Smith Chiropractic
1550 6th St. SE, Winter Haven, FL 33880 863-293-8836

New Patient Information

Name:	Nickname:	Date of Birth:
Address/City/St/Zip:		Email:
Home Phone:	Cell Phone:	Work Phone:
SSN:	Employer:	Occupation: ☐ FT ☐PT
☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Student		☐ Male ☐ Female
Emergency Contact:	Phone:	Realtionship:
Referred by:	☐ Yellow Pages ☐ Advertising ☐ Other _____	

Responsible Party (if different form above)

Name:	Date of Birth:	Realtionship:
Address:		
Home Phone:	Cell Phone:	Work Phone:
SSN:	Employer:	Occupation:

Primary Insurance Information

Insurance Company:	Phone:	ID Number:

If you do not have insurance or we are out of your insurance network we will be happy to see you. Payment is expected at the time services are rendered.

Consent for Treatment

I voluntarily consent to receive medical and health care services that may include diagnostic procedures, examinations and treatment.

Financial Responsibilty and Assignment of Benefits

By signing this form you are granting Smith Clinic of Chiropractic permission to disclose your protected health information for the purpose of treatment, payment and health care operations. Our Notice of Privacy Policy Practices provides more detailed information about how we may use and disclose this protected health information. You have the legal right to review this Notice before you sign this consent and we encourage you to do so. You have the right to restrict how we use and disclose your protected health information. We are not required by law to grant your request unless we have an agreement. You have the right to revoke this consent in writing, except to the extent that we already have used or disclosed your protected health information in reliance on your consent. With your signature you also acknowledge that you were provided a copy of the Notice of Privacy Policy Practices and that you have read it or declined the the opportunity to read it and understand the Notice of Privacy Policy Practices. This form will be placed in your chart and mantained for six years.

Our Commitment to You:
We Want You to "Get Well" and "Stay Well"

Patient or Legal Guardian's Signaure Date

MAJOR COMPLAINT INFORMATION

Please tell us the reason for your visit: _____

Describe your symptoms: _____

Is it due to: [ ]Work [ ]Sports [ ]Auto [ ]Trauma [ ]Chronic [ ]Maintenance [ ]Slip & Fall [ ]Improper Lifting [ ]Other

Explain: _____

Describe the nature of your symptoms.

[ ] Sharp [ ] Dull Ache [ ] Numb [ ] Tingling [ ] Shooting [ ] Burning [ ] Stiffness [ ] Weakness [ ] Nagging Discomfort [ ] Other _____

Is your pain or sensation [ ] Radiating [ ] Well Localized

How long have you had this symptom(s): _____ When did this symptom(s) ***recently*** start? _____

Have you had the same or a similar condition in the past? [ ] Yes [ ] No Explain: _____

_____

How often & frequent does it occur? [ ] Constantly (76-100% if the day) [ ] Frequently (51-75% of the day)
[ ] Occasionally (26-50% of the day) [ ] Intermittently (0-25% of the day)

What aggravates this condition? _____

What decreases the symptom(s)/ pain? _____

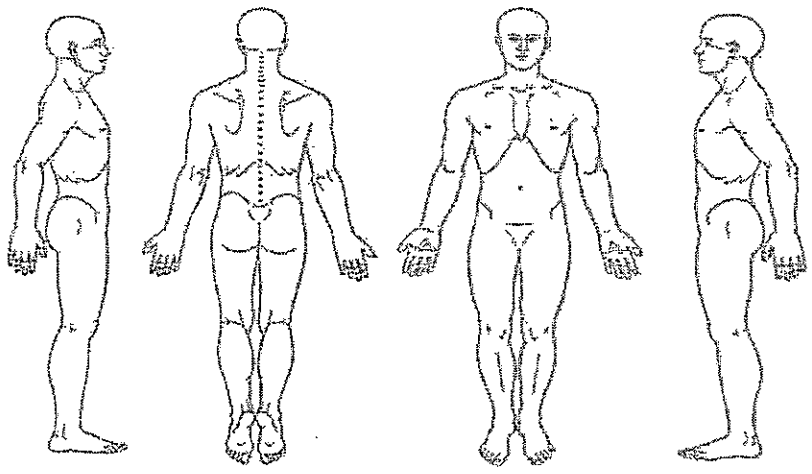
Is the condition: [ ] Getting Worse [ ] Getting Better [ ] No Change [ ] Comes & Goes [ ] Other: _____

Is this condition interfering with: [ ] Work [ ] Sleep [ ] Daily Activities Explain: _____

Indicate the average intensity of your symptom(s).

None										Unbearable
0	1	2	3	4	5	6	7	8	9	10

Please mark the ***exact*** area(s) of your symptoms



Please check those activities below during which you experience difficulty or pain:

[ ] Lying on back
[ ] Lying on side
[ ] Turning over in bed
[ ] Lying flat on stomach
[ ] Getting in/ out of car
[ ] Dressing/ Washing Self
[ ] Sexual Activity
[ ] Pushing
[ ] Pulling
[ ] Kneeling
[ ] Reaching
[ ] Lifting
[ ] Stooping
[ ] Bending
[ ] Sitting
[ ] Get up from sitting
[ ] Bending forward
[ ] Bending backward
[ ] Standing for long periods
[ ] Sneezing/ Coughing
[ ] Other:_____

Have you been treated elsewhere for this condition? [ ] Yes [ ] No By Whom: _____

Have you ever had chiropractic care: [ ] Yes [ ] No *If Yes*: with whom, when and for what condition? _____

_____

What other therapies/ treatments for this condition did you have? _____

_____

Have you missed any work as a result of this condition? [ ] Yes [ ] No If so, please list the dates_____

FILL OUT THE NEXT THREE SECTIONS AS THEY APPLY TO YOU

Lower Back Pain

Does pain radiate into the leg? [ ] Yes [ ] No Which Leg? [ ] Right [ ] Left [ ] Both Where: _____
Does it radiate into the abdomen? [ ] Yes [ ] No Do you have numbness or tingling into the leg(s)? [ ] Yes [ ] No
Do you *ever* have impairment of bowel or urinary function? [ ] Yes [ ] No Explain: _____

Neck Pain

If you have a neck injury, does it affect: (Check all that apply) [ ] Hearing [ ] Vision [ ] Balance [ ] Cause ringing in your ears
Does pain radiate into the arm? [ ] Yes [ ] No Which Arm? [ ] Right [ ] Left [ ] Both Where: _____
Do you hear grating/ crunching sounds? [ ] Yes [ ] No Do you feel pressure/ pain behind your eyes? [ ] Yes [ ] No
Do you have difficulty lifting/ turning your head? [ ] Yes [ ] No If so, in which direction? [ ] Right [ ] Left [ ] Up [ ] Down

Headaches

Do you get headaches? [ ] Yes [ ] No How often do they occur?_____
Do you have a family history of headaches? [ ] Yes [ ] No
Do you experience the following along with your headaches? Pain/ popping in your jaw? [ ] Yes [ ] No
Abnormal blood pressure? [ ] Yes [ ] No [ ] High [ ] Low Nausea, Vomiting or Visual Disturbances? [ ] Yes [ ] No
When was your last eye exam by a doctor? [ ] 1-6 months [ ] 6-12 months [ ] 1-2 years [ ] over 2 years
Results of this eye exam._____

ADDITIONAL COMPLAINTS

Please circle all additional complaints that you have *at this time*.

Loss of Concentration
Eyes Sensitive to Light
Memory Loss
Heavy Feeling of Head
Dizziness
Ringing in Ears
Loss of Balance
Loss of Smell
Loss of Taste
Pain Behind Eyes
Fainting
Palpitation
Vision Problems
Chest Pain
Shortness of Breath
Irritable
Insomnia
Fatigue
Excess Perspiration
Digestive Trouble
Nausea
Vomiting
Diarrhea
Constipation
Cold Hands
Cold Feet
Convulsions

ADDITIONAL MEDICAL HISTORY

Have you had *ANY* of the following in the past?

[ ] Surgery [ ] Major Illness [ ] Hospitalization [ ] CT Scan [ ] MRI [ ] Spinal X-rays [ ] Accident/ Fall

If Yes, please list with the year and place this happened/ was performed: _____

_____

_____

List current medications (including supplements): _____

_____

List all allergies: _____

Medical Doctor's name and address: _____

Date of last physical exam: _____ With Whom: _____ Significant findings of this exam: _____

_____

Would you like for us to send your reports to your Medical Doctor? Yes_____ or No _____

Circle any that apply to you:

AIDS/ HIV	Diabetes	Hypoglycemia	Skin Condition(s)
Alcoholism	Digestive Disorder(s)	Knee/ Hip Replacement(s)	Stroke
Allergies	Dizziness	Nervousness	TMJ Problem(s)
Anemia	Epilepsy	Neuritis	Tuberculosis
Anorexia	Fatigue	Osteoporosis	Ulcer
Anxiety	Gout	Pacemaker/ Defibulator	Urinary Trouble
Arthritis/ Joint Pain	Headaches	Parasites	Venereal Disease
Asthma	Heart Trouble	Pinched Nerve	Weight Gain
Bleeding Disorder(s)	Hepatitis	Poor Circulation	Weight Loss
Breathing Problem(s)	Hernia	Prostate Problem(s)	Yeast/ Candida
Bulimia	Herniated Disc	Prosthesis	Fibromyalgia
Cancer	High Cholesterol	Rheumatic Fever	Psychological Concerns
Depression	Hypertension	Sinus Trouble	

Briefly describe the illnesses circled above: _____

_____

_____

THIS SECTION FOR WOMEN ONLY

Is there any chance that you ***might*** be pregnant? (Circle) [ ] Yes [ ] No Date of last cycle:_____ Initials:_____

Patient Interests

___ Massage ___ Foot Orthotics ___ Diet/ Nutrition ___ Exercise/ Weight Control ___ Detoxification

New Conditions, Complaints, Accidents or Aggravations

If you have a new complaint, have had a new accident or have recently aggravated a current or chronic condition you need to call prior to coming in for your previously scheduled appointment. It is possible that a re-evaluation and x-rays will be needed for diagnosis and treatment.

Informed Consent

It is our responsibility to fully inform you of all aspects of your treatment. Part of this includes a discussion of any potential side effects or complications. All treatments potentially can cause these reactions and chiropractic manipulation is no different. It, however, has one of the safest records of the wide range of treatments that can be used for spinal disorders.

THE NECK DISABILITY QUESTIONNAIRE

Please Read: This questionnaire is designed to enable us to understand how much your **neck pain** has affected your ability to manage everyday activities. Please answer each Section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but ***please just circle the one choice which closely describes your problem right now.***

SECTION 1--Pain Intensity

A. I have no pain at the moment
B. The pain is mild at the moment.
C. The pain comes and goes and is moderate.
D. The pain is moderate and does not vary much.
E. The pain is severe but comes and goes.
F. The pain is severe and does not vary much.

SECTION 2--Personal Care (Washing, Dressing etc.)

A. I can look after myself without causing extra pain.
B. I can look after myself normally but it causes extra pain.
C. It is painful to look after myself and I am slow and careful.
D. I need some help, but manage most of my personal care.
E. I need help every day in most aspects of self-care.
F. I do not get dressed, I wash with difficulty and stay in bed.

SECTION 3--Lifting

A. I can lift heavy weights without extra pain.
B. I can lift heavy weights, but it causes extra pain.
C. Pain prevents me from lifting heavy weights off the floor but I can if they are conveniently positioned, for example on a table.
D. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
E. I can lift very light weights.
F. I cannot lift or carry anything at all.

SECTION 4 --Reading

A. I can read as much as I want to with no pain in my neck.
B. I can read as much as I want with slight pain in my neck.
C. I can read as much as I want with moderate pain in my neck.
D. I cannot read as much as I want because of moderate pain in my neck.
E. I cannot read as much as I want because of severe pain in my neck.
F. I cannot read at all.

SECTION 5--Headache

A. I have no headaches at all.
B. I have slight headaches which come infrequently.
C. I have moderate headaches which come in-frequently.
D. I have moderate headaches which come frequently.
E. I have severe headaches which come frequently.
F. I have headaches almost all the time.

SECTION 6 -- Concentration

A. I can concentrate fully when I want to with no difficulty.
B. I can concentrate fully when I want to with slight difficulty.
C. I have a fair degree of difficulty in concentrating when I want to.
D. I have a lot of difficulty in concentrating when I want to.
E. I have a great deal of difficulty in concentrating when I want to.
F. I cannot concentrate at all.

SECTION 7--Work

A. I can do as much work as I want to.
B. I can only do my usual work, but no more.
C. I can do most of my usual work, but no more.
D. I cannot do my usual work.
E. I can hardly do any work at all.
F. I cannot do any work at all.

SECTION 8--Driving

A. I can drive my car without neck pain.
B. I can drive my car as long as I want with slight pain in my neck.
C. I can drive my car as long as I want with moderate pain in my neck.
D. I cannot drive my car as long as I want because of moderate pain in my neck.
E. I can hardly drive my car at all because of severe pain in my neck.
F. I cannot drive my car at all.

SECTION 9--Sleeping

A. I have no trouble sleeping
B. My sleep is slightly disturbed (less than 1 hour sleepless).
C. My sleep is mildly disturbed (1-2 hours sleepless).
D. My sleep is moderately disturbed (2-3 hours sleepless).
E. My sleep is greatly disturbed (3-5 hours sleepless).
F. My sleep is completely disturbed (5-7 hours sleepless).

SECTION 10--Recreation

A. I am able to engage in all recreational activities with no pain in my neck at all.
B. I am able to engage in all recreational activities with some pain in my neck.
C. I am able to engage in most, but not all recreational activities because of pain in my neck.
D. I am able to engage in a few of my usual recreational activities because of pain in my neck.
E. I can hardly do any recreational activities because of pain in my neck.
F. I cannot do any recreational activities all.

SIGNATURE:_____ **DATE:**_____

Chirocare Solutions LLC — Oswestry Low Back Questionnaire

Patient name:_____ Signature:_____ Date: _____

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage in everyday life. **Please answer every section and mark in each section only ONE box** which applies to you. We realize you may consider that two of the statements in any one section relate to you, but **please just mark the box which MOST CLOSELY describes your problem.**

Section 1 – Pain Intensity

☐ The pain comes and goes and is very mild.
☐ The pain is mild and does not vary much.
☐ The pain comes and goes and is moderate.
☐ The pain is moderate and does not vary much.
☐ The pain comes and goes and is severe.
☐ The pain is severe and does not vary much.

Section 2 – Personal Care (Washing, Dressing, etc.)

☐ I would not have to change my way of washing or dressing in order to avoid pain.
☐ I do not normally change my way of washing or dressing even though it causes some pain.
☐ Washing and dressing increase the pain but I manage not to change my way of doing it.
☐ Washing and dressing increase the pain and I find it necessary to change my way of doing it.
☐ Because of the pain I am unable to do some washing and dressing without help.
☐ Because of the pain I am unable to do any washing and dressing without help.

Section 3 – Lifting

☐ I can lift heavy weights without extra pain.
☐ I can lift heavy weights but it gives extra pain.
☐ Pain prevents me from lifting heavy weights off the floor.
☐ Pain prevents me from lifting heavy weights off the floor but I can manage if they are conveniently positioned, e.g. on a table.
☐ Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
☐ I can only lift very light weights at the most.

Section 4 – Walking

☐ I have no pain on walking.
☐ I have some pain with walking but it does not increase with distance.
☐ I cannot walk more than One Mile without increasing pain.
☐ I cannot walk more than 1/2 Mile without increasing pain.
☐ I cannot walk more than 1/4 Mile without increasing pain.
☐ I cannot walk at all without increasing pain.

Section 5 – Sitting

☐ I can sit in any chair as long as I like.
☐ I can only sit in my favorite chair as long as I like.
☐ Pain prevents me from sitting more than one hour.
☐ Pain prevents me from sitting more than 30 minutes.
☐ Pain prevents me from sitting more than 10 minutes.
☐ I avoid sitting because it increases pain straight away.

Section 6 – Standing

☐ I can stand as long as I want without pain.
☐ I have some pain on standing but it does not increase with time.
☐ I cannot stand for longer than one hour without increasing pain.
☐ I cannot stand for longer than 1/2 hour without increasing pain.
☐ I cannot stand for longer than 10 minutes without increasing pain.
☐ I avoid standing because it increases pain straight away.

Section 7 – Sleeping

☐ I get no pain in bed.
☐ I get pain in bed but it does not prevent me from sleeping well.
☐ Because of pain my normal nights sleep is reduced by less than 1/4.
☐ Because of pain my normal nights sleep is reduced by less than 1/2.
☐ Because of pain my normal nights sleep is reduced by less than 3/4.
☐ Pain prevents me from sleeping at all.

Section 8 – Social Life

☐ My social life is normal and gives me no pain.
☐ My social life is normal but increases the degree of my pain.
☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing, etc.
☐ Pain has restricted my social life and I do not go out very often.
☐ Pain has restricted social life to my home.
☐ I have hardly any social life because of the pain.

Section 9 – Traveling

☐ I get no pain while traveling.
☐ I get some pain while traveling but none of my usual sorts of travel make it any worse.
☐ I get extra pain while traveling but it does not compel me to seek alternative forms of travel.
☐ I get extra pain while traveling which compels me to seek alternative forms of travel.
☐ Pain restricts all forms of travel.
☐ Pain prevents all forms of travel except that done lying down.

Section 10 – Changing Degree of Pain

☐ My pain is rapidly getting better.
☐ My pain fluctuates but overall is definitely getting better.
☐ My pain seems to be getting better but improvement is slow at the present.
☐ My pain is neither getting better or worse.
☐ My pain is gradually worsening.
☐ My pain is rapidly worsening.

SMITH CHIROPRACTIC

FINANCIAL AGREEMENT

We are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals we need your assistance and your understanding of our financial policy.

Payment due at the time services are rendered. We accept cash, checks, MasterCard, Visa, Discover and American Express. **Returned checks are subject to a $25.00 collection fee. Balances older than 30 days may be subject to interest charges of 1 ½% per month.**

Charges may also be made for any missed appointments and appointments cancelled without 24 hours advanced notice. If you prematurely discontinue treatment for any reason, your full balance will be due and payable immediately. The fee for any missed or short cancellation of your first and every subsequent massage appointment is $25.00. For all other types of appointments; the $25.00 fee will be assessed upon your third missed or short cancelled appointment. This fee is due on your next visit and cannot be billed to your insurance. **There will be a $5.00 charge for any forms completed for other coverages (disability, credit, life, etc.) Additional charges may apply if research of your records is necessary.**

Your first visit MUST be paid in full at the time of the service. The only exceptions are PRE-VERIFIED health insurance and PRE-AUTHORIZED Worker's Compensation claims and 100% coverage Personal Injury claims. All co-pays, co-insurances, deductibles, or any other patient responsibility is due and owing at the time of service.

We accept assignment on most primary insurance. We DO NOT accept assignment NOR do we file your secondary or supplement insurance UNLESS prior arrangements have been made with our insurance department. We will be happy to assist you with filing your claims if requested.

You must realize, however, that:

1. Your insurance is a contract between you, your employer and the insurance company. We are not a party to the contract.
2. Our fees are generally considered to fall within the acceptable range by most companies and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage (such as 50% or 80%) of UCR. UCR is defined as usual customary and reasonable by most companies. This statement does not apply to companies, who reimburse based on arbitrary "schedule" of fees, which bears no relationship to the current standard and cost of care in this area.
3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. For this reason, supplements, supports, pillows, etc. MUST BE PAID FOR IN FULL WHEN PURCHASED.

We must emphasize that as health care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. Ultimately the patient is responsible for any balance due to be paid in a timely manner. We realize that temporary financial problems do arise; we encourage you to contact us promptly for assistance in the management of your account. We do utilize the services of a collection agency for over due accounts.

MISSED APPOINTMENTS AND NO CALL NO SHOW APPOINTMENTS FEE

You MUST contact this office 24 hours BEFORE any of your scheduled appointments; should you need to cancel. Failure to do so will result in a **$25.00** short cancellation fee. A **$25.00** fee will also be assessed for no call/ no show appointments. This fee will be due on your next visit and cannot be billed to your insurance.

I have read and fully understand the above policies and hereby acknowledge them.

Patient's Signature: _____ Date: _____

Witness: _____ Date: _____

Smith Clinic of Chiropractic, PA
1550 6th Street SE, Winter Haven, FL 33880
863-293-8836

Informed Consent For Chiropractic Care

Chiropractic care, like all forms of health care, while offering considerable benefit may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to stroke.

Prior to receiving chiropractic care this Chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, your spine health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

I understand and accept that there are risks associated with chiropractic care and give my consent to the examinations that the doctor deems necessary, and to the chiropractic care including spinal adjustments, as reported following my assessment.

_____	_____
Patient Name (printed)	Relationship to patient
_____	_____
Patient or legal Guardian Signature	Date
_____	_____
Witness Signature (office staff)	Date

ChiroCare Solutions, LLC
Smith Chiropractic

Assignment of Benefits Form/Notice of Privacy Practices

Name of Insured (print): _____

Social Security Number: _____

I request that payment of authorized insurance benefits, including Medicare, if I am a Medicare beneficiary, be made on my behalf to ChiroCare Solutions, LLC for any medical services provided to me by that organization.

I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related equipment or services to the organization, the Health Care Financing Administration, my insurance carrier or other medical entity. A copy of this authorization will be sent to the Health Care Financing Administration, my insurance company or other entity if requested. The original will be kept on file by the organization.

I understand that I am financially responsible to the organization for any charges not covered by health care benefits. It is my responsibility to notify the organization of any changes in my health care coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the organization and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form I am accepting financial responsibility as explained above for all payment for products received.

By signing this document, I also acknowledge that I may request a copy of the organization's Notice of Privacy Practices. This acknowledgement is required by the Health Insurance Portability and Accountability Act (HIPAA) to ensure that I have been made aware of my privacy rights.

Name of person signing below (print): _____

Relationship to Insured: _____

Signature of Insured or Parent/Guardian: _____