

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 major 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 problemsⁱ. 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 manipulationsⁱⁱ.

Stroke: The overall incidence of stroke in the general population is about 2 per 1000 peopleⁱⁱⁱ. 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 UNDESIRE 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 Physiol. 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

ASSIGNMENT OF BENEFITS, LIENS, DIRECT PAYMENT AUTHORIZATION, AUTHORIZATION TO RELEASE INSURANCE INFORMATION, AND AUTHORIZATION TO ESCROW UNPAID MEDICAL & PIP BENEFITS

Cobb Rehab & Wellness

INSURANCE CARRIER: _____ POLICY NUMBER: _____ DATE OF LOSS: _____

For and in consideration of Cobb Rehab & Wellness agreeing to pursue the responsible automobile insurance carrier for payment of benefits due and not requiring prepayment for services, I hereby irrevocably assign all rights and benefits to Cobb Rehab & Wellness for Personal Injury Protection, extended Personal Injury Protection, Medical Payment Coverage, and other benefits which I may have in accordance with Florida Statute §627.736. This includes any benefits from my insurance company and any other entity which may be responsible for medical expenses incurred. I further authorize Cobb Rehab & Wellness to collect payments & prosecute any necessary actions to collect payment for services as they see fit and allowable by law and contract. THIS DOCUMENT CONSTITUTES AN ASSIGNMENT OF RIGHTS AND BENEFITS.

I hereby further give a lien to Cobb Rehab & Wellness against any and all insurance benefits named herein, and any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of the injuries or illness for which I have been treated by Cobb Rehab & Wellness as a result of the above stated loss date. This document acts as an irrevocable absolute assignment of my rights and benefits to the extent of the charges for services provided. I agree to cooperate with Cobb Rehab & Wellness and their attorney's (at their choosing), and to do all things reasonable to effect payment of the bills by the insurance company or other entity to Cobb Rehab & Wellness including, but not limited to, disclosing my medical condition, being available for factual discovery or other cooperation.

This assignment concerns only the bills for Cobb Rehab & Wellness and those costs including, but not limited to, attorney's fees, other costs, and interest necessary in procuring payment from the above-named insurance company and/or other entities. This assignment is not intended to assign any other causes of action that may belong to the undersigned patient. I agree to pay any applicable deductible or co-payment not covered by any policy of insurance cited above. I understand that as a benefit and convenience to me, Cobb Rehab & Wellness will bill and pursue collection against the insurance company or other responsible entity on my behalf. I hereby instruct and direct my insurance company to pay my benefits directly to Cobb Rehab & Wellness at the address provided on the bill. If my current policy prohibits direct payment to doctors, then I hereby instruct and direct my insurance company or other responsible entity to make the check payable to me and mail it to Cobb Rehab & Wellness at the address on the bill. Cobb Rehab & Wellness' medical care is being provided for a reasonable fee for treatment causally related to the above loss date and is medically necessary. I instruct my insurance carrier or other responsible entity to pay these bills to the full extent of my available benefits under the insurance policy and Florida law. If any portion of the charge for these services is either reduced or denied in whole or in part, my insurance company or other entity is to place funds equal to the amount of the reduced or denied charges into escrow and hold the escrowed funds until agreement or resolution of legal action by Cobb Rehab & Wellness. I further instruct my insurance company to make payment for charges submitted by Cobb Rehab & Wellness in priority to any other requests to escrow benefits, including a request by myself to reserve benefits for pending disability claims. I hereby give Cobb Rehab & Wellness limited power of attorney to endorse and sign my name on any draft for payment to either Cobb Rehab & Wellness or myself if said draft represents payment for charges related to services rendered by Cobb Rehab & Wellness.

I further direct my insurance carrier or responsible other entity to provide information to Cobb Rehab & Wellness which is otherwise available to me including but not limited to a copy of any applicable insurance policy, declaration page, all applicable endorsements, transcripts and/or copies of any recorded statements, examinations under oath and requests for same, independent medical evaluations and requests for same, peer review reports, and a listing of all PIP benefits paid to date which shall include when claims were made, when the claims were received, the payment or denial of each claim, the amount of the deductible and the claims applied thereto, and whether benefits have been exhausted and the amount of PIP benefits available, commonly known as a "PIP log". This request includes the name of other medical providers to whom payments have been under my policy of insurance. This agreement is intended to serve as an assignment of rights and benefits under my policy of insurance in favor of Cobb Rehab & Wellness. If any language within this agreement has the effect of invalidating this agreement, that language shall be deemed void and the remainder of the assignment shall maintain full force and effect. A photocopy of this assignment shall be considered as effective and valid as the original.

Patient Signature

Date

Patient Name

If patient is incapacitated or under the age of 18, please indicate the patient name, guardian name and relation to patient, and obtain guardian signature.

**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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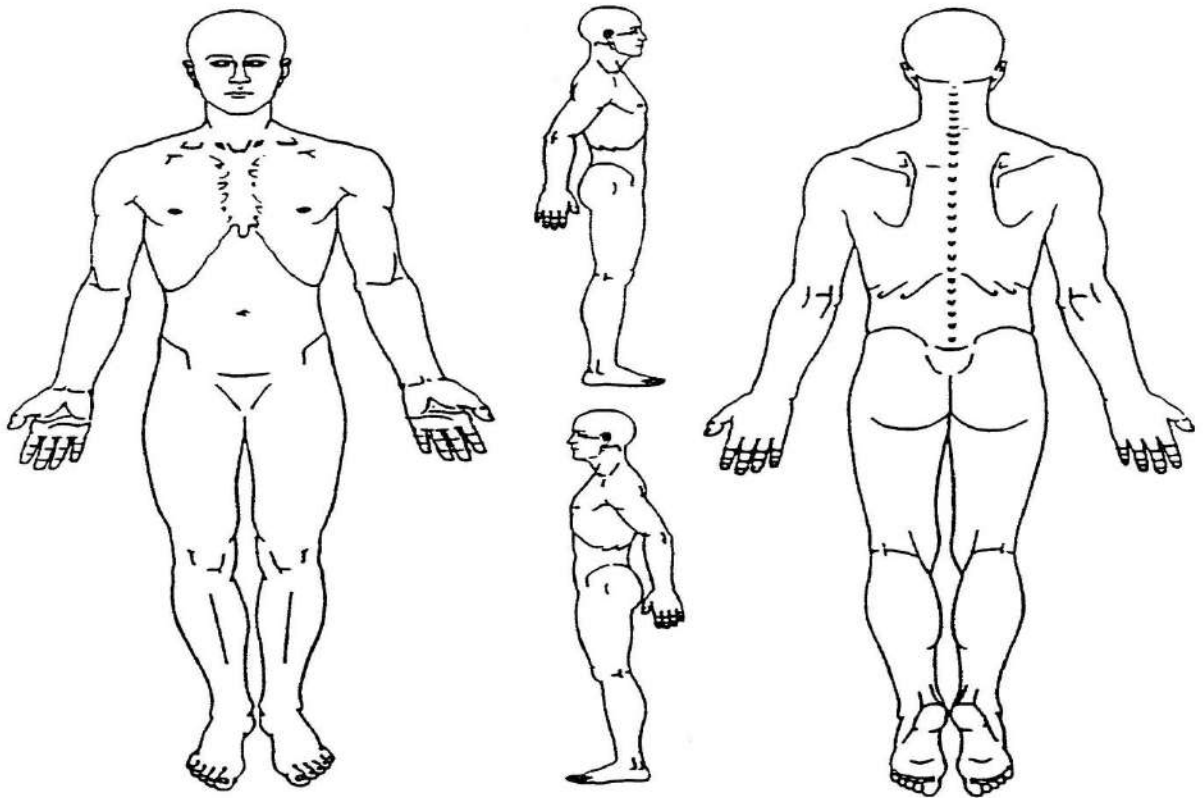
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SYMPTOM SURVEY

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 _____

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

PATIENT SIGNATURE

DATE

PATIENT INTAKE FORM

1. **Is today's 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 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
 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 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:**
 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.

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

<input type="checkbox"/> Sit:	<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half of the day	<input type="checkbox"/> A little of the day
<input type="checkbox"/> Stand:	<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half of the day	<input type="checkbox"/> A little of the day
<input type="checkbox"/> Computer Work:	<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half of the day	<input type="checkbox"/> A little of the day
<input type="checkbox"/> On the Phone:	<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half of the day	<input type="checkbox"/> 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