Welcome to Deerwood Lake Chiropractic

Patient Information

Date_____

First Name: _____

Last Name: _____ Middle Initial: ____

Address_____Apt #_____

City/State_____ Zip_____

Email_____

What are the top 3 things you would like us to help you with today?

(i.e. back pain, neck pain, headaches etc.)

1. _____
2. _____
3. _____

Sex □ **Male** □ **Female** **Birthdate:** _____ **Age:** _____

□ Married □ Widowed □ Single □ Minor

□ Separated □ Divorced □ Partnered for _____ years

Current Height: _____Current Weight: _____

Number of Children/Ages_____

Occupation_____

Patient Employer/School_____

Spouse's Name_____

How did you hear about our office? _____

Insurance

Insurance Co._____

Member # _____

Subscriber's Name _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____and assign directly to Deerwood Lake Chiropractic, Dr. Peter Anthony Fort all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on al insurance submissions.

Dr. Peter Anthony Fort may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____

Signature of Patient, Parent, Guardian or Personal Representative

_____

Please print name of Patient, Parent, Guardian or Personal Representative

_____

Contact Information

Home Phone (_____)_____

Cell Phone (_____)_____

Best time to reach you_____

IN CASE OF EMERGENCY, CONTACT

Name_____

Relationship_____

Contact Number (_____)_____

Accident Information

Is condition due to an accident? □ Yes □ No

Date of Accident:_____

Type of Accident □ Auto □ Motorcycle □ Work □ Home

Was the accident in Florida? □ Yes □ No

To whom have you made a report of your accident?

□ Auto Insurance □ Employer □ Worker Comp. □ Other

Attorney Name (if applicable): _____

PATIENT CONDITION (PLEASE FILL OUT EACH SECTION)

Rate the severity of your pain from 1 (least pain) to 10 (severe pain). **Please circle:** 1 2 3 4 5 6 7 8 9 10

When did your symptoms appear?_____

What do you think started the pain?_____

Is this condition getting progressively worse? □ Yes □ No □ Unknown

Type of pain: □ Sharp □ Dull □ Throbbing □ Numbness □ Aching □ Shooting

□ Burning □ Tingling □ Cramps □ Stiffness □ Swelling

Pain is worse in the: □ Morning □ Afternoon □ Evening □ Constant/All Day & Night □ Comes & Goes

Does it interfere with your □ Work □ Sleep □ Daily Routine □ Recreation

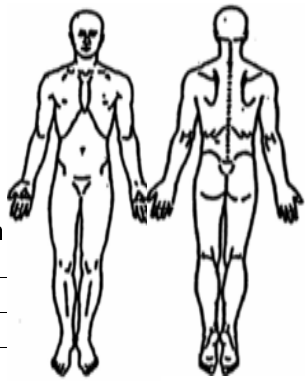
Activities/movements that are painful to perform: □ Sitting □ Standing □ Walking □ Bending □ Lying Down

Do you get headaches? □ No □ Yes: if yes, how often? _____

Is there any tingling or numbness? If so, which area? _____

Is anything helping with the pain and symptoms? (i.e., stretching, icing) _____

Mark an "X" on the picture where you continue to have Pain, Numbness, or Tingling.



Health History

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ None ☐ Other_____

Name & Address of other doctors who have treated you for your condition_____

_____

Have you been to a Chiropractor before? ___ NO ___ Yes, if who? _____ Last visit:_____

Date of Last: Physical Exam _____ Spinal X-Ray_____ Blood Test_____

Spinal Exam _____ Chest X-Ray_____ Urine Test_____

Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

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

AIDS/HIV	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Alcoholism	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	Measles	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Allergy Shots	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Migraine Headaches	☐ Yes	☐ No	Sexually Transmitted Disease	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Fractures	☐ Yes	☐ No	Miscarriage	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Anorexia	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Mononucleosis	☐ Yes	☐ No	Suicide Attempt	☐ Yes	☐ No
Appendicitis	☐ Yes	☐ No	Goiter	☐ Yes	☐ No	Multiple Sclerosis	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Gonorrhea	☐ Yes	☐ No	Mumps	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Gout	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Bleeding Disorders	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No	Tumors, Growths	☐ Yes	☐ No
Breast Lump	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No	Parkinson's Disease	☐ Yes	☐ No	Typhoid Fever	☐ Yes	☐ No
Bronchitis	☐ Yes	☐ No	Hernia	☐ Yes	☐ No	Pinched Nerve	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Bulimia	☐ Yes	☐ No	Herniated Disk	☐ Yes	☐ No	Pneumonia	☐ Yes	☐ No	Vaginal Infections	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	Polio	☐ Yes	☐ No	Whooping Cough	☐ Yes	☐ No
Cataracts	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Prostate Problem	☐ Yes	☐ No	Other: _____		
Chemical Dependency	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No	Prosthesis	☐ Yes	☐ No			
Chicken Pox	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No			
						Rheumatoid Arthritis	☐ Yes	☐ No			

Exercise

- ☐ None
- ☐ Moderate
- ☐ Daily
- ☐ Heavy

Work Activity

- ☐ Sitting
- ☐ Standing
- ☐ Light Labor
- ☐ Heavy Labor

Habits

Smoking	Packs/Day	_____
Alcohol	Drinks/Week	_____
Coffee/Caffeine Drinks	Cups/Day	_____
High Stress Level	Reason	_____

Are you pregnant? ☐ Yes ☐ No, Due Date _____ Past Auto Accidents? ☐ Yes ☐ No, Year? _____

Injuries/Surgeries you have had	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

Medications/For What?	Allergies	Vitamins/Herbs/Minerals
_____	_____	_____
_____	_____	_____
_____	_____	_____
Pharmacy Name_____	_____	_____
Pharmacy Phone (_____)_____	_____	_____

INFORMED CONSENT

The nature of the chiropractic adjustment:

The primary treatment used by the Doctors of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. They may cause an audible "pop" or "click", much as you have experienced when you "crack" your knuckles. You may sense a feel of movement.

Analysis/Examination/Treatment:

As part of the analysis, examination, and treatment, you are consenting to the following procedures:
- Spinal Manipulative Therapy - Range of Motion Testing
- Muscle Strength Testing – Radiographic Studies
- Palpation - Orthopedic Testing - Posture Analysis
- Hot/Cold Therapy – Vital Signs - EMS
- Basic Neurological Testing - Laser Therapy

The material risks inherent in chiropractic adjustments:

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. The Doctor will make every reasonable effort during examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to the Doctor's attention it is your responsibility to inform the Doctor.

The probability of those risks occurring:

Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availaibilty and nature of other treatment options:

Other treatment options for your condition may include:

- Self Administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants, and pain killers.
-Hospitalization
-Surgery

If you choose the above noted "other treatment options" you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated:

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

(Please check the appropriate block and sign below)

I have read [ ] or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Anthony Fort and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated: _____

Patient's Name: _____

Patient's Signature: _____

Doctor's Signature: _____

HIPPA Notice of Privacy

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In the course of your care as a patient at Deerwood Lake Chiropractic, we may disclose personal and health related information about you in the following ways:

- Your protected 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.
- 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 be responsible for the payment of services provided to you.
- 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.

You have a right to request restrictions on our use of your protected health information for treatment, payment and operations purposes. Such requests are not automatic and require the agreement of this office.

Your name, address, telephone number, e-mail address, and health 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 home to receive an appointment reminder or other related information, a message may be left on your answer machine or with a person in your household. You have a right to confidential communications and to request restrictions relative to such contacts. You also have the right to be contacted by alternative means or at alternative locations.

We are permitted and may be required to use or disclose your health information without your authorization in these following circumstances:

- If we provide health care services to you in an emergency
- If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
- If we are ordered by the courts or another appropriate agency.

You have a right to receive an accounting of any such disclosure made by this office.

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization. If you provide an authorization for release of information you have the right to revoke that authorization at a later date.

Information that we use or disclose based on this privacy notice may be subjected to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules. We normally provide information about your health to you in person at the time you 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 in a specific form please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for as long as the information remains in our files. In addition, you have the 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. 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.

This notice is effective as FIRST DATE OF TREATMENT. 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.

Dated: _____

Patient's Name: _____

Patient's Signature: _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND COMMUNICATION PREFERENCES AND AUTHORIZATION

Please read and initial:

___ I acknowledge that I was provided a copy of the Notice of Privacy Practices (HIPAA). I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices (HIPAA). I understand that this form will be placed in my patient chart and maintained for six (6) years unless I provide written notice to revoke this authorization.

__ I understand that the staff at Deerwood Lake Chiropractic may on occasion send me notifications or newsletters via mail or e-mail. I authorize this type of communication to the address and or e-mail address I have provided on my initial paper work.

__ I understand that Deerwood Lake Chiropractic utilizes phone calls, text messaging and e- mail messaging for appointment reminders and or missed appointments. I authorize the staff at Deerwood Lake Chiropractic to contact me with these reminders and leave a voicemail message if necessary.

_____
Patient Name Printed

_____
Patient Signature

_____
Parent/ Guardian Name & Relationship Printed (If under 18)

_____
Parent or Guardian Signature (If under 18)

_____
DATE

List below the names and relationship of people to whom you authorize the Practice to release PHI (protected health information).

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

X-RAY CONSENT FORM

During your examination, the doctor may feel that x-rays will be needed in order to provide your treatment. In order to perform x-rays on any patient our office requires that patients consent for such tests to be performed.

Please choose one of the following:

_____I understand that the doctor may need x-rays in order to administer my treatment and I give my permission to perform such tests.

_____I understand that it may be necessary for the doctor to take x-rays to administer my care. I choose not to have any x-rays at this time and release the doctor of all liabilities. I also understand that the doctor has the right to refuse treatment to me if I choose this option.

Consent To X-Ray A Minor:

I am the parent or legal guardian of_____, who is a minor,_____years of age. I hereby authorize the performance of diagnostic x-rays of the minor named above. Deerwood Lake Chiropractic has requested the x-rays for further diagnostic purposes. At this time, I know of no other condition which the taking of x-rays would further complicate.

Cardiovascular Health History

Do you wear a pacemaker? ☐ No ☐ Yes:

Do you have a history of heart disease? ☐ No ☐ Yes: If yes, please describe condition: _____

_____

Females: Regarding Possibility of Pregnancy

This is to certify that, to the best of my knowledge, I am **NOT** pregnant. The doctors and certified staff Deerwood Lake Chiropractic have permission to perform diagnostic x-rays. I am aware that taking x-rays, particularly those involving the pelvis, can be hazardous to an unborn child.

PLEASE CHECK MARK AN X	YES	NO	DON'T KNOW
I am pregnant			
I could be pregnant			
My menstrual period is late			
I have an IUD			
Birth Control Pills			
I have had a tubal ligation			
I have had a hysterectomy			
I have irregular menstrual periods			

How many weeks? _____

Signed:_____

Date: _____