INITIAL PATIENT QUESTIONNAIRE

Name: _____ DOB: ___ /___ /___ Age: ___ SSN: ___-___-___ Sex: M☐F☐

Home Address: _____ City / State: _____ Zip:_____

Phone: (h) _____ (c) _____ Email:_____

Marital Status: _____ Occupation: _____ Employer:_____

Emergency Contact & Relation: _____ Phone:_____

I give permission for text messaging appointment reminders, communication and marketing: Yes ☐ No ☐

PATIENT INFORMATION CONSENT

State law requires offices to obtain your informed consent prior to examination and treatment. The purpose of this form is to inform you. What you're being asked to sign is simply a confirmation that you have been informed of the following:

EXAMINATIONS

Chiropractic adjustment/manipulation: The doctor will use his hands or a mechanical device upon your body in such a way as to move your joints in various directions. This procedure may cause an audible "pop" or "click" to be heard coming from your joints; this is not a cause for alarm. There are some risks involved in doing these procedures. They are as follows:

Pain: Chiropractic treatments may result in a temporary increase in soreness in the area receiving treatment.
Rib fractures: Fractures caused by chiropractic treatments are rare. They occur most frequently in patients with osteoporosis or weakened bones. Evidence of osteoporosis can be noted on your x-rays, and, if detected, the most appropriate and gentle treatments are used, minimizing the possibility of fractures to the ribs.
Disc Injury: Chiropractic treatment is appropriate for the treatment of many kinds of back problems, including some disc problems[i]. Occasionally, chiropractic may aggravate or cause a problem if the disc is in a severely weakened state. However, this occurs so rarely that statistics to quantify the probability are unavailable but estimates place risk of serious injury at about 1 serious complication per 100 million low back manipulations[ii].
Stroke: The overall incidence of stroke in the general population is about 2 per 1000 people[iii]. Although chiropractic adjustment/manipulation has been implicated as a possible cause of stroke, this possibility is extremely rare. The best available data suggests that stroke, secondary to chiropractic/adjustment/manipulation may occur in 1 per 100,000 patients[iv], a rate well below the overall average risk in the general population. In comparison, the overall average risk of death from taking non-steroidal anti-inflammatory drugs (aspirin, ibuprofen, naproxen sodium, etc.) is 4 per 100,000 patients[v]. The risk of serious complication or death from spine surgeries of the neck is 1.25 per 1000 patients[vi]. As you can see, the risk of stroke from chiropractic treatments is much lower than other common medical treatments. Even though the risk is small, we have implemental procedures and tests that will likely reduce the potential for stroke even more.

Chiropractic is a system of health care delivery. As with any health care delivery system, we cannot promise a cure for any symptom, disease or condition as a result of treatment in this office. We will always give you our best care, and if your results are not acceptable, we will refer you to another health care provider who we feel will assist your situation.

If you have any questions on the above information, please ask the doctor. When you have a clear understanding, please sign and date below.

I HAVE READ, OR HAVE HAD READ TO ME, THIS CONSENT FORM AND I HAVE BEEN INFORMED OF THE MOST LIKELY COMPLICATIONS, OF THE POSSIBLE UNDESIRED RESULTS OF CHIROPRACTIC EXAMINATION AND TREATMENT IN THIS OFFICE AND UNDERSTAND THEM. I HEREBY AUTHORIZE AND DIRECT DR. COBB AND HIS ASSOCIATES OR ASSISTANT TO PROVIDE SUCH ADDITIONAL SERVICES AS THEY MAY DEEM REASONABLE AND NECESSARY.

Patient Signature: _____ Date: _____

Patient's Printed Name: _____ Date: _____

Parent's/Guardian's Signature: _____ Date: _____

(If patient is less than 18 years of age)

Parent's/Guardian's Printed Name: _____ Date: _____

[i] Troyanovich SJ, Harrison DE • Low back pain and the lumbar intervertebral disc. Clinical considerations for the Doctor of Chiropractic. [ii] Shekelle PG, Spine update. Spinal Manipulation, Spine 1994, 19, 858-86
[iii] Clayman CB, The American Medical Association Home Encyclopedia, New York, Random House: 947-948
[iv] Dabbs v. Lauretti WJ Risk Assessment and Cervical Manipulation vs. NSAIDS for the treatment of neck pain J Manipulative Physol. THE: 1995; 18•530536
[v] Harwitz PI, Acker PD, Adams AH, Meeker WP, Shekelle PG Manipulation and mobilization of the cervical spine; A systematic review of the literature. Spine, 1996, 21.1746-1760

FINANCIAL RESPONSIBILITIES

_____ **Insurance, Co-Payments, Deductibles and Coinsurance**: Payment is expected at time of service. Insurance companies do not pay all fees and may exclude certain services from coverage. It is your responsibility to understand your insurance plan. All co-payments, deductibles and co-insurance are to be paid at the time of service.

_____ **Statement Policy**: Patient statements are sent each month for accounts with balances. Payments are due upon receipt of the statement. You understand that, if we participate with your insurance company, we are required to bill them for services rendered. The sending of a statement may be delayed until your insurance responds to claim, which can take anytime between 30-60 days. At rare instances, insurance claims processing can take up to 90 days.

_____ **Notice of non-covered services**: I am aware that some services performed may be non-covered by my insurance carrier, therefore I will be fully responsible for payment of these services.

_____ **Patient Discharge**: The practice reserves the right to discharge a patient for any reason. Because of quality care considerations, the practice may discharge you for failure to comply with treatment plans. In addition, we will discharge patients due to continued no-show appointments and/or disorderly conduct in the office, on the phone or with our staff.

_____ **Permission for Treatment**: Permission is hereby granted for physicians, employees or agents or Cobb Rehab & Wellness to render such medical treatment as deemed necessary.

_____ There will be a $25.00 fee for FMLA/Disability paperwork & any and all outstanding balances must be satisfied prior to paperwork being complete.

Patient/Guardian Name: _____

Patient/Guardian Signature: _____

Date: _____

Cobb Rehab & Wellness
Dr. Gregory Cobb
4205 E. Busch Blvd. Tampa, FL 33617
Phone: (813) 914-8500 Fax: (813) 914-8511
www.cobbrehabwellness.com

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____ to release healthcare

information for the above-named patient.

This request and authorization apply to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Other: _____

_____

To be completed by staff:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Patient Signature: _____ Date Signed: _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

I acknowledge that a copy of the Notice of Privacy Practices is posted and available at my request, and that I have read them or declined the opportunity to read them and understand the Notice 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 Patient's Legal Representative: _____

Signature: _____

THIS FOR WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS

How did you hear about our clinic?

☐ Location / Sign

☐ Friend / Relative / Co-worker

(Name): _____

☐ Insurance Provider

☐ Dr. / clinic

☐ Other (Name):_____

Thank you for choosing **Cobb Rehab & Wellness** for your healthcare needs!

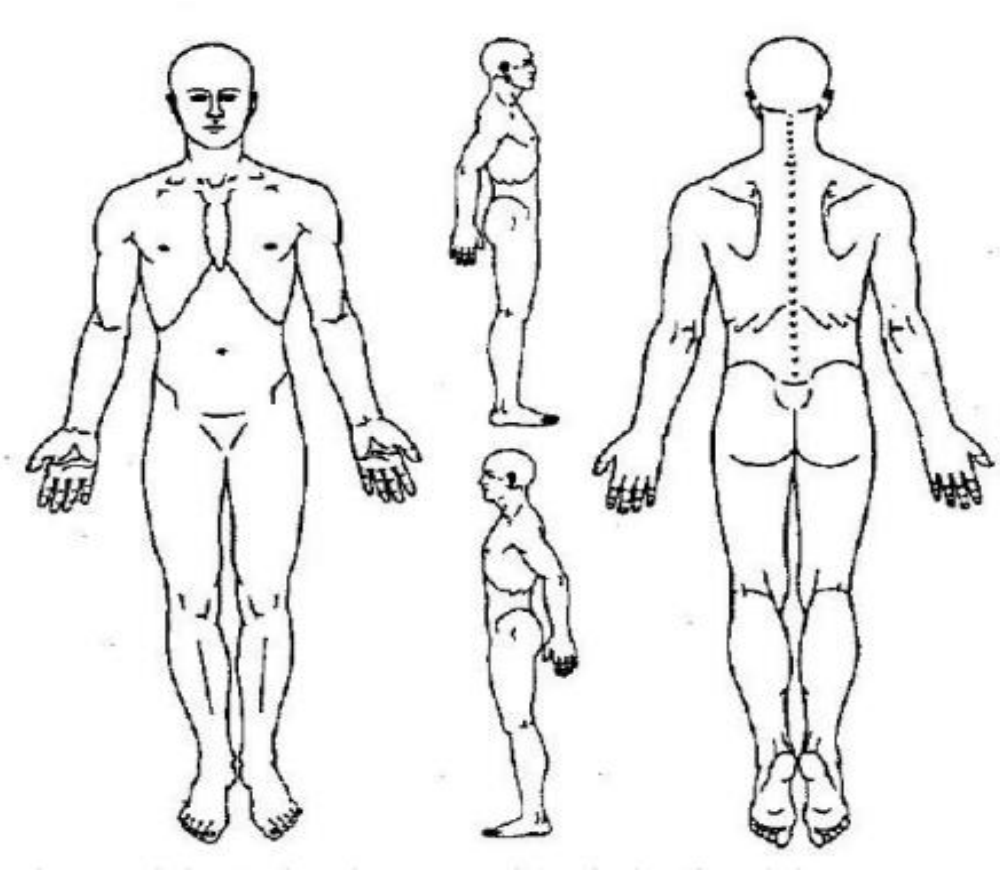
Cobb Rehab and Wellness • 4205 E. Busch Blvd. • Tampa FL 33617 • (813) 914-8500

Name: _____ Date:_____

Patient Condition

Please be sure to fill this out accurately. Mark the area on your body where you feel the described sensation(s). Use the appropriate symbol(s), nark areas of radiating pain and include all affected areas. You may draw on the figure.

Numbness: ---- Pins and Needles: oooo Burning Pain: xxxx Stabbing Pain: //// Aching Pain: ((((



If there are any other specifics list them here

Rate the severity of your pain on a scale from 1 (LEAST PAIN) to 10 (UNBEARABLE PAIN):

Right Now: 1☐ 2 ☐ 3☐ 4 ☐ 5 ☐ 6☐ 7☐ 8☐ 9 ☐ 10 ☐

Average Pain: 1☐ 2 ☐ 3☐ 4 ☐ 5☐ 6☐ 7 ☐ 8☐ 9 ☐ 10☐

At Best: 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9 ☐ 10☐

At Worst: 1☐ 2 ☐ 3☐ 4☐ 5 ☐ 6☐ 7 ☐ 8☐ 9 ☐ 10 ☐

Name: _____ Date: _____

PATIENT INTAKE

1. Is today's problem caused by: ☐ Auto Accident ☐ Workman's Compensation
2. How often do you experience your symptoms?

   Constantly ☐ Frequently ☐ Occasionally ☐ Intermittently ☐

   (76-100% of the time) (51-75% of the time) (26-50% of the time) (1-25% of the time)
3. How would you describe the type of pain?

   ☐ Numb ☐ Achy ☐ Sharp ☐ Sharp with motion ☐ Stabbing with motion

   ☐ Dull ☐ Burning ☐ Shooting ☐ Shooting with motion ☐ Electric with motion

   ☐ Tingly ☐ Stiff ☐ Diffuse ☐ Other: _____
4. How are your symptoms changing with time? ☐ Getting worse ☐ Staying the same ☐ Getting better
5. Using a scale from 0-10 (10 being the worse), how would you rate your problem?

   ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
6. How much has the problem interfered with your work?

   ☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely
7. How much has the problem interfered with your social activities?

   ☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely
8. Who else have you seen for your problem?

   ☐ Chiropractor ☐ Neurologist ☐ Primary Care Physician

   ☐ Massage Therapist ☐ Physical Therapist ☐ ER Physician

   ☐ Orthopedist ☐ No one ☐ Other _____
9. How long has this episode been happening? _____
10. How do you think your problem began? _____
11. Do you consider this problem to be severe? ☐ Yes ☐ Yes, at times ☐ No
12. What aggravates your problem? _____

_____

13. What makes it better? _____
14. What concerns you the most about your problem; what does it prevent you from doing?

_____

15. What is your: Height: _____ Weight: _____

16. How would you rate your overall health?

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

17. What type of exercise do you do?

☐ Strenuous ☐ Moderate ☐ Light ☐ None

18. Indicate if you have any immediate family members with any of the following:

☐ ALS ☐ Lupus ☐ Cancer ☐ Diabetes ☐ Heart Problems ☐ Rheumatoid Arthritis

19. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have the condition, place a check in the "present" column.

Past	Present		Past	Present		Past	Present	
☐	☐	Headaches	☐	☐	Asthma	☐	☐	Muscular Incoordination
☐	☐	Neck Pain	☐	☐	Chronic Sinusitis	☐	☐	Liver/Gallbladder Disorder
☐	☐	Upper Back Pain	☐	☐	High Blood Pressure	☐	☐	Abnormal Weight Gain/Loss
☐	☐	Mid Back Pain	☐	☐	Heart Attack	☐	☐	Loss of Appetite
☐	☐	Low Back Pain	☐	☐	Chest Pains	☐	☐	Diabetes
☐	☐	Shoulder Pain	☐	☐	Stroke	☐	☐	Excessive Thirst
☐	☐	Elbow/Arm Pain	☐	☐	Angina	☐	☐	Frequent Urination
☐	☐	Wrist Pain	☐	☐	Kidney Stones	☐	☐	Smoking/Tobacco Use
☐	☐	Hand Pain	☐	☐	Kidney Disorders	☐	☐	Drug/Alcohol Dependence
☐	☐	Hip Pain	☐	☐	Bladder Infection	☐	☐	Allergies
☐	☐	Upper Leg Pain	☐	☐	Painful Urination	☐	☐	Depression
☐	☐	Knee Pain	☐	☐	Loss of Bladder Control	☐	☐	Systemic Lupus
☐	☐	Ankle/Foot Pain	☐	☐	Prostate Problems	☐	☐	Epilepsy
☐	☐	Jaw Pain	☐	☐	Abdominal Pain	☐	☐	Dermatitis/Eczema/Rash
☐	☐	Joint Pain/Stiffness	☐	☐	Ulcer	☐	☐	HIV/AIDS
☐	☐	Arthritis	☐	☐	Hepatitis			
☐	☐	Rheumatoid Arthritis	☐	☐	Dizziness			**For Females Only**
☐	☐	Cancer	☐	☐	General Fatigue	☐	☐	Birth Control Pills
☐	☐	Tumor	☐	☐	Visual Disturbances	☐	☐	Hormonal Replacement
☐	☐	Other: _____				☐	☐	Pregnancy

20. List all prescription medications you are currently taking: _____

_____

21. List all of the over-the-counter medications you are currently taking: _____

_____

22. List all the supplements you are taking: _____

_____

23. List all the surgical procedures you have had: _____

_____

24. What is your occupation? _____

25. What activities do you do at work

Sit: ☐ Most of the day ☐ Half of the day ☐ A little of the day

Stand: ☐ Most of the day ☐ Half of the day ☐ A little of the day

Computer Work: ☐ Most of the day ☐ Half of the day ☐ A little of the day

On The Phone: ☐ Most of the day ☐ Half of the day ☐ A little of the day

26. What activities do you do outside of work? _____

27. Have you ever been hospitalized? If yes, why? _____

_____

28. Have you had significant trauma? If yes, why? _____

_____

29. Anything else pertinent to your visit today? _____

_____

Patient Signature: _____ Date: _____