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 and Relation:_____ Phone:_____

If you would like to receive text message appointment reminders, please put cell phone provider here: _____

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

X-Rays: This office uses highly sensitive x-ray film, intensifying screens and filters that provide high quality x-rays with the lowest possible x-ray exposure. The only risk with taking x-rays is with pregnancy. If there is any possibility that you are pregnant, inform us prior to any x-ray procedure. If there is no possibility of this condition, the risks are so rare we have no available statistics to qualify their probability.

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 mat 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 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 REASONABLEAND 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

ACKNOWLEDGMENT OF RECEIPT

OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices 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 FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.

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 of the patient named above it:

Name: _____

Address: _____

City: _____ State: ____ Zip Code: _____

This request and authorization applies to:

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

_____

❑ All healthcare information

❑ Other: _____

_____

Patient Signature: _____ Date Signed: _____

How did you hear about our clinic?

Sign/Location: _____

Friend/Relative/Co-worker _____

Attorney: _____

PPO/HMO Provider Book: _____

Another Doctor/Clinic _____

Name: _____ Date: _____

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

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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), mark areas of radiating pain and include all affected areas. You may draw in the face as well.

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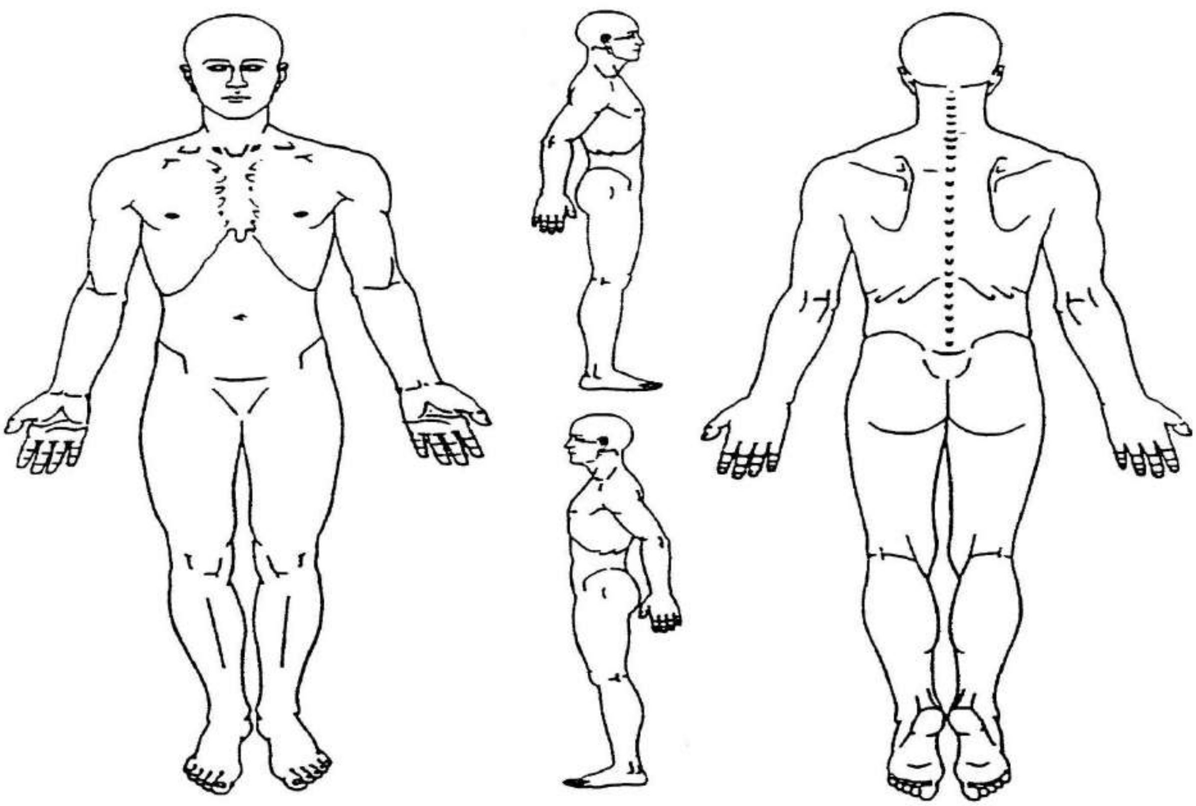

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SYMPTOM SURVEY

Please circle all that apply and indicate pain level based on a scale of 1 – 10

L = Left R = Right B = Both

General Symptoms

Nervousness☐ Irritability☐ Fatigue Depression☐
Loss of Sleep☐ Tension☐ PMS☐

Head

Headache: Mild☐ Moderate ☐
Severe☐ Constant☐ Intermittent☐
Throbbing☐
How Often: _____
Located: Back of Head☐ Forehead☐
Temples☐ L☐ R☐ Behind Eyes☐
With: Lightheaded☐ Memory Loss☐ Fainting☐
Blurred Vision☐ Double Vision☐
Sensitivity to Light☐ Loss of Balance Hearing☐
Loss☐ Ringing in Ears☐

Scale of 1-10: _____

Neck

Pain: L☐ R☐ B☐ ____
Tension: L☐ R☐ B☐ ____
Pain Across Shoulder: L☐ R☐ B☐ ____
Limited Movement: L☐ R☐ B☐ ____

Shoulders

Pain in Joint: L☐ R☐ B☐ ____
Pain Across Shoulders: L☐ R☐ B☐ ____
Limited Movement: L☐ R☐ B☐ ____
Tension: L☐ R☐ B☐ ____

Arms

Pain Above Elbow: L☐ R☐ B☐ ____
Pain in Elbow: L☐ R☐ B☐ ____
Pain in Forearm: L☐ R☐ B☐ ____
Pins and Needles(Arm): L☐ R☐ B☐ ____
Numbness in Arm: L☐ R☐ B☐ ____
Numbness in Forearm: L☐ R☐ B☐ ____

Hands

Pain in Wrist: L☐ R☐ B☐ ____
Pain in Hand: L☐ R☐ B☐ ____
Pins and Needles: L☐ R☐ B☐ ____
Numbness: L☐ R☐ B☐ ____

_____
PATIENT SIGNATURE

Chest

Deep Chest Pain: L☐ R☐ B☐ _____
Pain Level: Mild☐ Moderate☐ Severe☐
Pain Around Ribs: L☐ R☐ B☐ _____
With: Shortness of Breath☐
Irregular Heartbeat☐

Abdominal Symptoms

Pain: Mild☐ Moderate☐ Severe☐
With: Nervous Stomach☐ Nausea☐ Gas☐
Constipation☐ Diarrhea☐
Heartburn Indigestion☐ Loss of Appetite☐

Scale of 1-10: _____

Hips and Legs

Pain: mild☐ Moderate☐ Severe☐
Pain in Buttocks: L☐ R☐ B☐ ____
Pain in Hip Joint: L☐ R☐ B☐ ____
Pain Down Leg: L☐ R☐ B☐ ____
Radiating to: Knee☐ Calf☐ Foot ☐
Numbness in Leg: L☐ R☐ B☐ ____
Pins and Needles: L☐ R☐ B☐ ____
Knee Pain: L☐ R☐ B☐ ____
Leg Cramps: L☐ R☐ B☐ ____

Feet

Ankle Pain: L☐ R☐ B☐ ____
Swollen Ankles: L☐ R☐ B☐ ____
Foot Pain: L☐ R☐ B☐ ____
Numbness: L☐ R☐ B☐ ____

Back

Upper Back: L☐ R☐ B☐ ____
Mid Back: L☐ R☐ B☐ ____
Lower Back: L☐ R☐ B☐ ____
Muscle Spasms: L☐ R☐ B☐ ____
Location of Spasms: _____
Pain Level: Mild☐ Moderate☐
Severe☐
Type: Sharp/Stabbing☐ Dull/Ache☐

Other symptoms that you have: _____

_____

Are all of these symptoms directly caused by the accident? YES – NO

_____
DATE

PATIENT INTAKE FORM

1. **Is todays problem caused by:** ☐ Auto Accident ☐ Workman's Compensation
2. **How often do you experience your symptoms?**
   ☐ Constantly (76-100% of the time) ☐ Occasionally (26-50% of the time)
   ☐ Frequently (51-75% of the time) ☐ Intermittently (1-25% of the time)
3. **How would you describe the type of pain?**
   ☐ Sharp ☐ Numb
   ☐ Dull ☐ Tingly
   ☐ Diffuse ☐ Sharp with motion
   ☐ Achy ☐ Shooting with motion
   ☐ Burning ☐ Stabbing with motion
   ☐ Shooting ☐ Electric like with motion
   ☐ Stiff ☐ 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 activates?**
   ☐ 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
   ☐ ER Physician ☐ Orthopedist ☐ Massage Therapist
   ☐ Physical Therapist ☐ 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 sever?** ☐ 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:**
    ☐ Rheumatoid Arthritis ☐ Diabetes ☐ Lupus
    ☐ Cancer ☐ ALS ☐ Heart Problems

PATIENT SIGNATURE: _____ **DATE:** _____

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

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 supplements you are taking: _____

23. List all 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 activates do you do outside of work? _____

_____

27. Have you ever been hospitalized? ☐ No ☐ Yes

If yes, why? _____

28. Have you had significant past trauma? ☐ No ☐ Yes

If yes, why? _____

29. Anything else pertinent to your visit today? _____

Patient Signature: _____ **Date:** _____

COMMUNICATION LOG

Date	Conversation/Note