# SEMINOLE CHIROPRACTIC INJURY AND WELLNESS CENTER

*10863 PARK BLVD. #2 SEMINOLE, FL 33772*
*PHONE #727-399-2229 FAX #727-399-2228*

## 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.**

**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: _____ Cell Phone: _____ Cell Carrier: _____

Home Email: _____ Work Email: _____

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

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

**Patient Signature:** _____ **Date:** _____

***** For office use only *****

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

# PAST AND GENERAL HISTORY

To help us better understand your unique condition please complete the information below related to your past and general history.

**Past History:** Please Make Below With an "X"

| Past | Present | Condition | Past | Present | Condition | Past | Present | Condition |
|---|---|---|---|---|---|---|---|---|
| x | | *Example* | x | x | *Example* | | x | *Example* |
| | | Angina / Chest Pain | | | HIV | | | Seizures |
| | | Arthritis | | | Hypertension | | | Sleeping Problems |
| | | Asthma | | | Irritability | | | Soreness |
| | | Back Pain | | | Joint Stiffness | | | Speaking Problems |
| | | Balance Problems | | | Joint Swelling | | | Spinal Curvature |
| | | Broken Bones | | | Joint Tenderness | | | Stiffness |
| | | Cancer | | | Loss of Sleep | | | Stroke / TIA |
| | | Chills | | | Lumps | | | Tingling |
| | | Concentration Loss | | | Masses | | | Thyroid Problems |
| | | Diabetes I / II | | | Memory Loss | | | Tremors |
| | | Dizziness | | | Muscle Cramps | | | Vertigo |
| | | Fatigue | | | Muscle Pain | | | Weakness |
| | | Fainting | | | Nervousness | | | Other Please List: |
| | | Fever | | | Night Sweats | | | |
| | | Headaches | | | Numbness | | | |
| | | Heat Problems | | | Paralysis | | | |

**Medication and Surgical History:**

**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 |
|---|---|
| | |
| | |
| | |

***Please list any prior surgeries, major injuries or hospitalizations you may have had:**_____

_____

☐ **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 / Guardian Signature:* _____ *Date:* ____/____/____ Dr:_____

# SOCIAL AND FAMILY HISTORY

In an effort to provide you with the best care possible, please take a moment to answer the following questions related to your social history, daily activities and family history.

## Social History:

- ✓ What Is Your Current Work Status?

  __Employed Full time __Employed Part Time __Retired __Unemployed __Disabled __Student

- ✓ How Often Do You Exercise?

  __Never __1-3 Times per month __1-2 Times per week __3-4 times per week __Daily

- ✓ How Would You Rate the Intensity of Your Workout?

  __Never Exercise __Low Level __Moderate Level __High Level __Competition Level

- ✓ How Many Hours Do You Sleep Per Night?

  __<4 Hours __5-6 Hours __7-8 Hours __8-10 Hours __>10 Hours

- ✓ How Often Do You Eat A Balanced Diet?

  __Never __Rarely __Sometimes __Regularly __Always

- ✓ How Often Do You Drink A Caffeinated Beverage?

  __Never __1-3 Times Per Month __1-2 Times Per Week __3-4 Times Per Week __Daily __>2 Per Day

- ✓ How Often Do You Smoke Cigarettes?

  __Never __Past __1-3 Packs Per Month __1-2 Packs Per Week __3-4 Packs Per Week __>1 Pack A Day

- ✓ How Often Do You Drink Alcohol?

  __Never __Past __1-3 Drinks Per Month __1-2 Drinks Per Week __3-4 Drinks Per Week __Daily

- ✓ Have You Used Illicit / Street Drugs In The Past 6 Months?

  __Yes __No

**Daily Activities:** So that we may have an idea as to your daily routine please list a few of your daily activities and your favorite hobbies: _____

_____

- ✓ Does Your Current Condition Affect Your Performance In These Activities Or Hobbies? __ Yes __ No

  If So, How: _____

# SOCIAL AND FAMILY HISTORY

In an effort to provide you with the best care possible, please take a moment to answer the following questions related to your social history, daily activities and family history.

**Family History Information: Please Indicate If Anyone In Your Family Currently Has, Or Has In The Past, Suffered From Any Of The Conditions Listed Below:**

***Arthritis:**
__Yes __No Whom:_____

***Back Pain:**
__Yes __No Whom:_____

***Cancer:**
__Yes __No Whom:_____

***Diabetes:**
__Yes __No Whom:_____

***Heart Disease:**
__Yes __No Whom:_____

***High Blood Pressure:**
__Yes __No Whom:_____

***High Cholesterol:**
__Yes __No Whom:_____

***Osteoporosis:**
__Yes __No Whom:_____

***Stroke:**
__Yes __No Whom:_____

***Thyroid Conditions:**
__Yes __No Whom:_____

*Patient / Guardian Signature:* _____ *Date:* ____/____/____ *Dr:* _____

# CHIROPRACTIC PATIENT HISTORY

So that we may better understand your unique condition, please complete the following information with regard to your current complaint.

## Location:

What is your Primary Complaint? _____

What Caused the Onset? _____

When did it Start? ____/____/____

Does the Complaint Radiate or Travel? If so, Where? _____

## Timing and Duration:

- ✓ Since the onset of your complaint how has it been changing? __ Getting Better __ Not Changing __ Getting Worse
- ✓ How often do you experience the complaint?
  __ Constantly (100%) __ Frequently (75%) __ Occasionally (50%) __ Intermittently (25%)
- ✓ When does it feel worse? __ No Change __ Morning __ As day progresses __ Afternoon __ Evening __ During the night
- ✓ When does it feel better? __ No Change __ Morning __ As day progresses __ Afternoon __ Evening __ During the night
- ✓ How much has the complaint interfered with your normal work? (including both work and outside the home and housework)
  __ Not at all __ A little bit __ Moderately __ Quite a bit __ Extremely
- ✓ How much would you say this complaint has affected your social activities?
  __ All the time __ Most of the time __ Some of the time __ A little of the time __ None of the time

## Severity:

Use the key below to rate the severity of your pain.

0 = No Pain 1 = Minimal 2 = Very Mild 3 = Mild 4 = Mild to Moderate 5 = Moderate 6 = Moderate to Severe
7 = Mildly Severe 8 = Severe 9 = Very Severe 10 = Excruciating a

Please Circle where you rate your pain: 1 2 3 4 5 6 7 8 9 10

## Quality:

How would you describe the sensation of your complaint? (Circle all that apply)

Sharp Pain Shooting Numbness Tingling Dull Ache
Burning Throbbing Other _____

## Modifying Factors:

What makes your complaint feel worse? (Circle all that apply)

Coughing / Sneezing Standing Lifting Exercising Bending Twisting Pushing / Pulling
Sitting Walking Driving Climbing Other: _____

## Alleviating Factors:

What makes your complaint feel better? (Circle all that apply)

Rest / Sleep Stretching Lifting Exercising Bending Twisting Pain Medication Ice Heat
Shower Walking Other: _____

## Previous Treatment:

Who have you seen for this condition?

___ Medical Doctor ___ Physical Therapist ___ Chiropractor ___ Other: _____

Have you had Chiropractic care in the past? ___ Yes ___ No If so, When? ___/___/___

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: _____

_____

## Risk Factors:

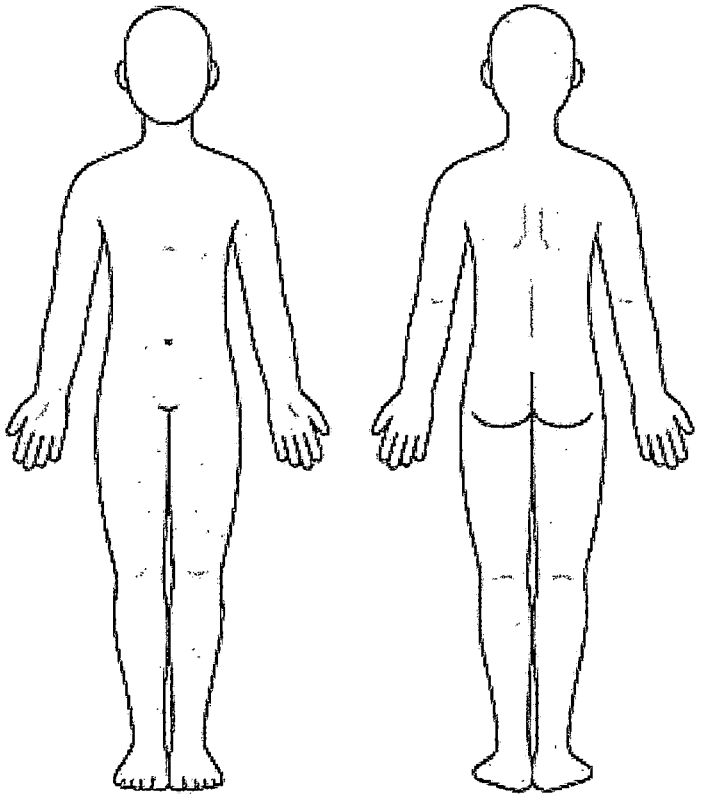
Do you have a pace maker? ___ Yes ___ No Are you pregnant? ___ Yes ___ No ___ Maybe

Do you have any metal implants or devices? ___ Yes ___ No

*Patient / Guardian Signature:* _____ *Date:* ____/____/____ *Dr:* _____

*On the diagram below please mark with an x any area you are experiencing pain or discomfort!*

Right Left Left Right



Front Back

*How long can you perform each of the activities below before pain increases?*

Walking? _____ Minutes Sitting? _____ Minutes Standing? _____ Minutes

Driving? _____ Minutes Exercising? _____ Minutes Sleeping? _____ Minutes

*Please circle any of the following activities that are affected by pain.*

Standing from a seated position Getting out of bed going up and down stairs

Cleaning Ironing Pet Care Gardening Laundry

Meal Prep/Cleanup Shopping Vacuuming

How far can you walk with no or minimal pain? __ 0-50ft __ 50-200 ft __500+ft __ ½ Mile+

Patient Signature_____ Date_____

# 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 compilcations 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

# Seminole Chiropractic Injury and Wellness Center

Dr. Stephen Nickse
NPI:1881687374 / TIN: 59-3715094
10863 Park Blvd, Suite 2
Seminole, FL 33772
727-399-2229

Patient Name: _____ DOB:_____

## Good Faith Estimate

| Estimated Services and Items | | | Appointment Date: | |
|---|---|---|---|---|
| Description | Diagnosis Code | Service Code | Quantity | Expected Cost |
| New Patient | | 99202 | 1 | $145.00 |
| ReEntry Patient | | 99212 | 1 | $75.00 |
| ReEntry Patient | | 99211 | 1 | $40.00 |
| Adjustment Age 14 and up | | 98940 | 1 | $51.00 |
| Adjustment Age 0 to 13 | | 98940-1 | 1 | $25.00 |
| Electric Muscle Stimulation | | 97010/97014 | 1 | $25.00 |
| Traction | | 97012 | 1 | $25.00 |
| Ultrasound | | 97035 | 1 | $25.00 |
| P - Primary service ( initial reason for visit )<br>C - Co-Provider Services<br>R - Recurring Services or Item ( Valid for up to 12 months from date on this form ) | | Total Expected Charges: _____<br>Date of Good Faith Estimate:_____ | | |

Disclaimers:

*The Diagnosis listed above is only a working diagnosis that may change pending the outcome of the physician's full examination.

*There may be additional items or services that we recommend as part of the course of care that must be scheduled or requested separately and are not reflected in this good faith estimate.

*The information provided in this good faith estimate is only an estimate of the items or services reasonably expected to be furnished at the time this good faith estimate was and actual items, services or charges may differ from the good faith estimate.

*You have the right to initiate the patient provider dispute resolution process if the actual billed charges are $400 more that the expected charges included in the good faith estimate and the dispute is initiated within 120 days after the date of the bill or the items or services. To start the process you may contact us at the phone number or address listed above to let us know the billed charges are higher than the good faith estimate. You can ask us to start a dispute resolution service with the U.S. Department of Health and Human Services with 120 calendar days ( about 4 months ) of the date on the original bill and if the agency disagrees with you, you will have to pay the higher amount. To learn more and get a form to start the process go to www.cms.gov/nosuprises.

*This Good Faith Estimate is not a contract and does not require you to obtain the items or services from any of the providers or facilities identified in the good faith estimate.

Patient Signature:_____ Date:_____