Gator Family Chiropractic Intake Form

Date: _____

Title: (circle one) Mr. Mrs. Miss Dr. Other_____

First Name_____ Middle Initial____ Last Name_____

I prefer to be called by _____

Date of Birth_____/_____/_____ Sex/Gender_____

Address_____

City_____ State_____ Zip Code_____

Cell Phone ( )_____ Work Phone ( )_____

Email_____

Marital Status: (circle one) Single Married Other
Employment Status: (circle one) Employed FT Student PT Student Other
Occupation if employed: _____

Emergency Contact: _____
Relationship to Patient: _____ Cell Phone ( )_____

How did you hear about our office? _____
Have you ever had chiropractic care before? (circle one) Yes No
For what problem? _____
Were the results satisfactory? (circle one) Yes No N/A
Have you seen anyone else for this problem? _____

Are you pregnant? Yes No N/A

What brings you in today? Please be specific in describing your major complaints:

_____

_____

When did you FIRST notice this problem/pain? _____

_____

How do you believe this problem/pain began? _____

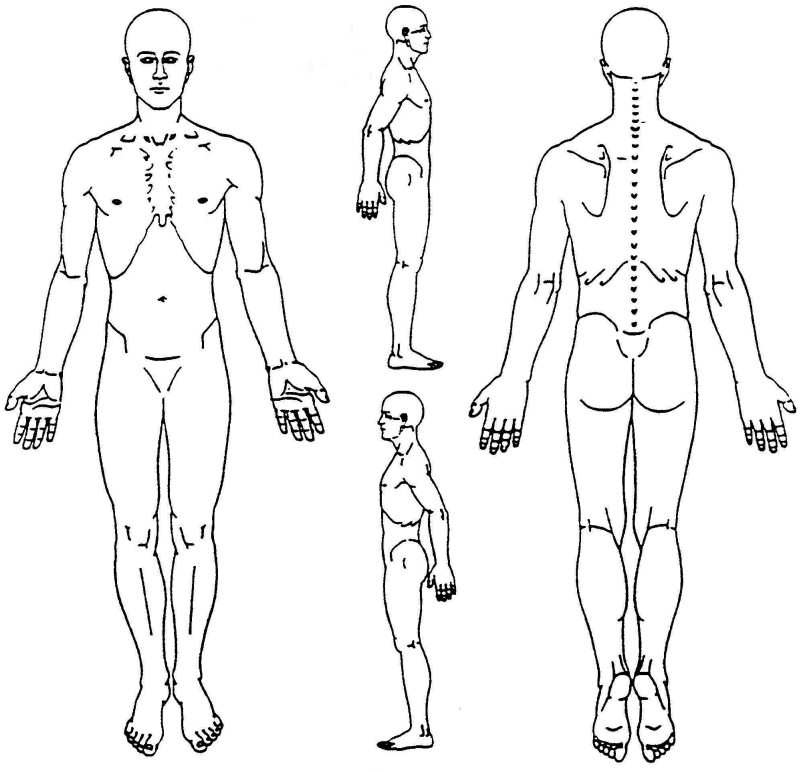
_____

On a scale of 1 to 10 (ten being worst) how is your pain today? _____

During the course of the day how often do you experience your symptoms?

- Intermittently 0 – 25%
- Occasionally 26 – 50%
- Frequently 51 – 75%
- Constantly 76 – 100%

Please indicate on the body diagram where you are experiencing pain:



Medical History

Medical Conditions: check all that apply to you

Arthritis
Diabetes
Heart Disease
Hypertension
Stroke

Other:_____

Surgeries: check all that apply to you

Appendectomy
Joint Replacement
Brain
Carpal Tunnel
Shoulder
Cardio-vascular procedure
Prostate
Gastro-intestinal
Cervical spine
Lumbar Spine
Thoracic Spine
Hysterectomy
Knee
Hernia
Other: _____

Allergies: (please list any and all) _____

_____

Please list ALL current medications, vitamins, and/or supplements being taken:

_____

_____

Social History: (please circle all that apply to you)

Caffeine use: Occasional Often Never
Drink Alcohol: Occasional Often Never
Tobacco use: Occasional Often Never
Exercise: Occasional Often Never

Sleep: Hours per night= _____

Stress level: (circle one) High Moderate Low None

Family History: Circle all that apply

Arthritis: Parent Sibling
Cancer: Parent Sibling
Diabetes: Parent Sibling
Heart Disease: Parent Sibling
Hypertension: Parent Sibling
Thyroid: Parent Sibling
Kidney disease: Parent Sibling
Ulcer: Parent Sibling
Asthma: Parent Sibling
Stroke: Parent Sibling
Other: _____

For the following questions please use a scale of 1-10:

1= no pain: 10 = worst pain imaginable

If you are experiencing **neck pain**, please circle the pain level over the last week: 1 2 3 4 5 6 7 8 9 10

If you are suffering from **back pain**, please circle the pain level over the last week: 1 2 3 4 5 6 7 8 9 10

If you are enduring **shoulder pain**, please circle the pain level over the last week: 1 2 3 4 5 6 7 8 9 10

Does this pain cause you **difficulty when standing** over the last week?

1 2 3 4 5 6 7 8 9 10

Does this pain cause you **difficulty when sitting**? 1 2 3 4 5 6 7 8 9 10

Do you feel that your **pain limits or hampers** your **personal life**?

1 2 3 4 5 6 7 8 9 10

Do you feel **pain** that **prevents** you from **walking**? 1 2 3 4 5 6 7 8 9 10

Does this pain cause you **difficulty trying** to **fall asleep** or **stay asleep**? 1 2 3 4 5 6 7 8 9 10

Does your pain make it more **difficult** for you to **concentrate**? 1 2 3 4 5 6 7 8 9 10

For the following questions please use a scale of 1-10:

1= very easy: 10= difficult or painful

How **difficult** is it for you to **touch your toes**? 1 2 3 4 5 6 7 8 9 10

How **easily** can you **reach your hand behind your head** to touch your shoulder blades? 1 2 3 4 5 6 7 8 9 10

How **difficult** is it for you to **bend your neck downward**? 1 2 3 4 5 6 7 8 9 10

How **challenging** is it to rotationally **twist your torso**? 1 2 3 4 5 6 7 8 9 10

Do you feel that a **lack of flexibility or mobility** is impacting your personal life? 1 2 3 4 5 6 7 8 9 10

Do you find that your **physical performance is hindered** by limited flexibility or mobility? 1 2 3 4 5 6 7 8 9 10

Please total your score from each question: = _____Total Points

Score over: 0-45	Recommendation: Red light deep tissue laser
Score over: 46	Recommendation: red light deep tissue laser and assisted stretching

Patient Signature: _____

Date: _____

Please list all imaging studies (XRAY/MRI/etc.) taken in last 6 months: _____

_____

My pain/symptoms have previously been made better by: (check all that apply)

- o Chiropractic
- o Physical Therapy
- o Stretching
- o Corrective Exercise
- o Massage
- o NSAIDS
- o Heat
- o Ice
- o Other: _____

My pain is: (check all that apply)

- o Worse in the morning
- o Worse during the day
- o Worse at night
- o Worse while sleeping
- o Does NOT change during course of day
- o Other: _____

What type of treatment are you looking for? Check which apply

____ I am looking for the most minimal amount of care to “patch up the symptoms” of my problem

____ I am looking to resolve my symptoms and then go on to “fix the cause: of my problem

____ I am looking to take care of my problem and then go on to “achieve optimal health and wellness”

Signature: _____

Date: _____

Auto Accident Form

Please circle your involvement in the auto accident: Pedestrian Driver Passenger

Date of Accident _____/_____/_____

Type of accident:

- Front end collision * rear end collision *driver side impact *side impact

Patient was located:

- Driver *P mid front *P right front *P left rear *P mid rear *P right rear

Patient Vehicle Type:

- Compact *Mid-size *Full-size *SUV *Pick-up *Motorcycle

Second Vehicle Type:

- Compact *Mid-size *Full-size *SUV *Pick-up *Motorcycle

Third Vehicle Type:

- Compact *Mid-size *Full-size *SUV *Pick-up *Motorcycle

Road Conditions:

- Clear *Dark *Dry *Foggy *Icy *Wet

Road Type:

- Asphalt *Concrete *Dirt *Gravel

Were you aware the accident was going to occur? Yes No
Were you wearing a seatbelt? Yes No
Did your airbag deploy? Yes No
Does your car have a head rest? Yes No
What position was the head rest in? Up Middle Down
Patients Head Position: *looking straight up *left level *left up *left down *right level *right up *right down *looking up *looking down

Accident Details

Was your car braking? Yes No
Was your car moving? Yes No
If yes, how fast? (mph) *<5 *6-10 *11-15 *16-20 *21-30 *31-40 *41-50 *51-60+
Was the second vehicle braking? Yes No
Was the second vehicle moving? Yes No
If yes, how fast? (mph) *<5 *6-10 *11-15 *16-20 *21-30 *31-40 *41-50 *51-60+
Was the third vehicle braking? Yes No
Was the third vehicle moving? Yes No
If yes, how fast? (mph) *<5 *6-10 *11-15 *16-20 *21-30 *31-40 *41-50 *51-60+

Collision Details

First Impact: *hit by other vehicle *hit other vehicle *hit by object *hit object
Impact location: *front *front-right *front-left *left *right *right-rear *left-rear *rear *top
Second Impact: *hit by other vehicle *hit other vehicle *hit by object *hit object
Impact location: *front *front-right *front-left *left *right *right-rear *left-rear *rear *top

Collision Results

Body was thrown: *forward *backward *left *right *can't remember
Head Hit: *airbag *front windshield *rearview mirror *steering wheel *dashboard *back of front seat *side window/door *another person's body *headrest
Chest Hit: *airbag *steering wheel *dashboard *back of front seat *side window/door *another person's body
Shoulders Hit: *shoulder harness *side window/door *back of seat *another person's body
Knees Hit: *steering wheel *dashboard *back of front seat *door panel *center console *another person's body
Hips Hit: *steering wheel *dashboard *back of front seat *door panel *center console *another person's body

Vehicle Damage

Patient Vehicle: *totaled *significant damage *light damage *no damage
Second Vehicle: *totaled *significant damage *light damage *no damage
Third Vehicle: *totaled *significant damage *light damage *no damage

Hospitalized

Were you hospitalized? *Yes *No If yes, please answer the questions below.
When were you hospitalized? *immediately *later same day *next date *date_____
How were your transported to the hospital? *ambulance *life flight *private transportation
What did hospital recommend? *no instructions *see this clinic *see DC *see own doctor *see orthopedist *see neurologist *prescription medication *other: _____
Did you have any imaging? If so, what kind? _____
_____
And what areas?
_____

Assignment on Benefits/Insurance Assignment

I hereby assign Gator Family Chiropractic insurance benefits and any causes of action on all insurance policies otherwise payable to me. I authorize Gator Family Chiropractic to submit insurance claims to insurance companies and apply insurance proceeds to my bill and to make refunds to insurance companies, as refunds are due, under the provision of the insurance policies. I authorize Gator Family Chiropractic or its billing agent or suppliers, to release information necessary to apply for payment of these benefits. I direct my insurance carrier to accept a photocopy of this assignment in lieu of the original.

Name (print): _____

Sign (responsible party): _____

Date: _____

Witness: _____

Date of Accident: _____

Standard Disclosure and Acknowledgment Form

Personal Injury Protection – Initial Treatment or Service Provided

The undersigned insured person (or guardian of such person) affirms:

1. The services or treatment set forth below were **actually rendered**. This means that those services have **already been provided**.

_____

_____

2. I have the right and duty to confirm that the services have already been provided.
3. I was not solicited by any person to seek any services from the medical provider of the services described above.
4. The medical provider has explained the services to me for which payment is being claimed.
5. If I notify the insurer waiting of a billing error, I may be entitled to a portion of any reduction in the amount paid by my motor vehicle insurer. If entitled, my share would be at least 20% of the amount of the reduction, up to $500.

Only sign here:

_____ _____ _____

Print Name Signature Date

The undersigned licensed medical professional or medical doctor, if applicable, affirms the statement numbered 1 above and also:

A. I have not solicited or caused the injured person, who was involved in motor vehicle accident, to be solicited to make a claim for PIP benefits.
B. The treatment or services rendered were explained to the insured person or his guardian sufficiently for that person to sign this form with informed consent.
C. The accompanying statement or bill is properly completed in all materials provisions and all relevant information has been provided therein. This means that each request for information has been responded to truthfully, accurately, and in a substantially complete manner,
D. The coding of procedures on the accompanying statement or bill is proper. This means that no service has been up-coded, unbundled, or constitutes an invalid or not medically necessary diagnostic test as defined by Section 627.732 (15) and (16), Florida Statutes or Section 627.736(5)(b)6, Florida Statutes.

Licensed Medical Professional Rendering Treatment/Services or Medical Director

_____ _____ _____

Name (print or type) Signature Date

Missed Appointment Policy

Dear valued patient,

Your care plan has been designed specifically to expedite your complete recovery. That is why it is imperative that you do not miss your scheduled appointments. When one misses an appointment, it disrupts the healing process and slows down your recovery.

If you are unable to make your scheduled appointment, we ask you give our office a 24-hour notification. We do reserve the right to charge a cancellation fee for missed appointments without a 24-hour notice.

Adjustment Cancellation Fee- $45

Stretch Cancellation Fee- $30/$60

Massage Cancellation Fee- $70

Patient Name (print): _____

Patient Signature: _____

Date: _____

Notice of Initiation of Treatment

Please leave blank for Doctor.

Name of Insured: _____

Name of PIP Insurer: _____

Claim number: _____

Pursuant to Florida Statute 627.736(5)(c)1., you are hereby notified that treatment on your insured, _____, was initiated on _____ for injuries sustained in an automobile crash on _____.

_____

Deborah Hudson, D.C.