Todayøs Date: ______________________
^ **(Office Use only)**

Patient ID#_________________________
^ **(Office Use only)**

*Please read every question carefully and try answering **every** question, we pride ourselves in being extra thorough to provide you with the best care possible.*

Oasis Chiropractic Center Patient Application Form

Please note that ❑ **n/a** refers to **"Not Applicable"** on these forms

Last Name: ____ First Name: ____

Prefix / Title: (check one) Mr.❑ Mrs.❑ Ms. ❑ Miss ❑ Dr.❑ Other:__________________________________

Have you been vaccinated? Yes ❑ No ❑ If yes, date of 1st dose? _____/ _____/ _____, date of 2nd dose? ❑n/a J&J _____/ _____/ _____

What was the approximate date of your last Covid-19 and/or Antibody Test? _______/ _______/ _______ Positive ❑ Negative ❑ ❑n/a

Have you had Covid-19 in the past 30 Days? Yes ❑ No
If yes, approx. date of 1st Positive Exam _____/ _____/ _____, approx. date of last negative Exam _____/ _____/ _____

Preferred /Nick Name: ❑n/a __________________________________ (M.I.) Middle Name ❑n/a ____________________

Preferred Language: ❑English ❑Spanish ❑Other: ____________________

Date of Birth: ______/ ______/ ______ Age: ______ Are you active Military or a Veteran? Yes ❑ No ❑

>>>Single❑ Married❑ Widowed❑ Under 18 (Minor)❑ Separated❑ Divorced❑ Domestic Partnership❑

Address: ____ Apt: _______ City: ____________ State_____ Zip: _________

Cell Phone: ________________________ Work Phone: ❑n/a ____________ Assistant Phone: ❑n/a ___________________

Letøs keep in touch: Please note that your information is *kept* strictly *confidential* and is ***not*** shared with any outside parties.
If Dr. Starkman needs to send you any information like (homecare, nutritional survey, stretches etc.) He'll send it to the email address you have provided ^^^^above, if you choose to receive email appointment reminders it will be sent to the email you have provided above. Please make sure it's legible.

E-Mail address____@____
(Please print legibly)

Employment Status: Employed❑ Self Employed❑ Unemployed❑ F/T Student❑ P/T Student❑ Stay at home Mom❑ Homemaker❑ Other❑

Your Occupation ❑n/a __________________________________Employer____
Work Stress Level (*circle the number that best* describes you) > 6 always 5 almost always 4 most of the time 3 sometimes 2 rarely 1 never

Number of Children ❑n/a (___) Name:_____________ Age: ___Name: ______________ Age: ___Name: ___________ Age:____
Home Stress Level (*circle the number that best* describes you) > 6 always 5 almost always 4 most of the time 3 sometimes 2 rarely 1 never

Your favorite Hobbies or Interest (helps us identify physical stresses): ____
How did you find out about Oasis: ❑ Internet /Google ❑ FaceBook ❑ Twitter ❑ Can't remember
❑ Iøm a Prior Patient ❑ Health Fair/Educational Work Shop ❑ Office Staff
Other ❑ **If you were referred by someone, *please tell us* their name *so we can thank them*!**
❑ Co-Worker/ Employer / Name: ______________________________ ❑ Family Member/ Name_________________________
❑ Friend(s)/ Name(s): ____________________________ ❑ Spouse/GF/BF/Partner /Name __________________________

Have you been to a Chiropractor before? Yes ❑ No ❑ Whom? Dr. ____________________________/ Office Name: _______________State____ When?________

Have you ever had an automobile accident? No ❑Yes ❑ When? ____________________ / ____________ ❑Don÷t Remember
Month Year

Have you had a prior diagnostic imaging study or examination (MRI or X-ray) etc. in the last 2 years? If yes, please list: ❑ None

Body Part:	Month-Year
MRI ____	____________________ / ____________ ❑Donøt Remember
X-Ray ____	____________________ / ____________ ❑Donøt Remember
Ultrasound ____________________________________	____________________ / ____________ ❑Donøt Remember

OASIS CHIROPRACTIC CENTER
DR. MYLES STARKMAN
799 BRICKELL PLAZA #803
MIAMI, FL 33131

❏Here for a **Wellness Visit / Self-Care**, no complaints just want to feel my best and de-stress.

What are your present Complaints or Health Concerns? LIST

Complaint / Concern 1:	**Complaint** / Concern 3:
Complaint / Concern 2:	**Complaint** / Concern 4:

How many **Hours** do you sleep each night and do you have *difficulty* falling asleep? **Hours:** ___________ *difficulty* > Yes❏ No❏

❏ I'm trying to get pregnant ❏n/a ❏ I'm ________ weeks pregnant ❏n/a

Expecting Moms ONLY:❏n/a

❏ My Baby is Breech ❏n/a ❏ My baby is Late ❏n/a ❏ I'm here for preventive care **Due Date:** ________________________

Name OB Doctor: ____________________ ❏n/a Birthing Center: __________________________ ❏n/a Name of Mid-Wife:__________________ ❏n/a

Pain or problem started on ______/______/______ aprox. Pains are (please circle one): Sharp Dull Constant Intermittent
❏ I don't know^^^^

I think my condition was caused by: ___________________________ My condition is worse when I: _________________________________
❏ I don't know^^^^

Is condition worse during certain times of the day? Yes ❏ No ❏ When? ____

Have you been treated by another Physician for this condition ? Yes ❏ No ❏ Whom: ___________________ When?___________

MAJOR COMPLAINT INFORMATION CONTINUED...

Please mark your areas of pain on the figures below:

Is this condition interfering with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Other ____________________

Have you received any treatment for this condition? ☐ Yes ☐ No
If Yes, please explain ______________________________

Have you been in an auto accident: ☐ Past year ☐ Past 5 years ☐ Over 5 years ☐ Never

HABITS

❏ Smoking Packs/Day: ____________________
❏ Alcohol Drinks/Day: ____________________
❏ Coffee Cups/Day: ____________________
❏ Soft Drinks Drinks/Day: ____________________
❏ Water Glasses/Day: ____________________

EXERCISE

❏ None
❏ 1-2 days/week
❏ 3-4 days/week
❏ 5+ days/week
Type : ____________________

❏Do you smoke? YES❏ NO❏ If you smoke, would you like to quit? YES❏ NO❏

Please List ***all*** Surgeries (*elective & non-elective) you've* had with dates: ❏n/a : (____/_____/_____) ____________________________________

(____/_____/_____) ______________________________________ Date: (____/_____/_____) ____

List any significant and/or recent *stressful* life-changing *event(s)*: ❏ none ____

CHECK ALL THAT APPLY:

Life Style Activities

Type	Never Tried	Tried Before	Use Currently	Interested in:?
Acupuncture	❏	❏	❏	Yes ❏ No ❏
Massage	❏	❏	❏	Yes ❏ No ❏
Meditation	❏	❏	❏	Yes ❏ No ❏
Yearly Detox & Cleansing	❏	❏	❏	Yes ❏ No ❏

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Please read all the sections on this form, your health history is very important, check if youøve had **previously**. **These are NOT all Diseases.**

CHECK THE FOLLOWING CONDITIONS AS THEY APPLY TO YOU

Previously	Presently	GENERAL SYMPTOMS/ CONDITIONS
☐	☐	Migraines
☐	☐	Headache
☐	☐	Bronchitis
☐	☐	Chills (Constant)
☐	☐	Convulsions
☐	☐	Dizziness
☐	☐	Fainting
☐	☐	Fatigue
☐	☐	Trouble Sleeping
☐	☐	Loss of Weight
☐	☐	Nervousness
☐	☐	Night Sweats
☐	☐	Numbness or Pain in arms/legs/hands
☐	☐	Wheezing
☐	☐	Polio
☐	☐	Alcoholism
☐	☐	Anemia
☐	☐	Chicken Pox
☐	☐	Rheumatic Fever
☐	☐	Pleurisy
☐	☐	Arthritis
☐	☐	Mumps
☐	☐	Cancer
☐	☐	Tuberculosis
☐	☐	Venereal Disease
☐	☐	HIV Positive
☐	☐	Diabetes
☐	☐	Measles
☐	☐	Serious Injury
☐	☐	Allergy (to what) ________________

Previously	Presently	GASTRO-INTESTINAL
☐	☐	Belching or Gas
☐	☐	Acid Reflux
☐	☐	Heart Burn
☐	☐	Colon Trouble
☐	☐	Constipation
☐	☐	Diarrhea
☐	☐	Gall Bladder Trouble
☐	☐	Hemorrhoids (piles)
☐	☐	Jaundice
☐	☐	Liver Trouble
☐	☐	Nausea
☐	☐	Stomach Pain
☐	☐	Vomiting
☐	☐	Vomiting Blood
☐	☐	Bloody Stool
☐	☐	Irritable Bowel
☐	☐	Ulcers

Previously	Presently	CARDIO-VASCULAR
☐	☐	High Blood Pressure
☐	☐	Strokes
☐	☐	Low Blood Pressure
☐	☐	Chest Pain
☐	☐	Heart Trouble
☐	☐	Poor Circulation
☐	☐	Rapid Heart
☐	☐	Slow Heart
☐	☐	Swollen Ankles
☐	☐	Varicose Veins
☐	☐	Pacemaker
☐	☐	____________other
☐	☐	____________other

Previously	Presently	EYE/EAR/ NOSE/THROAT
☐	☐	Sinusitis
☐	☐	Asthma
☐	☐	Deafness
☐	☐	Earache
☐	☐	Ear Discharge
☐	☐	Ear Noises
☐	☐	Thyroid Problems
☐	☐	Frequent Colds
☐	☐	Hay Fever
☐	☐	Nasal Obstruction
☐	☐	Nose Bleeds
☐	☐	Pain in Eyes
☐	☐	Poor Vision
☐	☐	Blurred Vision
☐	☐	Sore Throats
☐	☐	Tonsillitis

Previously	Presently	MUSCLES & JOINTS
☐	☐	Backache
☐	☐	Pain Between Shoulders
☐	☐	Stiff Neck
☐	☐	Foot Trouble
☐	☐	Hernia
☐	☐	Painful Tail Bone
☐	☐	Spinal Curvature
☐	☐	Swollen Joints
☐	☐	Tremors
☐	☐	Twitching
☐	☐	Spinal Disc Disease
☐	☐	Dislocated Joints

Previously	Presently	RESPIRATORY
☐	☐	Chronic Cough
☐	☐	Difficulty Breathing
☐	☐	Spitting Blood
☐	☐	Spitting Phlegm

Previously	Presently	GENITO-URINARY
☐	☐	Bed Wetting
☐	☐	Blood in Urine
☐	☐	Frequent Urination
☐	☐	Inability to Control Urine
☐	☐	Kidney Infections
☐	☐	Kidney Stones
☐	☐	Painful Urination
☐	☐	Prostate Trouble

Previously	Presently	NEUROLOGICAL
☐	☐	Anxiety
☐	☐	Mood Swings
☐	☐	Phobias
☐	☐	Mental Disorders
☐	☐	Multiple Sclerosis
☐	☐	Epilepsy
☐	☐	Memory Loss or Impairment
☐	☐	Depression

Previously	Presently	FOR FEMALES ONLY
☐	☐	Irregular Cycle
☐	☐	Cramps
☐	☐	Hot Flashes
☐	☐	Painful Periods

☐ Yes ☐ No **Pregnant at this time?**

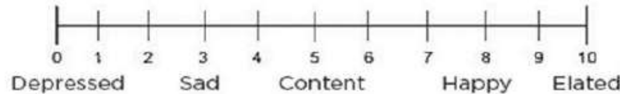
__________Last Menstrual Cycle

YES, WE REALLY DO WANT YOU TO FILL OUT THE FOLLOWING SECTION, pick a number and a face:

Rate Your Happiness: R U Happy?

On a scale of 1-10 rate your level of general happiness.

With 1 being not at all happy and 10 being as happy as can be. Not just today but in general.



Check all that apply:

over-worked ❑ Short of time ❑ The conditions in my life are excellent ❑ over-stressed ❑ I am satisfied with life ❑
under-valued ❑ living life out of balance ❑ plagued by busyness ❑ In most ways my life is close to ideal ❑
under-productive ❑ If I could live my life forever I would change almost nothing ❑ I'm full of energy ❑ I feel helpless ❑

Check here if None apply ❑

ADDITIONAL INFORMATION

List all medications you are taking now, including over the counter medication: ______________________________

____

Do you have, or have you ever had, any diseases or medical problems not listed? ☐ Yes ☐ No

If so, please list: ____

____

Any additional information you would like the doctor to know about before beginning care ?

____

Oasis Chiropractic Center Payment Information

Responsible Party:

Name of person responsible for this account: _______________________________________ ❑ Self

Relationship to patient: _______________________________________ ❑ Self

Are you currently being represented by an attorney? ❑ No ❑ Yes, if yes whom & why? ____

Name: ______________________________ Address: ____________________________ Telephone No. ____________________

To the best of my knowledge, the information I have provided in page 1, 2, 3 & 4 of the Patient Application Form is complete and correct. **I understand that it is my responsibility to inform my doctor and the office staff if I or my minor/child ever has a change in health, are injured in any type of accident, retain legal representation or if there is ever a change in my contact information such as address or telephone number etc.** It is also my responsibility to inform the doctor of any medications prescribed in the course of my treatment and to advise the staff if I am scheduled for any type of in/outpatient procedure.

- Oasis Chiropractic Center is a **NON-PARTICIPATING PROVIDER/ *out-of-network provider*** with insurance companies. We are a cash (we accept credit cards) based practice and do not accept insurance as of January **2014. Oasis Chiropractic Center will however provide you with a Super Bill/ Receipt of services rendered and paid so that you may submit the claims yourself for direct reimbursement.** Please note that Oasis Chiropractic Center can no longer verify patient's insurance benefits, you will need to contact your insurance company directly to obtain your reimbursement information.

- **Our office does not guarantee that your insurance company will pay for treatment** you receive from our practice. We perform routine insurance billing procedures for only Medicare and Personal Injury patients.

- **Our office will not enter into a dispute with your insurance company** over any claim, although we will provide necessary documentation your insurance company requests to sort out any confusion or questions that may arise. We will cooperate fully with the regulations and requests of your insurance company. It is ultimately your responsibility to resolve any type of dispute over payments made or not made by your insurance company.

●**USUAL AND CUSTOMARY RATES:**
Our practice is committed to providing the best care for our patients. Our charges are within the usual and customary charges for our specialty in our area. You are responsible for payment regardless of any non-participating insurance company's arbitrary determination of usual and customary rates.

●**MASSAGE APPOINTMENTS**: If you miss a scheduled massage appointment or do not cancel your appointment **24 hours** in advance, we cannot bill your insurance company and you will be responsible for the full amount owed before you can schedule a next massage appointment. If you have pre-scheduled massage appointments you will be removed from the scheduling book until you have paid your missed massage appointment. Please review Massage Cancelation Policies prior to booking any massage appointments.

I understand that payment is due at the time of service for all CASH patients unless otherwise arranged with Oasis Chiropractic Center.

My signature below attests that I have read and understood the Oasis Chiropractic Center Payment Information.

____

Please print name of **Patient**, Parent, Guardian or Personal Representative Relationship to Patient

____ ____________________

Signature of **Patient**, Parent, Guardian or Personal Representative Date

OASIS CHIROPRACTIC CENTER
DR. MYLES STARKMAN
799 BRICKELL PLAZA #803
MIAMI, FL 33131
PHONE: 305-374-5866

INFORMED CONSENT TO SERVICES

I hereby consent to the performance of comprehensive examinations, chiropractic adjustments, and other chiropractic procedures, various modes of physiotherapy, acupuncture, massage, and nutritional advice by Dr. Myles Starkman and staff, who now or in the future treat me in this office. I have had an opportunity to discuss with Dr. Myles Starkman and Oasis Chiropractic Center staff the nature and purpose of the recommended treatment/ care. I understand that results are **not** guaranteed.

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

I am informed that clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities, or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or healthcare if he is aware that such care may be contra-indicated.

Some treatments may include electrical stimulation which has the following contraindications:

Pacemaker
Pregnancy
Epilepsy/Seizures (no treatment above the neck)
Cancer

Electrical stimulation or õe-stim,ö involves the use of electric devices such as TENS (Transcutaneous Electrical Nerve Stimulation), or MENS (Microcurrent Electrical Nerve Stimulation).

I understand I must inform my doctor if I have any of the above contra-indications.

I do not expect the doctor to anticipate and explain all risks and complications. Further, I wish to rely on the physician to exercise judgment during the course of the procedure which the physician feels are in my best interest at the time, based upon the facts then known.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommended by my physician. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment for at this facility.

____

Please print name of **Patient**, Parent, Guardian or Personal Representative Relationship to Patient

____

Signature of **Patient**, Parent, Guardian or Personal Representative

____

Date

OASIS CHIROPRACTIC CENTER
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Informed Consent to Acupuncture

I hereby request and consent to the performance of acupuncture and other procedures related to acupuncture if necessary including needling, laser, electro acupuncture, and other techniques within the scope of practice of the doctor.

These procedures may be performed by the doctor or another duly authorized person in the clinic.

I have had the opportunity to discuss with the doctor and/or with other office or clinic personnel the nature and purpose of acupuncture care and other procedures. I understand that the results are not guaranteed.

I have been advised that all insertion needles are pre-sterilized and disposable.

I further understand and am informed that, as with all health care, the practice of acupuncture possesses slight risks from treatment, including, but not limited to, temporary soreness, bruising, blistering, nausea, fainting, bleeding, infection and shock.

I do not expect the doctor to anticipate and explain all the risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, are in my best interest.

I have read the above consent. I have also had the opportunity to ask questions about its content, and by signing below I agree to the above named procedures(s). I intent this consent form to cover the entire course of my present condition and for any future condition(s) for which I seek treatment.

Informed Consent to Gua Sha & Cupping

Massage Cupping uses negative pressure created within a specialized glass or rubber cup that is applied to the affected body part. The pressure can be deep to provide relief from tension, pain and injuries. Gentler pressure increases lymph flow, circulation and relaxation, and is excellent for facial treatments. Gua Sha is similar to cupping in results, but a round-edged tool is used in strokes to pressure specific areas of muscle pain.

There is a possibility of discoloration that can occur from the release and clearing of stagnation and toxins from the body. The reaction is not bruising, but the cellular debris, pathogenic factors and toxins being drawn to the subcutaneous layers for dissipation by the circulatory system.

The discoloration, or *sha*, will dissipate in as soon as a few hours or up to 1 week, and in relation to after-care activities. It is important to drink plenty of water to stay hydrated, and avoid vigorous exercise for 24 hours after treatment.

Avoid exposure to extreme temperatures, including cold, wet and/or windy weather conditions, hot showers, baths, saunas, hot tubs, for 24 hours after treatment.

- ○ I understand that all treatments at this facility are therapeutic in nature. I agree to communicate to the therapist any physical discomfort or draping issues during the session.
- ○ If I choose to experience cupping therapy and/or Gua Sha during treatments, I understand the potential side-effects and the after-care recommendations.
- ○ I also agree that I have read, understand and will follow all the information stated above and will not hold the practitioner responsible.

____

Signature Date