FCIC

Florida Chiropractic and Rehabilitation Clinics PL
Jared Winters D.C., Bobbi-Jo Donner D.C.

General Patient Information

First and last name _____ Nick name _____

Date of Birth ____/____/____ Age_____ Gender ☐ F ☐ M

Address _____

City _____ State _____ Zip Code _____

Primary Phone _____ Secondary/mobile _____

Email _____ SSN _____

What is your Occupation _____ Employer _____

Job requirements _____

Primary Care Physician Name and Clinic _____

Marital status ☐ S ☐ M ☐ D ☐ W Spouse's name_____

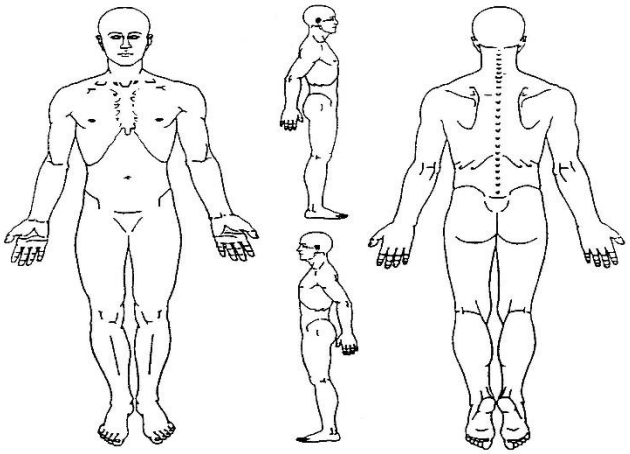
Do you have children ☐ Y ☐ N How many? _____

Emergency contact: Name _____ Relationship _____Ph: _____

Whom may we thank for referring you to our office? _____

Chief Complaint

Please mark the areas of your symptoms on the figures below.



Please circle your level of pain below:

1 = minimal pain 10 = worst pain imaginable

Pain Currently

1 2 3 4 5 6 7 8 9 10

Pain at its worst

1 2 3 4 5 6 7 8 9 10

What is your chief complaint? _____

Is this condition due to an accident? ☐ Yes ☐ No ☐ Auto ☐ Work ☐ Home ☐ Other Date_____

When did your symptoms start? _____

What do you think caused your symptoms? _____

How long does your pain last? Is it: ☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent

Does this pain interfere with your: ☐ Work ☐ Sleep ☐ Daily routine ☐ Recreation

Does your pain radiate? ☐ Yes ☐ No If Yes please explain where _____

Activities or movements that are difficult or painful to perform: ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lifting ☐ Lying down ☐Twisting ☐ other_____

What time of day are your symptoms worse? ☐ Morning ☐ Evening ☐ Middle of night ☐ As day progresses

This pain can be described as: ☐ Dull ☐ Sharp ☐ Aching ☐ Shooting ☐ Spasm ☐ Throbbing ☐ Burning ☐ Numbing ☐ Tingling ☐ Other _____

What treatments have you received for this condition? ☐ Medications ☐ Surgery ☐ Physical Therapy ☐ Chiropractic ☐ Other_____

Name the other doctors that have treated you for this condition and how: _____

Were you satisfied with the results of your treatment, please explain? _____

Patient health history

Are you currently under the care of a Healthcare Provider or any other doctor? ☐ Yes ☐ No

If Yes, for what conditions _____

Providers Name _____

Have you had: ☐ X-ray ☐ CT scan ☐ MRI ☐ other When? _____

If yes: Where did you have the imaging done? _____ Who prescribed them? _____

Have you seen a chiropractor in the past? ☐ Yes ☐ No Date of last visit _____

If yes, what was their name and location? _____

Were you satisfied with your care? ☐ Yes ☐ No Why? _____

Medications

Please list current medications, including frequency and dosage. If **not taking medications** please check here ☐

Medication Name	Quantity/Dosage	Frequency	Condition treating	Prescribed by

Please use the back if you need more space.

Do you have any allergies? ☐ Yes ☐ No If yes please explain _____

Do you currently smoke tobacco? ☐Yes, for _____years ☐Never been a smoker ☐Quit smoking on _____date

If yes, how often do you smoke: ☐ Current every day smoker ☐ Current sometimes smoker

Past or Present Illnesses:

Have you had any of the following?

☐ ADD/ADHD
☐ allergies/hay fever
☐ Alzheimer's
☐ anemia
☐ arthritis
☐ asthma
☐ atopic dermatitis
☐ bedwetting
☐ cancer
☐ cerebral palsy
☐ chicken pox
☐ Crohn's/colitis
☐ CRPS (RSD)
☐ CVA (stoke)
☐ cystic kidney disease
☐ depression
☐ diabetes
☐ ear infections
☐ eczema
☐ emphysema
☐ eye problems
☐ fibromyalgia
☐ headaches
☐ heart disease
☐ hepatits
☐ HIV
☐ high blood pressure
☐ influenza pneumonia
☐ liver disease
☐ lung disease
☐ lupus erythema
☐ measles
☐ mumps
☐ multiple sclerosis
☐ Parkinson disease
☐ pleural effusion
☐ pneumonia
☐ psoriasis
☐ psychiatric condition
☐ scoliosis
☐ seizures
☐ shingles
☐ sickle cell
☐ spina bifida
☐ STDs
☐ suicide attempts
☐ thyroid problems
☐ vertigo
☐ other_____

Surgical History

	Date	Procedure (exp: Knee repair)	Description	Please circle one
1				In patient/Out patient
2				In patient/Out patient
3				In patient/Out patient
4				In patient/Out patient
5				In patient/Out patient
6				In patient/Out patient

Family History

Please list any diseases/illnesses that run in your family, ☐ Cancer ☐ Diabetes ☐ Stroke ☐ Heart disease ☐ Arthritis ☐ Other_____

_____

Review of systems

Please indicate if you have any of the following **currently.** Please mark **None** is none apply.

General
☐ **None**
☐ chills
☐ daytime drowsiness
☐ fainting
☐ fatigue
☐ fever
☐ night sweats
☐ loss of appetite
☐ weight gain/loss
☐ weakness

Eyes/Vision
☐ **None**
☐ blind spots
☐ blindness
☐ cataracts
☐ double vision
☐ eye problems
☐ itching
☐ sensitivity to light
☐ tearing
☐ wears contacts/glasses

Ears, Nose, and Throat
☐ **None**
☐ dizziness
☐ ear discharge
☐ ear pain
☐ fainting
☐ frequent sore throats
☐ hearing loss
☐ history of head injury
☐ loss of sense of smell
☐ nosebleeds
☐ nasal congestion
☐ runny nose
☐ sinus infection

Cardiovascular
☐ **None**
☐ heart problem
☐ heart murmur
☐ high blood pressure
☐ low blood pressure
☐ palpitations
☐ orthopnea (difficulty breathing lying down)
☐ paroxysmal nocturnal dyspnea
☐ stroke
☐ shortness of breath with exertion

Hematologic
☐ **None**
☐ anemia
☐ bleeding
☐ blood clotting
☐ blood transfusion
☐ easy bruising
☐ fatigue
☐ lymph node swelling

Gastrointestinal
☐ **None**
☐ abdominal pain
☐ abnormal stool (color/consistency)
☐ black/tarry stool
☐ constipation
☐ diarrhea
☐ difficulty swallowing
☐ hemorrhoids
☐ indigestion
☐ jaundice
☐ ulcers
☐ rectal bleeding
☐ loss of bowel control
☐ bedwetting

Respiration
☐ **None**
☐ asthma
☐ cough
☐ coughing up blood
☐ shortness of breath
☐ sputum production
☐ wheezing

Male
☐ **None/N/A**
☐ erectile dysfunction
☐ burning urination
☐ hesitancy/dribbling
☐ frequent urination
☐ urine retention/incontinence
☐ prostate problems

Female
☐ **None/N/A**
☐ abnormal vaginal bleeding
☐ taking birth control
☐ breast lump/pain
☐ burning urination
☐ frequent urination
☐ hormone therapy
☐ irregular menstruation
☐ vaginal discharge
☐ urine retention/incontinence
☐ cramps
I am… ☐ currently pregnant
☐ NOT currently pregnant
I have … ☐regular menses
☐ irregular menses
☐ No longer have menses
Age of first menses _____
Age when menopause began_____
Date of last period ___/____/___

Skin
☐ **None**
☐ change in nail texture
☐ change in skin color
☐ hair loss
☐ hives
☐ history of skin disorders
☐ itching
☐ masses
☐ numbness
☐ rash
☐ skin lesions/ ulcers
☐ varicosities

Nervous System
☐ **None**
☐ dizziness
☐ facial weakness
☐ headaches
☐ limb weakness
☐ loss of consciousness
☐ loss of memory
☐ numbness
☐ seizures
☐ sleep disturbance
☐ slurred speech
☐ stress
☐ unsteadiness of gait/ loss of balance
☐ vertigo

Psychological
☐ **None**
☐ anxiety
☐ behavioral change
☐ bi-polar disorder
☐ confusion
☐ convulsions
☐ depression
☐ insomnia
☐ loss or change of appetite
☐ memory loss

All the answers I have given are correct to the best of my knowledge.

_____ _____ _____ _____ _____
Patient Signature Date Parent/Guardian Signature Relationship Date

_____ _____
Reviewing Physicians Signature Date

Patient Consent for Treatment

Consent for Treatment: I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of my physician. I also understand that all risks involved with treatment will be explained to me upon request.

Consent for Active Rehabilitation: I voluntarily consent to participation in active rehabilitation at the Florida Chiropractic and Rehabilitation Clinics. I understand that my participation in this program is voluntary and that I can stop the rehab program at any time. Since the process of strengthening and conditioning are a form of "controlled strain" there is a chance of aggravation or injury. I therefore understand the importance of communication to my physician any aggravation or injury that I observe during my rehabilitative process. I understand that all exercises and equipment will be fully explained to me before use.

I have read the above and understand the risks and benefits of the rehabilitation program. I agree to participate and have my rehabilitation information released to my doctor, insurance company or attorney, if requested.

_____

Patient Name

_____ _____

Patient Signature Date

_____ _____

Witness Date

Financial Policy

Our policy is to extend to you the courtesy of allowing you to sign your insurance benefits directly to us. This policy reduces your out-of-pocket expense and relieves you of the responsibility of filing your claims.

If you do not have insurance: All payments are expected at the time of service or by an authorized payment plan. Your personal balance may not exceed $100 at any time or your care may be terminated. Our various payment plans make care an affordable part of your family budget.

If you have insurance: All deductibles and co-payments are expected at the time of service or by an authorized payment plan. Your co-insurance balance may not exceed $100 at any time or your care may be terminated.

You are considered a cash patient until you bring in your insurance card and completed insurance forms and we qualify and accept your insurance coverage. We are happy to answer any questions you may have at any time regarding your coverage and financial arrangements.

Our fees are considered usual, customary and reasonable by most companies and therefore are covered up to the maximum allowance determined by the carrier. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees bearing no relationship to the current standard of care in this area.

If your carrier has not paid a claim within sixty (60) days of submission, you agree to take an active part in recovery of your claim. If your insurance carrier has not paid within ninety (90) days of submission, you accept responsibility for payment in full of any outstanding balance.

When the “active” portion of your care plan is completed, you will not be eligible for insurance assignment. Charges for services rendered will be due as they are rendered.

If you discontinue care for any reason other than discharge by the doctor, all balances will become immediately due and payable in full by you, regardless of any claim submitted.

***CANCELLATION POLICY:** All appointments with the doctor require 24 hour cancellation notice. All massage therapy appointments require 48 hour cancelation notice. The fee for improper notification of a cancellation will be $50. The FCRC understands that many of us have busy schedules and exceptions can be discussed on an individual basis.

Patient Printed Name_____

Signature_____ Date _____

Witness_____ Date _____

Florida Chiropractic and Rehabilitation Clinics PL
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Records Release Authorization

I, _____ do hereby authorize the release of my medical records, x-rays and any other information regarding my health to:

To: Florida Chiropractic & Rehabilitation Clinics

Address: 1918 Robinhood Street ____City: Sarasota__ State: FL___Zip: 34231

Phone: 941-955-3272 Fax: 941-955-3273

Records are to be released from:

From: _____

Address:_____

Signature:_____ Date:_____

(Office Use)

Patient Name: _____ DOB:_____

Item(s) being requested: _____

_____

Consent to Discuss Medical & Personal Information

I, _____ do hereby authorize and give my consent to The Florida Chiropractic and Rehabilitation Clinics to discuss or release my medical records, x-rays and any other information regarding my health and appointments to:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Signature:_____ Date:_____

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Assignment of Benefits

Patient Name: _____ Employer: _____

Insurance Company: _____

Group Number: _____

Policy Number / ID Number: _____

I hereby instruct the _____ insurance company to pay by check made out to and mailed directly to:

Florida Chiropractic and Rehabilitation Clinics, PL.

1918 Robinhood Street

Sarasota, FL 34231

If my current policy prohibits direct payment to doctor, then I hereby instruct you to make the check out to me and mail it to the above address for professional and medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment towards the total charges for professional services rendered. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.** This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional fees for non-covered services and/or fees over and above the insurance payment or as required by my insurance policy.

A photocopy of this assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in this claim.

Dated at _____ County, this _____ day of _____, 20____.

_____

Signature of policy holder

_____

Signature of Claimant, if other than policy holder