed by Dr. Michael Major, P.A. are to be held in escrow and not dispersed until the dispute is resolved.

In the event my insurance company obligated to make payments to me upon the charges made by Assignee for their services refuses to make such payments, upon demand by me or Assignee, I herby give and transfer to Assignee any and all causes of action that I might have or that might exist in my favor against such company and authorize Assignee to prosecute said cause of action either in my name or in Assignee name and further I authorize Assignee to compromise, settle or otherwise resolve said claim or cause of action as they see fit.

I authorize Assignee to release any information pertinent to my case to any insurance company adjuster, or attorney to facilitate collection under this Assignment, Lien, and Authorization. I agree that the above-mentioned Assignee be given Special Power of Attorney to endorse/sign my name on and all checks and claim forms for payment of my bill.

PATIENT'S SIGNATURE

_____ **DATE**_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a Notice Of Privacy Practices and that I have read them or declined the opportunity to read them and I understand the Notices Of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

_____ _____
Patient Name (Please Print) Date

_____
Parent, Guardian or Patients legal representative

_____
Signature