Auburndale Chiropractic, LLC
214 S. Main Street
Auburndale, Florida 33823
863-968-0088
Fax: 863-968-0181

PATIENT INFORMATION

Full Name _____ Birth Date_____ Gender: M F

Address _____ City_____ State_____ Zip_____

Email: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Marital Status: S M W D Sep SS# _____-____-_____ Spouse Name_____

Emergency Contact Name_____ Relationship: _____ Phone: _____

Your Employer_____ Your Occupation_____

Employer Address_____ City_____ State_____ Zip_____

Spouse's Employer_____ Spouse's Occupation_____

Health Insurance _____ No _____ Yes Company _____
INSURANCE (please allow our staff to photocopy your Insurance Information and Driver License)
This is necessary for audit and billing purposes

How did you hear about our office? _____

Did someone refer you? _____ Who? _____

- I authorize payment of medical benefits to this office.
- I will allow this office to treat me, with other health care providers present, and to record my medical information, including consultation and examination, for documentation purposes, if necessary.
- I give this office the right to use my name for any in-office publications.
- Authorization may be denied or retracted by notifying the office manager.
- If your account is turned over to a collection agency for non-payment, you will be responsible for any cost incurred in collections of said balance. This could include collection agency fess of up to 50% of your outstanding balance, court costs and attorney fees.
- I understand that if my insurance company does not approve or pay for any treatment I receive, I will be responsible for them myself.
- I understand this office will do everything within its abilities to get the insurance company to pay but otherwise, it is my responsibility.

Patient's Signature_____ Date_____

Spouse's or Guardian's Signature_____ Date_____
(Authorization expires 3 years from date above)

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CASE HISTORY

History of Present Injury/Illness

Please list below the complaint(s) you have in the order of importance. Also the length of time you have had these complaint(s).

1. _____ How long? _____
2. _____ How long? _____
3. _____ How long? _____
4. _____ How long? _____

Is your condition(s) related to an accident? ___YES ___NO
Date of accident: _____ Type of Accident: ☐ Auto ☐ Work Related ☐ Other: _____

What words best describe your present condition(s)? (ex. ache, burn, tingling, etc)_____
Circle the number that matches your level of pain at its worst (0=no pain, 10=most sever) 0 1 2 3 4 5 6 7 8 9 10
How intense is the problem? MILD MODERATE SEVERE

When does the problem occur? (ex. Standing, sitting, exercise, etc)_____
When is your condition most severe? _____
When is your condition least severe? _____
Is your condition: ___ Getting worse _____Staying the same___ Getting better___ Comes & Goes___
Other (explain) _____
Have you ever had the same or similar conditions in the past? ___YES ___NO
IF YES, EXPLAIN _____

What makes your condition feel worse? _____
What makes your condition feel better? _____
Have you seen any other health care provider for your present condition? ___YES ___NO
Who? _____

Do you have a pacemaker?	No	Yes
Are you or could you be pregnant?	No	Yes
Do you have a sore throat that will not heal?	No	Yes
Do you have difficulty swallowing?	No	Yes
Do you have a persistent cough/hoarseness?	No	Yes
Do you have any bleeding /discharge?	No	Yes
Do you have a lump/thickening anywhere?	No	Yes
Do you have wart/mole changes?	No	Yes
Do you have weight loss without trying?	No	Yes
Do you have night pain?	No	Yes
Do you have any lung problems?	No	Yes
Do you have any bowl/urinary problems?	No	Yes
Have you ever been diagnosed with Diabetes?	No	Yes
Have you ever been diagnosed with Hypertension?	No	Yes
Have you ever been diagnosed with Heart problems?	No	Yes
Have you ever been diagnosed with Cancer?	No	Yes
Have you had an X-ray, MRI or CT Scan in the past 28 days?	No	Yes
Are you currently under a doctor's care for conditions other than the ones you are seeking for today?	No	Yes

List any surgeries you have had (including appendix, tonsils, wisdom teeth)

_____ Date_____
_____ Date_____
_____ Date_____
_____ Date_____
_____ Date_____

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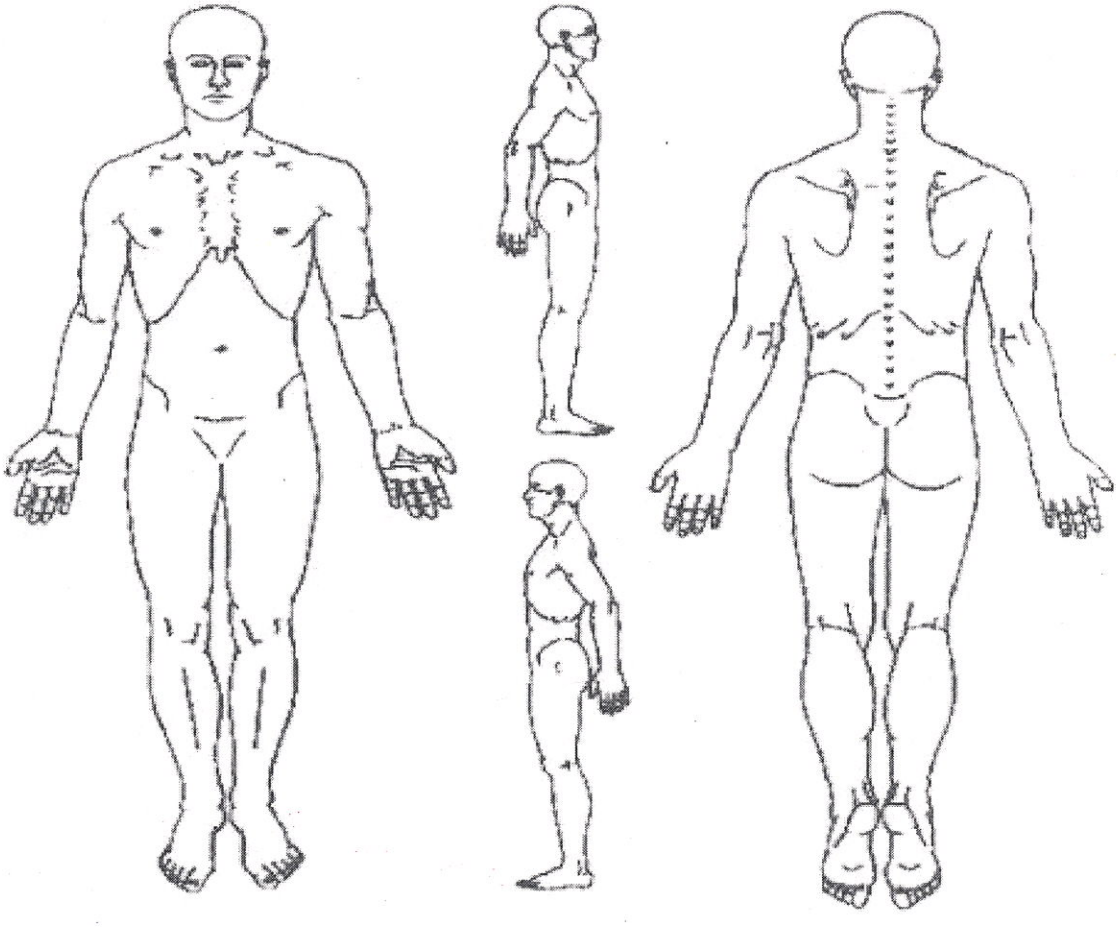
On the diagram below indicate your concerns with corresponding letters located at the bottom of the page



A= ACHE
P= PINS & NEEDLES

B= BURNING
S= STABBING

N= NUMBNESS
O= OTHER

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Informed Consent Form

I hereby request and consent to the performance of chiropractic adjustment and other chiropractic/medical procedures, including various modes of physical therapy and diagnostic x-rays by Auburndale Chiropractic, LLC. This consent is extended to other licensed chiropractic physicians, chiropractic assistants or licensed massage therapists, who now or in the future, are employed by, working with or associated with this office.

I certify that I have had the opportunity to discuss, with the doctor of chiropractic and/ or other office personnel, the nature and purpose of the care that is being provided. I understand that the results are not guaranteed. Further, I have been informed and I understand that, as in the practice of any of the healing arts, in the practice of chiropractic, there are some risks to treatment including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I also understand that the doctors who has explained all of these things to me, is not expected to be able to anticipate and explain all risks and complications. I will rely on the doctor to exercise appropriate judgment during the course of care, based on the facts known at this time, and in my best interest.

My signature below certifies that I have read, or have had read to me the above consent. I also certify that I have had the opportunity to ask questions and options to care have been explained. By signing this consent form, I agree to the care being provided to me for the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment.

_____
Patient's name (print)

X_____
Patient's Signature Date

X_____
Patient representative (If patient is a
Minor or if physically or mentally impaired)

X_____
Witness Signature

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ACKNOWLEDGEMENT 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 Signature

_____
Date

_____
Parent, Guardian or Patient's legal representative

_____
Patient Name

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