Manatee Wellness & Chiropractic Centers

8792 East S.R. 70, Suite 101, Bradenton, FL 34202
Phone (941) 756-4362 Fax (941) 755- 4652

8405 US-301, Suite 104, Parrish, FL 34219
Phone (941) 803 - 4474 Fax (941) 755- 4652

Today's Date:_____

PATIENT INFORMATION:

Patient's Full Name:_____ Birthdate:_____ Age:____ Sex: M/F
Address:_____ City:_____ State:____ Zip Code:_____
Home Phone:_____ Cell Phone:_____ SS# (Optional):_____
Email:_____ Height:_____ Weight:_____
Emergency Contact:_____ Relationship:_____ Emergency Contact #:_____
How did you hear about us (Circle): Website Phone Book Google Maps Office Sign Social Media

EMPLOYMENT INFORMATION:

Employment Status (circle): Retired Employed PT Student FT Student Other_____
Employer:_____ Occupation:_____
City:_____ State:____

SOCIAL HISTORY:

Do You Smoke? Y/N # of Cigarettes/Day?____ Do You Drink Alcohol? Y/N # of Drinks/Day?_____
Do You Exercise: Y/N How Often?_____

HEALTH HISTORY:

Has any member of your immediate family had any of the following (X)?

Disease	Father	Mother	Brother	Sister	Grandmother	Grandfather
Alcoholism						
Diabetes						
Cancer (Name Type)						
Heart Disease						
High Blood Pressure						
Stroke						
Arthritis						
Depression						
Thyroid Disease						
Osteoporosis						

Do you have a history of the following (circle):

Arthritis	Y/N	Kidney Stones	Y/N	Frequent Urination	Y/N
High Blood Pressure	Y/N	Nausea	Y/N	Blurred Vision	Y/N
Poor Circulation	Y/N	Hernia	Y/N	Heart Burn	Y/N
Loss of Bladder Control	Y/N	Weight Loss/Gain	Y/N	Dizziness	Y/N
Shortness of Breath	Y/N	Osteoporosis	Y/N	Hearing Loss	Y/N
Difficulty Walking	Y/N	Headaches	Y/N	Ringing in Ears	Y/N
Diabetes	Y/N	Fatigue	Y/N	Insomnia	Y/N

List any hospitalizations and dates:_____
List any injuries/accidents and dates:_____
List any major surgeries and dates:_____
Taking medications? Y/N If so, please list:_____
Taking over the counter medication? Y/N If so, please list:_____

Patient Name _____ Date _____

1. Describe your symptoms _____

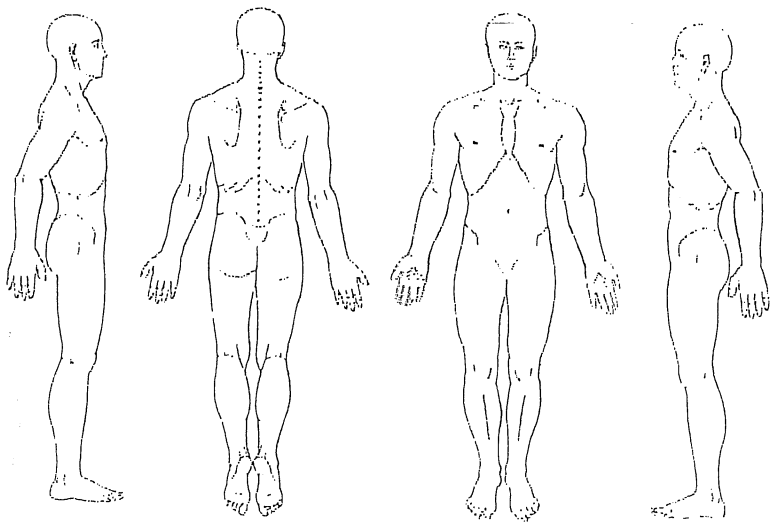
_____

a. When did your symptoms start? _____

b. How did your symptoms begin? _____

2. How often do you experience your symptoms?
   ① Constantly (76-100% of the day)
   ② Frequently (51-75% of the day)
   ③ Occasionally (26-50% of the day)
   ④ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?
   ① Sharp ④ Shooting
   ② Dull ache ⑤ Burning
   ③ Numb ⑥ Tingling

4. How are your symptoms changing?
   ① Getting Better
   ② Not Changing
   ③ Getting Worse

5. During the <u>past 4 weeks:</u>

   a. Indicate the average intensity of your symptoms

   None ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Unbearable

   b. How much has pain interfered with your normal work (including both work outside the home, and housework)
   ① Not at all ② A little bit ③ Moderately ④ Quite a bit ⑤ Extremely

6. During the <u>past 4 weeks</u> how much of the time has your condition interfered with your social activities? (like visiting with friends, relatives, etc)
   ① All of the time ② Most of the time ③ Some of the time ④ A little of the time ⑤ None of the time

7. In general would you say your overall health right now is...
   ① Excellent ② Very Good ③ Good ④ Fair ⑤ Poor

8. Who have you seen for your symptoms?
   ① No One ③ Medical Doctor ⑤ Other
   ② Other Chiropractor ④ Physical Therapist

   a. What treatment did you receive and when? _____

   b. What tests have you had for your symptoms and when were they performed?
   ① Xrays date: _____ ③ CT Scan date: _____
   ② MRI date: _____ ④ Other date: _____

9. Have you had similar symptoms in the past?
   ① Yes ② No

   a. If you have received treatment in the past for the same or similar symptoms, who did you see?
   ① This Office ③ Medical Doctor ⑤ Other
   ② Other Chiropractor ④ Physical Therapist

10. What is your occupation?
   ① Professional/Executive ④ Laborer ⑦ Retired
   ② White Collar/Secretarial ⑤ Homemaker ⑧ Other
   ③ Tradesperson ⑥ FT Student

   _____

   a. If you are not retired, a homemaker, or a student, what is your current work status?
   ① Full-time ③ Self-employed ⑤ Off work
   ② Part-time ④ Unemployed ⑥ Other

Patient Signature _____ Date _____

Cervical Spine – Bournemouth Questionnaire

Name _____ Date _____ Age _____

The following scales have been designed to find out about your *NECK* pain and how it is affecting you. Please answer ALL the scales by circling ONE number on EACH scale that best describes how you feel:

1. Over the past week, on average, how would you rate your Neck pain?
   No pain — Worst pain possible
   0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your Neck pain interfered with your daily activities (housework, washing, dressing, lifting, reading, driving)?
   No Interference — Unable to carry out activity
   0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your Neck pain interfered with your ability to take part in recreational, social, and family activities?
   No interference — Unable to carry out activity
   0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/ relaxing) have you been feeling?
   Not at all anxious — Extremely anxious
   0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?
   Not at all depressed — Extremely depressed
   0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your Neck pain?
   Have made it no worse — Have made it much worse
   0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce/help) your Neck pain on your own?
   Completely control it — No control whatsoever
   0 1 2 3 4 5 6 7 8 9 10

_____
Signature

BACK BOURNEMOUTH QUESTIONNAIRE

Patient Name _____ Date _____

Instructions: The following scales have been designed to find out about your back pain and how it is affecting you. Please answer ALL the scales, and mark the ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average, how would you rate your back pain?

No pain — Worst pain possible

0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your back pain interfered with your daily activities (housework, washing, dressing, walking, climbing stairs, getting in/out of bed/chair)?

No interference — Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your back pain interfered with your ability to take part in recreational, social, and family activities?

No interference — Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

Not at all anxious — Extremely anxious

0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed — Extremely depressed

0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your back pain?

Have made it no worse — Have made it much worse

0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce/help) your back pain on your own?

Completely control it — No control whatsoever

0 1 2 3 4 5 6 7 8 9 10

_____
Examiner

OTHER COMMENTS: _____

With Permission from: Bolton JE, Breen AC: The Bournemouth Questionnaire: A Short-form Comprehensive Outcome Measure. I. Psychometric Properties in Back Pain Patients. *JMPT* 1999; 22 (9): 503-510.

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INFORMED CONSENT

I, _____, hereby request and consent to the performance of procedures, which may include, but is not limited to, spinal and extremity manipulation, massage, electrical muscular stimulation, ultrasound, and/or therapeutic modalities by either Dr. Amanda Mitchell D.C., Dr. Justin Mitchell D.C., and/or other licensed therapists or doctors who, now or in the future, treat me while employed by or associated with Manatee Wellness & Chiropractic Centers. I have had an opportunity to discuss with the doctor and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and/or other procedures.

I understand and am informed that in the practice of chiropractic there are some risks to treatments including, but not limited to, fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all 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, is in my best interests.

I have read or have had read to me, 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. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Name:_____ Date:_____

Signature of Patient:_____

Signature of Representative (if minor):_____

Relationship to Patient:_____

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ACUPUNCTURE CONSENT

"Acupuncture" means the stimulation of a certain point or points near the surface of the body by the insertion of special needles. The purpose of acupuncture is to prevent or modify the perception of pain and is thus a form of pain control. In addition, through the normalization of physiological functions, it may also serve in the treatment of certain diseases or dysfunctions of the body. Acupuncture includes the techniques of electro-acupuncture (the therapeutic use of weak electric currents at acupuncture points), mechanical stimulation (stimulation of an acupuncture point or points on or near the surface of the body by means of apparatus or instrument), and moxibustion (the therapeutic use of thermal stimulus at acupuncture points by burning Artemisia alone or Artemisia formulations).

The potential risks: slight pain or discomfort at the site of needle insertion, infection (rare), bruises, weakness, fainting, nausea, and aggravation of problematic systems existing prior to acupuncture treatment.
The potential benefits: acupuncture may allow for the painless relief of one's symptoms without the need for drugs, and improve balance of bodily energies leading to the prevention of illness, or the elimination of the presenting problem.
Use of Disposable Needles: To reduce the possibility of infection from acupuncture, all needles are pre-sterilized, one-time-use needles made of surgical stainless steel needles. After each treatment they are disposed of as medical waste, needles are never reused. Additionally, Dr. Mitchell has had training in and follows the procedures of Clean Needle Technique and Universal Precautions.

I understand that Dr. Mitchell has recommended acupuncture treatment for me in the capacity of a pain mediator to reduce my symptoms. No cure or promises regarding my reaction to the treatment have been made or implied. I request and consent to the performance of the acupuncture procedure. I understand that I am free to withdraw my consent and that I may stop treatment or any procedure at any time. I understand that my signature in this form indicates that I have read and understand the preceding information regarding my treatment. I understand that if I have any questions about this information, I should ask my doctor. I, hereby release Dr. Mitchell and Manatee Wellness & Chiropractic Centers from any and all liability that may occur in connection with the above-mentioned procedures, except for failure to perform the procedures with appropriate medical care.

"With this knowledge, I voluntarily consent to the above procedures."

Patient Name:_____ Date:_____

Signature of Patient:_____

Signature of Representative (if minor):_____

Relationship to Patient:_____

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ASSIGNMENT OF BENEFITS

I, _____, hereby authorize _____
(name of insured) (name of insurance company)
to pay to and mail directly to Manatee Wellness & Chiropractic Centers the medical benefits otherwise payable to me for their services, but not to exceed the charges of those services. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. I hereby irrevocably assign to Manatee Wellness & Chiropractic Centers the benefits under any policy of insurance, indemnity agreement, or any other collateral source as defined in Florida Statutes for any services and charges provided by Manatee Wellness & Chiropractic Centers.

Patient Name:_____ Date:_____

Signature of Patient:_____

Signature of Representative (if minor):_____

Relationship to Patient:_____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, acknowledge that I was provided a copy of Manatee Wellness & Chiropractic Centers Notice of Privacy Practices, for which I have read, understood, and agree to the terms of the Privacy Practices.

Patient Name:_____ Date:_____

Signature of Patient:_____

Signature of Representative (if minor):_____

Relationship to Patient:_____

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AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name:
Social Security Number:
Birthdate:

I hereby authorize the Person/Organization providing the information to release medical information about me to Manatee Wellness & Chiropractic Centers.

Dates Of Service Needed: From:_____ To: _____

Person/Organization Providing The Information	Person/Organization Receiving The Information
Name:	**Name:** Manatee Wellness & Chiropractic Centers
Address:	**Address:** 8792 East State Road 70, Suite 101 Bradenton, FL 34202-3705
Phone:	**Phone:** 941-756-4362
Fax:	**Fax:** 941-755-4652

Specific Description of Information Needed:

___X-Ray Reports ___MRI Reports ___CT Reports
___EMG Reports ___Progress Notes ___All Records

- I am aware that such records may contain information related to mental health, substance abuse (both alcohol and drug), and sexually transmissible diseases (including test results related to HIV/AIDS), and I specifically authorize the release of such information pursuant to this authorization.
- I understand that I may revoke the authorization at any time in writing. I further understand that any such revocation will not apply to any information already released under this Authorization. I understand that I am under no obligation to sign this Authorization, and that my ability to obtain treatment from Manatee Wellness & Chiropractic Centers will not depend in any way on whether I sign this authorization.
- I understand that I have a right to request a copy of this Authorization.

By signing below, I authorize the release of my medical information as described above.

Patient Signature:_____ Date:_____

Representative Signature (if minor):_____ Date:_____

Relationship to Patient:_____