

# WELCOME

## Patient Information

Patient Name \_\_\_\_\_ Date \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone \_\_\_\_\_ Email \_\_\_\_\_ Birthdate \_\_\_\_\_ Sex \_\_\_\_\_

Married  Widowed  Single  Minor  Separated  Divorced  Partnered  
Spouse/Partner Name (if applicable) \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

### In Case of Emergency, Contact

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Who may we thank for referring you? \_\_\_\_\_

## Patient Condition

Reason for Visit \_\_\_\_\_

When did your symptoms start? \_\_\_\_\_

Did anything happen at the time of onset which may have led to your condition?  
\_\_\_\_\_

Is the condition getting progressively worse?  Yes  No  Unknown

Rate the severity of your pain on a scale from 0 (NO pain) to 10 (worst possible pain) \_\_\_\_\_

Type of pain:

Sharp  Dull  Throbbing  Numbness  Aching  Shooting  
 Burning  Tingling  Cramping  Stiffness  Swelling  Other

Other Descriptions: \_\_\_\_\_

How often do you have this pain? \_\_\_\_\_

Is it constant, or does it come & go? \_\_\_\_\_

Does it interfere with your:

Work  Sleep  Daily Routine  Recreation/Hobbies

Activities or movements that are painful to perform:

Sitting  Standing  Walking  Bending  Lying Down

### Accident Information

Is this condition due to an accident?  Yes  No

*(if YES, continue below)*

Type of Accident

Auto  Work  Home  Other

Attorney Name \_\_\_\_\_

### Health History

What treatment have you already received for this condition?

Medications  Surgery  Physical Therapy  Chiropractic  Other \_\_\_\_\_

Name of other doctor(s) who have treated you for this condition

\_\_\_\_\_

#### Weekly Exercise

- None
- Some
- Moderate
- Daily (or more)

#### Daily Work Activity

- Sitting
- Standing
- Light Labor
- Medium to Heavy Labor

#### Habits

- Smoke Tobacco (\_\_\_\_Packs/day)
- Coffee/Caffeine
- Alcohol (\_\_\_\_Drinks/week)
- Stress Levels \_\_\_\_\_

Other Comments: \_\_\_\_\_

Are you pregnant?  Yes  No

#### Medications

#### Allergies

#### Supplements

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Health History

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pinched Nerve	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Alcoholism	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pneumonia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Allergy Shots	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Gonorrhea	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Polio	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Gout	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Prostate		
Anorexia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart			Condition	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Appendicitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Prosthesis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hernia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Psychiatric		
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Herniated			Care	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bleeding			Disc	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Rheumatoid		
Disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Breast Lump	<input type="checkbox"/> Yes	<input type="checkbox"/> No	High			Rheumatic		
Bronchitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Cholesterol	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bulimia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Kidney			Scarlet Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cataracts	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Liver			Suicide Attempt	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chemical			Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Thyroid Condition	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Dependency	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Measles	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chicken Pox	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Migraines	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Miscarriage	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tumor(s)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Mononucleosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Typhoid Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Epilepsy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Multiple			Ulcers	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Fractures	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sclerosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Vaginal Inf.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Glaucoma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Mumps	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Venereal Dis.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Goiter	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Whooping		
Gonorrhea	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Cough	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Gout	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Parkinson's	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Other		

Previous Surgeries (w/approx. date) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

ASSIGNMENT OF BENEFITS TO

BELLEVIEW CHIROPRACTIC CLINIC

The undersigned hereby assigns the benefits of insurance available under any applicable insurance policy including, but not limited to, Personal Injury Protection (PIP) benefits to Belleview Chiropractic Clinic in exchange for the medical treatment and/or medical services rendered to the undersigned by Belleview Chiropractic Clinic

Dated this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_  
(Patient/Insured Name)

\_\_\_\_\_  
(Signature)

**ATTENTION MASSAGE PATIENTS:**

Our office understands that schedules change and emergencies occur, and we are happy to work with you as much as possible when scheduling appointment times for you.

It is office policy to charge a \$25 fee for missed or cancelled appointments for massage or muscular development and rehabilitation less than 24 hours from the scheduled appointment. This is due to our increase in patients wanting to schedule and keep appointments for massage or muscular development/rehabilitation and out of our consideration of our massage therapists. Appointments are made to reserve your time with our therapists. As a courtesy, these reservations need to be kept or rescheduled in a timely manner.

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

Belleview Chiropractic Clinic  
10341 US Hwy 441 Belleview, FL 34420  
352-245-0145

## Informed Consent to Chiropractic Treatment

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including, but not limited to, various modes of physical therapy and, if necessary, diagnostic x-rays on me (or on the patient named on this form for whom I am legally responsible) by the chiropractic physician and/or anyone working in this office authorized by the chiropractic physician. I further understand that such chiropractic services may be performed by the physician of chiropractic named here. Dr. Michelle Zielecki and/or other licensed physicians of chiropractic who may treat me now or in the future at this office.

The nature of chiropractic treatment – The doctor will use his/her hands or a mechanical device to move your joints. You may feel a “click” or “pop” similar to the noise made when a knuckle is “cracked”, and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, etc. may be used.

Possible risks – I understand that results are not guaranteed. I understand and am informed that, as in the practice of medicine and all healthcare, the practice of chiropractic carries some risks to treatment. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocation of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to the arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications. In the rare event there are specific risks pertaining to my individual case, the doctor will address these with me directly.

Probability of risks occurring – The risks of complications due to chiropractic treatment have been described as “rare”, about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke has been estimated at one in one million to one in twenty million and is even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered “rare”.

Risks of remaining untreated – Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal stability and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

I have read or had read to me the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I intend to receive the recommended treatment and hereby give my full consent to treatment.

To be completed by the patient or the patient’s representative if the patient is a minor or is physically or mentally incapacitated).

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Guardian/Representative Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Patient Daily Intake

Name: \_\_\_\_\_ Date: \_\_\_\_\_

On a scale from 1 to 10 since starting treatment to now, how would you rate your  
IMPROVEMENT?

1      2      3      4      5      6      7      8      9      10

What symptoms have improved? \_\_\_\_\_

What intensity?    Mild                    Moderate                    Severe

What symptoms do you still have? \_\_\_\_\_

Frequency of pain? Intermittent 0-25%    Occasional 25-50%    Frequent 50-75%  
Constant 75-100%

Do you have any questions about your phase of treatment/progress?

\_\_\_\_\_  
\_\_\_\_\_

Signature: \_\_\_\_\_ Staff Initials: \_\_\_\_\_