PATIENT INFORMATION & CONDITION FORM

Patient Name: ____ Today's Date: ____/____/______

Social Security Number ______________________ Birth Date: ____/____/______ Age: _____ Gender: F M

Height: ____________________ Weight: ____________________ Specify Right or Left Handed ______________________

Email ____

Address: ____

City ____ State ________ Zip ________________________

Phone (_______) ___________________ Marital Status: □ Married □ Separated □ Widowed □ Single

How did you learn about us? ____

If you are under 18 years of age, who are your legal parents or guardian?

Father: ______________________________________ Date of Birth: ____/____/____ Phone: (______) _______________

Mother: ______________________________________ Date of Birth: ____/____/____ Phone: (______) _______________

Guardian: ____________________________________ Date of Birth: ____/____/____ Phone: (______) _______________

Who do you normally live with? □ Mother and Father □ Father □ Mother □ Legal Guardian □ None of these

Your Occupation ______________________________ Employer ____

Work Address ____ Work Phone ______________________

Student at ____ □ FULL-TIME □ PART-TIME

Name of Spouse ____ Spouse's Date of Birth ____/____/____

Who should we contact in the event of an emergency? ________________________________ Phone (______) _______________

Do you have health insurance? □ YES □ NO □ Not Sure Company: ____

Full Name of Policy Holder: ____ Policy Holder's Date of Birth _____/_____/_______

Does the policy holder have the insurance through his/her employer? □ YES □ NO

If yes, who is the employer? ___________________________________

General Information Related to the Condition:

Approximately when did the conditions or symptoms begin to occur? ____/____/_______

Describe the conditions, symptoms or purpose of the appointment:

____

____

____

Additional Information Related to the Condition:

Describe your pain: ☐ Burning ☐ Sharp ☐ Dull ☐ Ache

What caused it? ____

What aggravates it? ____

What relieves it? ____

Have you ever had the same or similar condition in the past, prior to this most recent occurrence? ☐ Yes ☐ No **When?** ___/___/______

Describe: ____

____

____

Please indicate any other healthcare providers that you have seen for the current conditions or symptoms:

Name	Type of Licensure	Date of Last Visit
____________________	____________________________	___/___/___
____________________	____________________________	___/___/___

Please indicate any prior MRI's, X-Rays, or diagnostic testing in the past 7 years:

Diagnostic Testing	Facility	Date of Visit
____________________	____________________________	___/___/___
____________________	____________________________	___/___/___
____________________	____________________________	___/___/___

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Do you smoke? ☐ Yes ☐ No Number of packs: ________________________________

Do you drink alcohol? ☐ Yes ☐ No Number of Drinks __________________________________

Medical History:

List any previous accidents (automobile, on the job injuries, slips, falls, sports, etc.) and provide the accident date:

1) ____ ___/___/_____

2) ____ ___/___/_____

3) ____ ___/___/_____

What prior surgery have you had?

1) ____ ___/___/_____

2) ____ ___/___/_____

3) ____ ___/___/_____

Allergies (please list all):

____

____

What medications or drugs are you taking? ____

____

Serious illnesses or conditions not listed above?____

When? ________________________

WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant? ☐ YES ☐ NO ☐ UNCERTAIN

Due date: ______________________

Do you now have or have you ever had? Please check all that apply.

ALLERGIC-IMMUNOLOGIC: ☐ Hives/Eczema ☐Hay fever ☐ Catch colds easily ☐ Frequent sinus trouble ☐ Frequent influenza ☐ HIV ☐ AIDS ☐ Allergies ☐ Fever

CARDIOVASCULAR: ☐ Murmur ☐ Chest pain ☐ Palpitations ☐ Dizziness ☐ Shortness of breath ☐ Swollen ankles ☐ Heart attack ☐ Irregular heartbeat ☐ Pressure over the chest ☐ Pain down the left arm ☐ High triglycerides ☐ High cholesterol levels ☐ Profuse sweating ☐ Nausea ☐ Vomiting ☐ Low blood pressure ☐ Fainting spells ☐ High blood pressure ☐ Difficulty lying flat

CONSTITUTIONAL: ☐ Weight loss ☐ Fatigue ☐ Fever

EAR/NOSE/THROAT: ☐ Difficulty hearing ☐ Buzzing in ears ☐ Ringing in ears ☐ Vertigo ☐ Sinus trouble ☐ Nasal stuffiness ☐ Hearing loss ☐ Ear pain ☐ Mouth sores ☐ Hoarseness ☐ Nose bleeds ☐ Dental problem ☐ Frequent sore throat ☐ Difficulty swallowing

ENDOCRINE: ☐ Loss of hair ☐ Heat/Cold Intolerance ☐ Hypothyroidism ☐ Hyperthyroidism ☐ Diabetes ☐ Goiter
EYES: ☐ Glasses/Contacts ☐ Eye pain ☐ Light bothers eyes ☐ Double vision ☐ Cataracts ☐ Vision problems ☐ Blurred vision ☐ Glaucoma

GASTROINTESTINAL: ☐ Heartburn/Reflux ☐ Nausea/Vomiting ☐ Constipation ☐ Change in BMs ☐ Diarrhea ☐ Black or bloody BM ☐ Gallbladder problem ☐ Liver problem ☐ Hepatitis ☐ Distress from greasy food ☐ Ulcers ☐ Heartburn ☐ Hiatal hernia ☐ Colitis ☐ Blood in the stool ☐ Colon cancer ☐ Abdominal pain ☐ Burning in stomach ☐ Pancreatitis ☐ Jaundice ☐ Pain over stomach ☐ Mucus in stool

GENITOURINARY: ☐ Burning/Frequency ☐ Blood in urine ☐ Erectile dysfunction ☐ Abnormal discharge ☐ Leakage ☐ Incontinence ☐ Kidney infection ☐ Sexual difficulty ☐ Kidney stones ☐ Loss of libido

HEMATOLOGY/LYMPH: ☐ Easy bruising ☐ Gums bleed easily ☐ Enlarged glands ☐ Anemia ☐ Bleeding disorder ☐ Sickle cell anemia ☐ Lymphoma

MUSCULOSKELETAL: ☐ Joint Pain/Swelling ☐ Stiffness ☐ Muscle pain ☐ Neck pain ☐ Stiff neck ☐ Back pain ☐ Osteoarthritis ☐ Rheumatoid arthritis ☐ Bone spurs ☐ Broken bones ☐ Compression fracture ☐ Head injury ☐ Back injury ☐ Spinal trauma ☐ Birth trauma ☐ Birth defects ☐ Cancer ☐ Muscle weakness ☐ Muscular dystrophy ☐ Scheuerman's disease ☐ Scoliosis ☐ Lupus ☐ Spina bifida ☐ Spondylolisthesis ☐ Arthritis ☐ Neck injury ☐ Osteoporosis

NEUROLOGICAL: ☐ Loss of strength ☐ Numbness ☐ Headaches ☐ Heavy head ☐ Tremors ☐ Memory loss ☐ Difficulty speaking ☐ Multiple sclerosis ☐ Parkinson's disease ☐ Fainting ☐ Concussion ☐ Migraines ☐ Disorientation ☐ Loss of coordination ☐ Difficulty in walking ☐ Stroke ☐ Alzheimer's disease ☐ Weakness ☐ Disk problem ☐ Light Headed/Dizzy ☐ Epilepsy/Seizure ☐ Tingling

PSYCHIATRIC: ☐ Anxiety ☐ Depression ☐ Mood swings ☐ Difficult sleeping ☐ Nervousness ☐ Tension

RESPIRATORY: ☐ Cough ☐ Coughing blood ☐ Wheezing ☐ Chills ☐ Chronic cough ☐ Pneumonia ☐ Asthma ☐ Superficial breathing ☐ Chest pain ☐ Tuberculosis ☐ Bronchitis ☐ Emphysema ☐ Difficulty breathing ☐ Lung cancer

SKIN: ☐ Rash/Sores ☐ Lesions ☐ Itching/Burning ☐ Skin problem ☐ Slow healing ☐ Bruise easily ☐ Psoriasis ☐ Change in moles ☐ Change in skin color ☐ Skin cancer ☐ Scars ☐ Discolorations

MEN'S HEALTH ISSUES: ☐ Burning on urination ☐ Difficulty in starting urine ☐ Dripping urination ☐ Prostate trouble ☐ Prostate cancer

WOMEN'S HEALTH ISSUES: ☐ Hot flashes ☐ Vaginal discharge ☐ Nipple discharge ☐ Menstrual cramps ☐ Premenstrual depression ☐ Lumps in breast ☐ Hysterectomy

The date of last mammogram test was ___/___/_____ ☐ Mammogram is normal ☐ Mammogram is abnormal

The date of last pap test was ___/___/_____ ☐ Pap is normal ☐ Pap is abnormal

The age of onset for periods was ___ ☐ Periods are regular ☐ Periods are irregular

The age of onset for menopause was ___ Number of pregnancies ___

GENERAL: ☐ Recent weight gain ☐ Loss of sleep ☐ Recent weight loss ☐ Loss of appetite ☐ Fatigue ☐ Polio ☐ Rheumatic fever ☐ Cancer of any kind ☐ Metal Rods ☐ Pins ☐ Screws ☐ Staples ☐ Any type of Metal Beneath Skin

OTHER: ____

____

____

____

____

VALRICO
Spine & Rehab Center

ASSIGNMENT OF BENEFITS

I understand and agree that health and accident insurance policies are an arrangement between my insurance company and myself -- not between my insurance company and this office. I agree to pay my estimated patient responsibility and further understand that the estimated responsibility is neither a guarantee of payment by my insurance company, nor necessarily an accurate reflection of my actual responsibility as determined by my insurance company upon processing of my claims. In the event that my insurance company does not pay on my charges at the estimated rate or within a reasonable period of time, upon request of this office I will immediately pay the balance owing on my account unless otherwise agreed to in writing. I understand that an interest charge may appear on all accounts over 90 days. I further understand and agree, that if this office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse this office for all costs of such collection efforts, including, but not limited to, all court costs and attorney fees.

I authorize this office to release any medical information relating to my treatment to any insurance companies which may be responsible for paying benefits to me, and to any attorney s who may be representing me due to my condition, and to complete any usual and customary reports and forms at no charge to assist in collecting from my insurance companies, attorneys, or other payers.

I have read, understood, and agree to the foregoing. The information which I have provided is true and complete to the best of my knowledge.

Patient's Signature: ____ Date: ____________________

ACKNOWLEDGE OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below I acknowledge that I have received and reviewed a copy of Valrico Spine and Rehab Centers Notice of Privacy Practices.

The effective date of this agreement is this ________ day of ________________________, 20_____

____ ____________________
Signature of patient or personal representative Date

____
If signed by personal representative, relationship to patient

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Office Use Only:

Our organization has made a good faith effort to obtain a written acknowledgement of receipt of the Notice provided to the individual named below.

Patient name: ____

Refused to sign ☐ Physically unable to sign ☐

(Other)____

Employee Signature:______________________________ Date:______________________

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Informed Consent -- Chiropractic Care

Dr. Frank R. Fabbiano, DC State of Florida Department of Health License # CH9904
Dr. Ethan DeWeerd, DC State of Florida Department of Health License # CH12589

Patient's Name: ____

Date of Care Plan: _____/_____/________

Instructions: This document relates to your Informed Consent for care.
Please read carefully before signing.

General. I, the below-signed patient/individuals, have read this document and Care Plan in their entirety and understand the potential benefits and risks of the Care which you are recommending. I understand that there may be other forms of care which I may wish or need to seek provided by other health care practitioners. I also understand that there may be significant risks of not seeking any care for my condition.

I understand that while the Care Plan lists you as the "Rendering Provider," at any moment, other associates or staff in your office with appropriate scopes of practice and training may need to provide the Recommended Care based on factors which are not necessarily within anyone's ability to predict. You have made it clear that every health care practitioner who is licensed under state law may have different scopes of practice relating diagnoses and treatment and that the licenses of the primary Rendering Provider are listed below.

I do not expect you to be able to anticipate and explain all risks and complications, or forms of treatment, and I wish to rely on you to exercise judgment within your scope of practice during the course of the Care Plan which you feel at the time based upon the facts known. I understand that in rare cases, underlying physical defects, deformities or pathologies may render me susceptible to injury. It is my responsibility to make known before and throughout the Care whether I am suffering from any latent pathological defects, illnesses, or deformities that would otherwise not come to your attention, as well as any pathological defects, illnesses, or deformities I may be experiencing.

Possible Risks of the Care; Alternatives

Chiropractic manipulation / adjustment. As with any healthcare procedure, I understand that there are certain complications, which may arise during chiropractic manipulation, and that those complications include: fractures, disc injuries, dislocations, muscle strain, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I understand that fractures are rare occurrences and generally result from some underlying weakness of the bone. I also understand that stroke and other complications are also generally described as "rare."

<u>X-Rays.</u> I have been advised that x-rays can be hazardous to an unborn child. To the best of my knowledge. I am not pregnant.

<u>Other Potential Alternatives.</u> I understand that other treatment options for my condition may include: Self-administered, over-the-counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; hospitalization with traction; and surgery.

<u>Contraindications to Manipulation / Adjustment</u>. I understand that you will not give me an adjustment / manipulation, x-rays, modalities, or therapies if you feel that such are contraindicated. In the event that the Care does not include such procedures, I have discussed all contraindications with you and fully understand them.

<u>Definitions</u>. "You" and "office" refer to any provider who renders care to me at the Location above. "Care" includes all care outlined in my Care Plan as well as any other care I receive from you in the future, including care related to other conditions.

<u>Patient's Consent</u>. I have thoroughly discussed and reviewed my recommended Care with you, as well as your examination, diagnoses, and thoughts regarding my condition, and also all of the information in this Informed Consent. I have had ample opportunity to explore other potential forms of care, have asked you all of the questions that I have, and have no additional questions. I voluntarily and knowingly elect to receive the recommended Care.

Patient's Name: ____

Patient's Signature: ____

Date of Signature: ___/___/___

Name of Parent / Guardian / Authorized Representative: ______________________________

Signature: ____

Date of Signature: ___/___/___

Cancellation Policy

We know your time is valuable, and ours is too. Out of respect for our staff and our other clients, we ask that you give us at least 24 Hour notice if you need to cancel an appointment. Late arrivals (15 min after scheduled appointment time) will result in reschedule of appointment and you will be charged $25.00

- The first time a client misses an appointment, we will make a note in your file.
- All future missed appointments will incur a $25.00 fee.

______________________________ ____________

Patient Signature Date

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Medical Release of Information Form

TO WHOM IT MAY CONCERN:

Please furnish to Valrico Spine and Rehab Center and/or any or all of its personnel, information, copies of any and all hospital and medical record or reports of any sort, charts, notes, x-rays, lab reports, and prescription information. Valrico Spine and Rehab is to be furnished with any and all other information without limitation pertaining to any examination, treatment or condition of myself, including medical, examinations, or counseling for any condition, medical, dental, or psychological.

This AUTHORIZATION shall be considered as continuing and you may rely upon it in all respects unless you have previously been advised by me in writing to the contrary. It is expressly understood by the undersigned and you are hereby authorized to accept a copy of photocopy of this medical authorization with the same validity as though an original had been presented to you.

Patient Name: ____

DOB: ________________________ Last 4 of SSN: ________________________

Signature: ____ Date: ________________

If patient is under 18 years of age:

Name of Parent / Guardian: ______________________________________

Parent / Guardian Signature: ______________________________________

NECK BOURNEMOUTH QUESTIONNAIRE

Patient Name ____ Date ___________________________

Instructions: The following scales have been designed to find out about your neck pain and how it is affecting you. Please answer ALL the scales, and mark the ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average, how would you rate your neck pain?

No pain — Worst pain possible

0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your neck pain interfered with your daily activities (housework, washing, dressing, lifting, reading, driving)?

No interference — Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your neck pain interfered with your ability to take part in recreational, social, and family activities?

No interference — Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

Not at all anxious — Extremely anxious

0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed — Extremely depressed

0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your neck pain?

Have made it no worse — Have made it much worse

0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce/help) your neck pain on your own?

Completely control it — No control whatsoever

0 1 2 3 4 5 6 7 8 9 10

Patient Signature____**Examiner**____________________________________

With Permission from: Bolton JE, Humphreys BK: The Bournemouth Questionnaire: A Short-form Comprehensive Outcome Measure. II. Psychometric Properties in Neck Pain Patients. *JMPT* 2002; 25 (3): 141-148

BACK BOURNEMOUTH QUESTIONNAIRE

Patient Name ____ Date ___________________________

Instructions: The following scales have been designed to find out about your back pain and how it is affecting you. Please answer ALL the scales, and mark the ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average, how would you rate your back pain?

No pain — Worst pain possible

0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your back pain interfered with your daily activities (housework, washing, dressing, walking, climbing stairs, getting in/out of bed/chair)?

No interference — Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your back pain interfered with your ability to take part in recreational, social, and family activities?

No interference — Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

Not at all anxious — Extremely anxious

0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed — Extremely depressed

0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your back pain?

Have made it no worse — Have made it much worse

0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce/help) your back pain on your own?

Completely control it — No control whatsoever

0 1 2 3 4 5 6 7 8 9 10

Patient Signature ____**Examiner** _______________________________________

With Permission from: Bolton JE, Breen AC: The Bournemouth Questionnaire: A Short-form Comprehensive Outcome Measure. I. Psychometric Properties in Back Pain Patients. JMPT 1999; 22 (9): 503-510.