SEMINOLE CHIROPRACTIC INJURY AND WELLNESS CENTER

10863 PARK BLVD. #2 SEMINOLE, FL 33772
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NEW PATIENT ENTRANCE APPLICATION

Welcome! We are honored you chose us to evaluate your condition. So we may file your insurance forms for you, please fill out the personal information below. If you need assistance please inform the front desk person.
Thank you!

Personal Information:

Patient Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Social Security #: _____ Gender: M or F Marital Status: S M D W

Spouse Name: _____ Preferred Language: English / Other: _____

Date of Birth: ___/___/___ Age: _____

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

Home Email: _____ Work Email: _____

Preferred Method of Communication for Patient Reminders: (Circle One): Email / Phone / Mail

Emergency Contact: _____ Relationship: _____ Phone#: _____

CMS requires providers to report both race and ethnicity.

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) / Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

☐ **I choose to decline receipt of my clinical summary after every visit** (*These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: _____ **Date:** _____

Patient History

Are you seeing anyone else for other problems or health conditions? (Circle one) Yes / No

Please list the problem/s, date problem/s began, and provider/s treating you for the condition/s:

_____

_____

Past Health History

Have you ...	Yes	No	If yes, include date & provider seen
... Been diagnosed with Hypertension?	___	___	_____
... Been diagnosed with Diabetes?	___	___	_____

Type I _____ or Type II _____

Do you smoke? Never / Former Smoker / Current Every day Smoker / Current Someday Smoker

Are you currently taking any medications? (Please include regularly used over the counter medications, vitamins, herbs and minerals.) You may continue the medication information on the back if additional room is required.

Medication Name	Dosage and Frequency	Start Date of Medication

Do you have any allergies? (Circle all that apply): Food / Environment / Medication

Allergy	Reaction

Have you had any previous surgeries? Please list Surgery and year.

Surgeries	Year

*** For office use only ***

Height: _____ Weight: _____ Blood Pressure: _____ / _____

SEMINOLE CHIROPRACTIC INJURY AND WELLNESS CENTER
INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I herby request and consent to the performance of chiropractic adjustments and any other chiropractic procedures, including a comprehensive exam, diagnostic x-rays, physical therapy techniques, on me (or on the patient name below for which I am legally responsible).

I understand that, as with any health procedure, there are certain conditions that may arise during a chiropractic adjustment. Those complications include but are not limited to: fractures, dislocations, muscle strain, costovertebral strain and separations. Some types of manipulations of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. This is a very rare occurrence (a one in three million chance). We screen our patients for indications that they are candidates for chiropractic adjustments to the best of our ability; I do not expect the doctor to be able to anticipate all risk and complications during the course of the procedure(s) that the doctor feels at the time, based upon the facts then known, are in the best interest.

I have had the opportunity to discuss with the doctor the nature, purpose, and risk of chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed.

There are times when individuals other than staff may see me receive treatments at the clinic or overhear discussions on my condition or insurance. I consent to others perceiving these interactions at the clinic, if additional privacy is required, I will inform the clinic staff. I have read of have had read to me the above explanation of the chiropractic adjustment and related treatment. By signing below, I state that I weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the chiropractic treatment recommended. Having being informed of the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_____
Printed name of patient

_____ _____
Signature of Patient Date

_____ _____
Signature of patient's representative (if minor) Date

VEHICLE ACCIDENT HISTORY

Date & Time of Accident:_____

Please describe the accident in your own words:_____

_____

_____

_____

Were you the: [ ] Driver [ ] Front Passenger How many people in the accident vehicle?_____

[ ] Rear Passenger [ ] Pedestrian

ACCIDENT SITE

Road/Street Name_____

City & State_____

Nearest intersection with road/street_____

Driving Conditions: [ ] Dry [ ] Wet [ ] Icy [ ] Other

Which direction were you headed?_____

Speed you were traveling?_____

VEHICLE

Make and model of vehicle you were in:

_____

Were you wearing a seatbelt? [ ] Yes [ ] No

If yes, what type? [ ] Lap [ ] Shoulder

Was vehicle equipped with airbags? [ ] Yes [ ] No

If yes, did it/they inflate properly? [ ] Yes [ ] No

Did your seat have a headrest? [ ] Yes [ ] No

If yes, what was the position of the headrest?

[ ] Low [ ] Midposition [ ] High

OTHER VEHICLE (if applicable)

Make and model of other vehicle_____

Which direction was other vehicle headed?_____

Speed other vehicle was traveling_____

IMPACT

Did your car impact another vehicle? [ ] Yes [ ] No

Did your car impact a structure? [ ] Yes [ ] No

If yes, explain_____

_____

_____

Did any part of your body strike anything in the vehicle?

[ ] Yes [ ] No If yes, explain_____

Was impact from:

[ ] Front [ ] Rear [ ] Left [ ] Right [ ] Other

At the time of impact were you:

[ ] Looking straight ahead

[ ] Looking to the left

[ ] Looking up

[ ] Looking to the right

[ ] Looking down

Were both hands on the steering wheel? [ ] Yes [ ] No

If no, which hand was on the wheel?

[ ] Right [ ] Left

Was your foot on the brake? [ ] Yes [ ] No

If yes, which foot was on the brake?

[ ] Right [ ] Left

Were you: [ ] Surprised by impact [ ] Braced for impact

POLICE

Did the police come to the accident site? [ ] Yes [ ] No

Were there any witnesses: [ ] Yes [ ] No

Was a traffic violation issued?

If yes, to whom?_____

PATIENT CONDITION

Were you unconscious immediately after the accident? [ ] Yes [ ] No If yes, for how long?_____
Please describe how you felt immediately after the accident:

_____

_____

_____

TREATMENT

Did you go the hospital? [ ] Yes [ ] No
When did you go? [ ] Immediately after accident [ ] Next Day [ ] 2 days or more after the accident
How did you get to the hospital? [ ] Ambulance [ ] Private transportation

Name of hospital_____ Name of Doctor_____

Diagnosis_____

_____

Treatment received_____

_____

X-rays taken_____

SYMPTOMS/INJURIES

Have you been able to work since this injury? [ ] Yes [ ] No How many work days have you missed?_____
Prior to the injury were you able to work on an equal basis with others your age? [ ] Yes [ ] No
If you have had any of the following symptoms since your injury, please mark with a check:

[ ] Arm/Shoulder pain
[ ] Back Pain
[ ] Back stiffness
[ ] Chest pain
[ ] Dizziness
[ ] Ear Buzzing
[ ] Ear ringing
[ ] Fatigue
[ ] Feet/Toe numbness
[ ] Hand/finger numbness
[ ] Headaches
[ ] Irritability
[ ] Jaw problems
[ ] Leg pain
[ ] Memory loss
[ ] Nausea
[ ] Neck pain
[ ] Neck stiff
[ ] Shortness of breath
[ ] Sleep difficulty
[ ] Stomach upset
[ ] Tension
[ ] Vision blurred

Is this condition getting progressively worse? [ ] Yes [ ] No [ ] Unknown

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain)_____

Type of pain: [ ] Sharp [ ] Dull [ ] Throbbing [ ] Numbness
[ ] Aching [ ] Shooting [ ] Burning [ ] Tingling
[ ] Cramps [ ] Stiffness [ ] Swelling [ ] Other

How often do you have this pain?_____

Is it constant or does it come and go?_____

Does it interfere with your: [ ] Work [ ] Sleep [ ] Daily Routine [ ] Recreation

Activities or movements that are painful to perform: [ ] Sitting [ ] Standing [ ] Walking
[ ] Bending [ ] Lying Down

Seminole Chiropractic, Injury & Wellness Center

1) How long can you walk before pain increases? _____ minutes

2) How long can you sit before pain increases? _____minutes

3) How long can you stand before pain increases? _____ minutes

4) How long can you drive before pain increases? _____ minutes

5) How long can you exercise before pain increases? _____ minutes

6) How long can you sleep before pain increases? _____ minutes

7) Do you need assistance with dressing? Yes / No

8) Does your pain increase when standing from seated position? Yes / No

9) Does your pain increase when getting in and out of bed? Yes / No

10) What is the maximum weight you feel you could lift without pain increasing? _____pounds

11) Does your pain increase going up and down stairs? Yes / No

12) What chores have been affected by pain? Please circle all that apply.

Cleaning Ironing Pet Care Gardening Laundry

Meal Prep/Cleanup Shopping Vacuuming

13) How far can you walk with no or minimal pain?

___ 0-50FT ___ 50-200FT ___ 200-500FT ___ 500+FT ___ ½ Mile+

Patient Name _____

Patient Signature _____

Date _____