Kerinver
Chiropractic Health

Date: __/___/____

Last Name: _____ First Name: _____ Mid Init: _____

Address: _____ City: _____ Zip: _____

Home Phone: _____-_____-_____ Cell # _____-_____-_____ Other: _____

Birthday: _____ Sex: ____ M ____ F Email: _____

Marital Status: _____ Married _____ Single ___ Divorced ___ Widowed

****If Patient Is A Minor:** Responsible Party's Name: _____

Attorney Name: _____ Phone # _____-_____-_____

Best time to contact you: _____ AM _____ PM _____ Evenings Time: _____

Employer: _____ Ph # _____

Employer's Address: _____ Occupation: _____

Auto Insurance: Date of Accident: _____

Insurance Name: _____

Address: _____

State: _____ Zip: _____

Policyholder Name: _____

Policyholder DOB: _____

Policy ID #: _____

Claim #: _____

Health Insurance:

Insurance Name: _____

Address: _____

State: _____ Zip: _____

Policyholder Name: _____

Policyholder DOB: _____

Policy ID #: _____

SS #: _____ If used as ID#

Spouse's Name: _____ or Emergency Contact: _____

Spouse's Birthdate: _____ Relationship: _____

Employer: _____ Phone #: _____ Cell #: _____

Please check all reasons you selected us for your care: Which is the primary reason? # _____

1. Family Doctor (name) _____ 2. Previous Patient (name) _____

3. Referred by family/friend (name) _____ 4. Reputation of Clinic: _____

5. Insurance Handbook _____ 6. Website _____ 7. Other: _____

_____ _____

Patient Signature Date

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Medical History Form

Name: _____ Date_____
Medical Doctor Name_____ Phone Number_____

Main Problem

What pain causes you come to the office? _____
What caused this pain? _____
When did this pain start? _____
How long does this pain last?_____
Does this pain travel to any other area?
_____
What makes this pain better?
_____
What makes this pan worse?
_____
What else have you done to treat this pain?
_____

Other Problem

What other pain do you have? _____
What caused this pain? _____
When did this pain start? _____
How long does this pain last? _____
How often does this pain occur? Circle the one that applies) Occasional, Frequent, Constant
Does this pain travel to any other area?
_____
What makes this pain better? _____
What makes this pain worse? _____
What else have you done to treat this pain? _____

Medical History

Allergies	Anemia	Arthritis	Asthma Depression
Back Problems	Disorder Hearing	Cholesterol Disorder	Heart Murmur
Diabetes	Problems	Heart Disease	Kidney Disorder
HIV/ Hepatitis	Hypertension	Lung Disease	Other skin Problems
Prostate Disorder	Seizures	Skin Cancer	
Vision Problems	Stroke	Stomach/Digestive Disorder	

Cancer (Specific Type): _____

Other:_____

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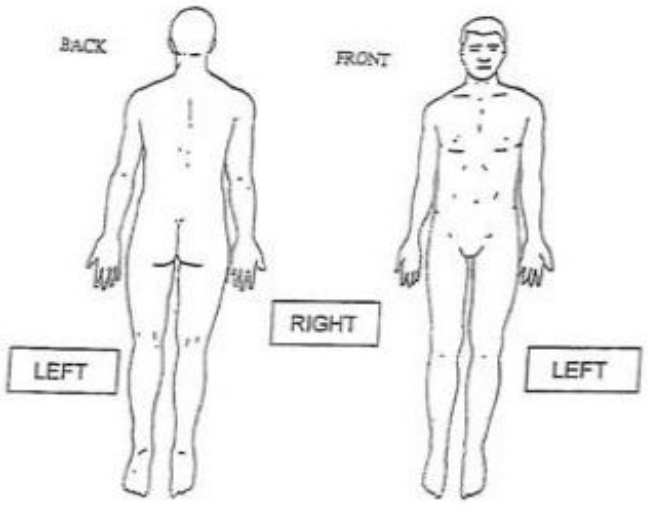
Patient name: _____ Date: _____

Height: _____ Weight: _____ BP: _____ /_____ Pulse: _____



Rate your overall pain, soreness or achiness. (circle one of the following)

No Pain is 0 **Severe Pain is 10**

1 2 3 4 5 6 7 8 9

On the picture, mark with an X the areas where you are experiencing pain or discomfort.

Additional Symptoms and Complaints:

_____

_____

_____

Have you lost time from work due to your injury? Y N

If yes, please give dates: _____

Type of employment: _____

Have you had previous injuries or accidents? Y N

Description of previous injury and/or accident:

_____

_____

_____

Is there any residual pain from the previous injury and/or accident? Y N

How much better did you feel prior to your current condition? (example 100%, 80% etc.)

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Patient Name: _____ DOB: _____

SYSTEM REVIEW

Circle the conditions in each category that cause you problems or discomfort

GENERAL
Recent weight change
Fever
Fatigue
Headache

INTEGUMENTARY (Skin/breast)
Rash or itching
Change in the hair or nails
Varicose veins
Breast pain
Breast lump
Breast discharge
History of breast cancer
Last mammogram _____
History of cyst

EYES
Eye disease or injury
Glasses/Contact lenses
Blurred/Double vision
Glaucoma

EARS/NOSE/THROAT/MOUTH
Hearing loss or ringing
Earache or drainage
Chronic sinus problems
Nose bleeds
Mouth sores
Bleeding gums
Bad breath or bad taste
Sore throat or voice change
Swollen glands in neck

RESPIRATORY
Chronic or frequent cough
Spitting up blood
Shortness of breath
Asthma or wheezing

CARDIOVASCULAR
Health trouble or murmur
Chest pain
Palpitation
Shortness of breath
Swelling of feet

GASTROINTESTINAL
Loss of appetite
Change of bowel movement
Nausea or vomiting
Frequent diarrhea
Constipation/painful bowel
Rectal bleeding/bloody stool
Abdominal pain or heartburn
Peptic ulcer

GENITOURINARY
Frequent urination
Burning/painful urination
Blood in urine
Forced/stained urination
Incontinence/dribbling
Kidney stone
Sexual difficulty
Painful menstruations
Vaginal discharge
Irregular menstruation
Last PAP smear _____
Total pregnancies _____
# of deliveries _____
# of miscarriages _____
Method of birth control_____
_____

MUSCULOSKELETAL
Joint stiffness
Joint pain
Muscle weakness
Back pain
Cold extremities
Difficulty walking
Muscle pain/cramps

NEUROLOGICAL
Frequent headaches
History of concussion
Light headed/dizziness
Seizures
Numbness/tingling
Tremors
Paralysis
Stroke

ENDOCRINE
Glandular/hormone problem
Thyroid disease
Diabetic
Excessive thirst/urination
Heat or cold intolerance
Dry skin
Change in hat or glove size

HEMATOLOGICAL/LYMPHATIC
Slow to heal after cuts
Bleeding or bruising
Anemia
Phlebitis
Past transfusion
Enlarged glands
Hepatitis A B C /HIV

LIST YOUR ALLERGIES
_____
_____
_____
_____
_____
_____

LIST ALL MEDICATIONS
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Patient initials: _____
Date: _____

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Authorization to obtain, release, or review protected health information

I, _____, hereby authorize Chiropractic Clinics of Central Florida to obtain, release, or review protected health information in accordance with deferral law and state law. This authorization will expire one (1) year from the date of my signature if I fail to specify a date, event, or condition of expiration._____

Issued to:

_____

Name of physician, individual, agent, or healthcare facility

_____

Address City State Zip code

For the purpose of: **( ) Medical Treatment** **( ) Other:**
Dates of Services: **From:** _____ **To:** _____

I understand that this authorization is revocable upon written notice to the office where the original authorization was retained, except to the extent that action has already been taken on this authorization. Mental health, alcohol, drug, HIV, and/or AIDS information is confidentially protected by Federal and State Law which prohibits disclosure without specific written authorization of the undersigned, or as otherwise permitted by such regulations. I further request that no genetic counseling/testing information in my record be released without my written authorization, except as otherwise required by law. Furthermore, I understand that any disclosure of information from my records carries with it the potential for an unauthorized redisclosure of my health information. I understand that my medical records with protected health information will be released to insurance companies for billing purposes during the processing of claims. I further understand that Chiropractic Clinics of Central Florida may not condition the provision of treatment, payment, and enrollment in health plan or eligibility for benefits on the provision of this authorization.

Place your initials by each item to be obtained, released, or review

____Complete medical record/Medical record abstract/All diagnostic test.
____Medical records and progress notes
____Pathology reports/Laboratory medicine
____Therapy & rehabilitation records
____Consultations/disability evaluations
____Operative records/procedural records
____Radiology/nuclear medicine studies
____Imaging studies/MRI/CT/VF/ultrasound
____Emergency room/hospital records
____Mental health records
____Electro diagnostic medicine
____HIV testing/AIDS information
____Drug of alcohol testing
____IME reports
____Other:_____

Revoked Authorization of Denied Releases

____ I do not want my medical record released to the following persons, agencies, or individuals and revoke any prior authorization to such persons or entities.

_____

Name and addresses of withheld release entities

Patient signature: _____ DATE: _____ DOB: _____
Address: _____

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Chiropractic Health

INFORMED CONSENT FOR CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic treatments (also known as chiropractic adjustments or chiropractic manipulative treatments) and any other associated procedures: physical examination, tests, diagnostic x-rays, physio therapy, physical medicine, physical therapy procedures, etc. on me by the doctor of chiropractic named above and/or other assistants and/or licensed practitioners.

I understand, as with any health care procedures, that there are certain complications, which may arise during chiropractic treatments. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, homers' syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains ns separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to complications including stroke.

I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, that ae in my best interest.

I have had an opportunity to discuss the nature, purpose and risks of chiropractic treatments and other recommended procedures. I have had my questions answered to my satisfaction. I also understand that specifics results are not guaranteed.

If there is any dispute about my care, I agree to a resolution by binding arbitration according to the American Arbitration Association guidelines.

I have read (or have had read to me) the above explanation of the chiropractic treatments. I state that I have been informed and weighed the risks involved in chiropractic treatments. I state that I have been informed and weighed the risks involved in chiropractic treatment at this health care office. I have decided that it is in my best interest to receive chiropractic treatment. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment.

SIGN ONLY AFTER YOU UNDERSTAND AND AGREE TO THE ABOVE

_____	_____	_____
Printed name of patient	Signature of Patient	Date

_____	_____	_____
Signature of Representative	Witness to Patient's Signature	Date

(If patient is a minor or is handicapped)

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PATIENT CONSENT FORM
Federally Mandated Privacy Regulation Requirement

I hereby give my consent for Chiropractic Clinics of Central Florida or my physician(s) to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by Chiropractic Clinics of Central Florida or my physician(s) describes such uses and disclosures more completely).

I have the right to review the Notice of Privacy Practices prior to signing this consent. Chiropractic Clinics of Central Florida or my physician(s) reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to (insert name and address of privacy officer for the practice).

With this consent, Chiropractic Clinics of Central Florida or my physician(s) may call my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to m clinical care, including laboratory test results, among others.

With this consent, Chiropractic Clinics of Central Florida or my physician(s) may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked “Personal and Confidential”.

With this consent, Chiropractic Clinics of Central Florida or my physician(s) may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Chiropractic Clinics of Central Florida or my physician(s) restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to y requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Chiropractic Clinics of Central Florida or my physician(s) to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Chiropractic Clinics of Central Florida or my physician(s) may decline to provide treatment to me.

Patient/guardian must be provided with a signed copy of this authorization form.

_____	_____	_____
Print Name	Patient’s Signature	Date

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We know you had a choice for your Chiropractic care and we at Kerinver are glad you choose us! At Kerinver Chiropractic it is our mission that our team of Musculoskeletal Injury Rehabilitation Professionals exist to enthusiastically provide the highest quality healthcare to the Central Florida Area. Our professional training and experience give us the essential tools to ensure proper rehabilitation, while our honesty and character will deliver an amazing Chiropractic experience. It is a daily goal of our team to strive for excellence.

Having that in mind please take a moment to comment on your experience so far:

1– How soon after you arrived where you greeted? ____Immediately ____ 2minutes or more

2- How did you hear about us? _____Dr. Referral _____Attorney Referral _____Walk in _____Radio _____ Television _____ Friend _____ Internet_____Other

3- Was your appointment confirmed prior to arriving? _____Yes ____No

4- Was your appointment scheduled by your referring Doctor? ____Yes _____No

5- Who may we thank for referring you? _____

6- We welcome any comments or suggestions on how we can better serve you?

_____

_____

Date_____ Zip Code _____

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Patient Agreement / Assignment of Benefits

(Please complete the form in full. Send copy of insurance card if available)

Patient Information

Patient name _____

Date of Birth _____ SS# _____ Date of injury or Onset of Symptoms _____

Address _____ City _____ State _____ Zip _____

Phone _____ Alt Phone _____ Email _____

Insurance Information

Insurance Type: Private PPO Workers Compensation Self Pay Auto Other: _____

Name of insured _____ Insurance Company _____

Policy/Claim# _____ Group # _____

Home Phone _____ Mobile Phone _____

Assignment of Benefits/Release of information

Patient Signature Required for Proof of Delivery, Assignment of Benefits, Acknowledgement of Receipt of Privacy Notice, and Terms and Conditions of agreement.

By signing below, I authorize Chiropractic Clinics of Central Florida to submit a claim for such service(s) to my insurer on my behalf and assign the benefits payable by my insurer to CCCF. I authorize my Health Care Provider and CCCF to release any of my medical information required by my insurer to process the claim.

I understand that CCCF does not waive patient balances and that I am responsible for any and agree to pay any portion of the amount due for such service(s) not paid for by my insurer, whether resulting from deductible, co-pays, determination of noncoverage, or otherwise. In the event benefit payments due CCCF are paid directly to patient, the payee shall immediately endorse and remit to CCCF all such benefit checks. I understand that the CCCF Privacy Policy and the Patient Bill of Rights and Responsibilities are available on the CCCF website (www.chiropractorkissimmee.com) and will be delivered to me with the device and I can contact customer service at 407-483-3598, if I have any questions.

I hereby acknowledge and affirm that I have received delivery of the device prescribe/ordered for my home use and that I have been fitter with the device and instructed upon its use and I understand the instruction I have received.

***NOTICE: Return of non-defective equipment accepted only if UNUSED and returned within 15 days of receipt ***

*Patient Signature _____ Date _____

Guarantor/Legal Rep (If patient unable to sign) _____

Relationship to patient _____ Date _____

FAX TO CCCF: (407) 483-3599

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