maxliving™
CITY OF PALMS CHIROPRACTIC

APPLICATION FOR CARE AT CITY OF PALMS CHIROPRACTIC

239.690.7794 ◆ 11621 South Cleveland Avenue, Fort Myers, FL 33907

Today's Date: _____ Who referred you to our clinic? _____

PATIENT DEMOGRAPHICS

Name: _____ Birth Date: _____-_____-_____ Age: _____ ☐ Male ☐ Female

Address: _____ City: _____ State: _____ Zip: _____

E-mail: _____ ❑ I agree to receive emails and texts from City of Palms Chiropractic

Marital Status: ❑ Single ❑ Married Do you have Insurance: ❑ Yes ❑ No Phone: _____

Social Security #: _____ Driver's License #: _____

Employer: _____ Occupation: _____

Spouse's Name _____ Spouse's Employer _____

Number of children and ages: _____

Name & Number of Emergency Contact: _____ Relationship: _____

HISTORY OF COMPLAINT

Please identify the condition(s) that brought you to this office: Primarily: _____

Secondarily: _____ Third: _____ Fourth: _____

When did the problem(s) begin? _____ When is the problem at its worst? ☐ AM ☐ PM ☐ Mid-day

How long does it last? ☐ Constant ☐ On and off during the day ☐ It comes and goes throughout the week

Is your problem the result of ANY type of accident? ☐ Yes ☐ No

If yes, identify type: ☐Auto ☐Work ☐ Home ☐Other (*please explain*):_____

Date of Accident: _____ / _____ / _____ Approximately what time that day? _____AM _____PM

Have you reported this accident to anyone? ☐ No ☐ Yes **If yes,** to whom: _____

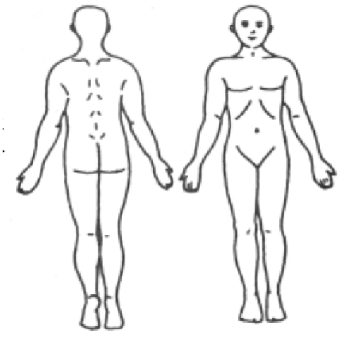
Condition(s) ever been treated by anyone in the past? ☐ Yes ☐ No

If yes, when: _____ by whom? _____ How long were you under care? _____

What were the results? _____

Name of Previous Chiropractor: _____ ☐ N/A

***PLEASE MARK** the areas on the Diagram with the following **letters** to describe your symptoms:
R=Radiating **B**=Burning **D**=Dull **A**=Aching **N**=Numbness **S**=Sharp/ Stabbing **T**=Tingling



What relieves your symptoms? _____

What makes them feel worse? _____

Identify any other injury(s) to your spine, minor or major, that the doctor should know about:

_____

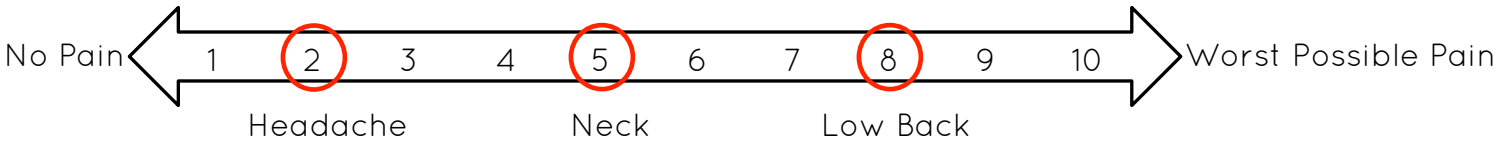
Name: _____ Date: _____

INTENSITY RATING

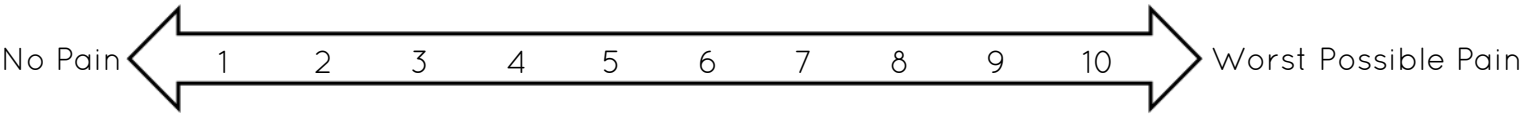
Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

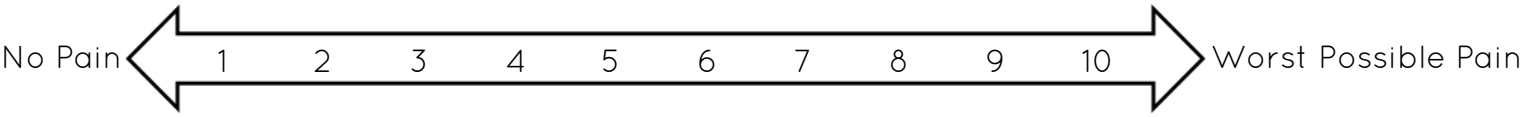
Example



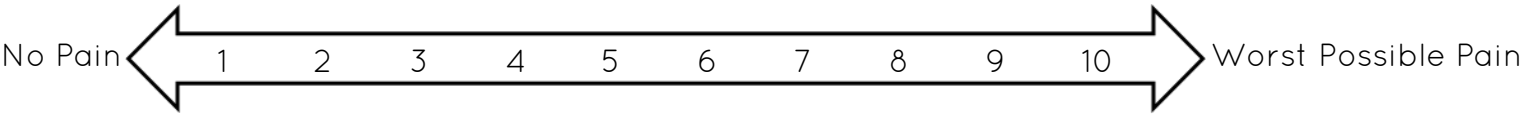
1. What is your pain **RIGHT NOW**?



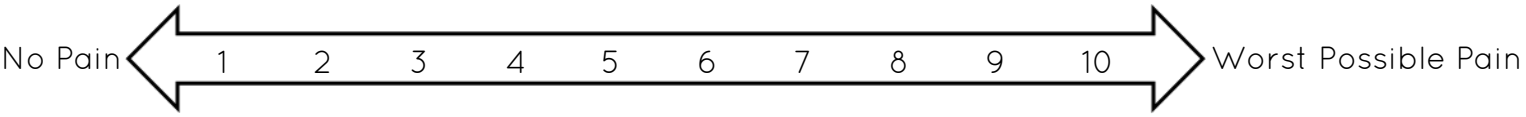
2. What is your **TYPICAL** or **AVERAGE** pain?



3. What is your pain level **AT ITS BEST** (How close to "0" does your pain get at its best)?



4. What is your pain level **AT ITS WORST** (How close to "10" does your pain get at its worst)?



LIST PRESCRIPTION & NON-PRESCRIPTION DRUGS YOU TAKE:

_____

_____

_____

_____

Name: _____ Date: _____

ACTIVITIES OF DAILY LIVING

Identify how your current condition is affecting your ability to carry out daily activities that are routinely part of your life:

Carrying Groceries	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform	
Sit to Stand	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform	
Climbing Stairs	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform	
Pet Care	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform	
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform	
Extended Computer Use	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform	
Household Chores	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform	
Lifting Children	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform	
Reading/Concentration	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform	
Dressing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform	
Washing/Bathing/Shaving	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform	
Sexual Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform	
Sleep	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform	
Sitting	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform	
Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform	
Yard Work	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform	
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform	
Sweeping/Vacuuming	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform	
Dishes	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform	
Laundry	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform	
Taking out Garbage	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform	
Other	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform	

Please give us more information regarding your most restricted activity due to your condition and your usual ability before you suffered from your condition.

LIST RESTRICTED ACTIVITY:	CURRENT ACTIVITY LEVEL	USUAL ACTIVITY LEVEL
EXAMPLE: Walking without pain	**¼ Mile**	**2 Miles**
EXAMPLE: Sitting without pain	**15 minutes**	**4 Hours**
_____:	_____	
_____:	_____	
_____:	_____	
_____:	_____	
_____:	_____	

Name: _____ Date: _____

PAST HISTORY

Have you suffered with any of this or a similar problem in the past? ❑ No ❑ Yes

If yes how many times? _____ When was the last episode? _____ How did the injury happen? _____

Other forms of treatment tried: ☐ No ☐ Yes

If yes, please state what type of treatment: _____ Who provided it: _____

How long ago? _____ What were the results: ☐ Favorable ☐ Unfavorable → please explain:

_____

Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body:

_____

Please mark **P** for in the **Past, C** for **Current, N** for **Never**:

___ Headache	___ Pregnant (Now)	___ Dizziness	___ Prostate Problems	___ Ulcers
___ Neck Pain	___ Frequent Colds/Flu	___ Loss of Balance	___ Impotence/Sexual Dysfun.	___ Heartburn
___ Jaw Pain, TMJ	___ Convulsions/Epilepsy	___ Fainting	___ Digestive Problems	___ Heart Problem
___ Shoulder Pain	___ Tremors	___ Double Vision	___ Colon Trouble	___ High Blood Pressure
___ Upper Back Pain	___ Chest Pain	___ Blurred Vision	___ Diarrhea/Constipation	___ Low Blood Pressure
___ Mid Back Pain	___ Pain w/Cough/Sneeze	___ Ringing in Ears	___ Menopausal Problems	___ Asthma
___ Low Back Pain	___ Foot or Knee Problems	___ Hearing Loss	___ Menstrual Problem	___ Difficulty Breathing
___ Hip Pain	___ Depression	___ PMS	___ Lung Problems	___ Sinus/Drainage Problem
___ Back Curvature	___ Swollen/Painful Joints	___ Irritable	___ Bed Wetting	___ Kidney Trouble
___ Scoliosis	___ Skin Problems	___ Mood Changes	___ Learning Disability	___ Gall Bladder Trouble
___ Diabetes	___ Rheumatoid Arthritis	___ Osteo Arthritis	___ Fracture	___ Dislocation
___ Broken Bone	___ Tumors	___ Hepatitis (A,B,C)	___ Liver Trouble	___ Eating Disorder
___ Trouble Sleeping	___ ADD/ADHD	___ Heart Attack	___ Cancer	___ Allergies
___ Numb/Tingling arms, hands, fingers			___ Disability	
___ Numb/Tingling legs, feet, toes				

PAST HISTORY RELATED TO CURRENT CONDITION

Identify ALL PAST and any CURRENT conditions you feel may be contributing to your present problem:

	WHAT	HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM
INJURIES →				
SURGERIES →				
CHILDHOOD DISEASES →				
ADULT DISEASES →				

SOCIAL HISTORY

1. Smoking: ❑Cigars ❑ Pipe ❑ Cigarettes → How often? ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never

2. Alcoholic Beverage: consumption occurs → ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never

3. Recreational Drug use: occurs → ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never

4. **Hobbies -Recreational Activities-** Exercise: ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never

FAMILY HISTORY

1. Does anyone in your family suffer with the same condition(s)? ❑ No ❑ Yes

   If yes, whom: ❑ Grandmother ❑ Grandfather ❑ Mother ❑ Father ❑ Sister(s) ❑ Brother(s) ❑ Son(s) ❑ Daughter(s)

   Have they ever been treated for their condition? ❑ No ❑ Yes ❑ I don't know

2. Any other hereditary conditions the doctor should be aware of? ❑ No ❑ Yes: _____

I hereby authorize payment to be made directly to City of Palms Chiropractic for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to City of Palms Chiropractic for any and all services I receive at this office. Discounts verified through Compliance Coupons.

_____ _____ / _____ / _____

Patient or Authorized Person's Signature **Date Completed**

_____ _____ / _____ / _____

Doctor's Signature **Date Form Reviewed**

City of Palms Chiropractic

Informed Consent

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at City of Palms Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____ ____/____/____ _____*Witness Initials*

Patient or Authorized Person's Signature **Date**

REGARDING: X-rays/Imaging Studies

FEMALES ONLY → please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.

☐ The first day of my last menstrual cycle was on date: ____-____-____

☐ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

MALES and FEMALES: By my signature below, I understand and give consent to be x-rayed if the doctor deems necessary.

_____ ____/____/____ _____ *Witness Initials*

Patient or Authorized Person's Signature **Date**

City of Palms Chiropractic
Notice of Privacy Practice

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your Personal Health Information. In addition, we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as dictated by our office policy, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled 'HIPAA' on tables in the reception. Once you have read this notice, please sign and return to our front desk receptionist. You will get a copy for your records.

PERMITTED DISCLOSURES:

1. Treatment purposes- discussion with other health care providers involved in your care
2. Inadvertent disclosures- open treating area mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes- to process a claim or aid in investigation
5. Emergency- in the event of a medical emergency we may notify a family member
6. For Public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement – to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons –discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders -we may call your home and leave messages regarding a missed appointment or apprize you of changes in practice hours or upcoming events.
11. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

YOUR RIGHTS:

1. To receive an accounting of disclosures
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice
3. To request mailings to an address different than residence
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction. 5. To inspect your records and receive one copy of your records at no charge, with notice in advance
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain one copy of your records at no charge, when timely notice is provided (72 hours). X-rays are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

I have received a copy of City of Palms Chiropractic's Patient Privacy Notice. I understand my rights as well as the practices duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this 'Notice of Privacy Practice" at any time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

_____ _____
Patient's Name DOB

_____ _____
Patient Signature Date

_____ _____
Witness Date

City of Palms Chiropractic
Office Policies

As a potential new patient, we feel it is important that you understand our office policies regarding, how patients of this practice are cared for, and the various methods we offer to facilitate payment for that care. Please read each policy carefully so there is no misunderstanding as to what you can expect as a patient of this practice, and what we expect in return. Once you have read "Our Office Policies", if you have any questions or any of these policies are unclear to you, and you would like further explanation before submitting your Application for Care, please let our front desk know and a member of our staff will be happy to discuss them with you further. We believe it is in everyone's best interests to provide potential new patients as much information as possible about how the doctors at this office practice chiropractic so that an informed decision can be made as to whether they wish to become a patient.

Over time, individuals who are accepted, as patients at this office, gain a greater understanding as to the purpose of chiropractic. Since the majority of patient care occurs in an open bay area, patients have a unique opportunity to observe firsthand the positive results that are achieved and the benefits derived from being under chiropractic care. This knowledge and awareness reaps a positive environment that promotes healing and encourages families to maintain good health. We want your experience with us to be an exceptional one, so help us to help you and together we can make affirmative changes in your life and the lives of those you care about.

☐ PATIENT PRIVACY – Since the majority of patient care takes place in an open bay area it is important to understand that any conversations you have with the doctor can be overheard by other patients. In order to maintain patient privacy, it is the policy of this practice to refrain from discussing any confidential matters with patients during treating hours while patients are being adjusted. If you have a confidential matter you wish to discuss please let us know and we will schedule time for you to speak to the doctor in a private consultation room. These consultations must be scheduled in advance.

☐ YOUR CARE - When a patient seeks chiropractic health care and we agree to provide that care, it is essential for the patient and the doctor to be working toward the same objective. Chiropractic care at City of Palms Chiropractic is rendered primarily to minimize and reduce subluxations, which are a major interference to the expression of the body's innate wisdom. The doctors use a myriad of techniques to accomplish this goal, including but not limited to the latest techniques for spinal correction. It is important that you understand both the objective and the method(s) so there is no confusion or disappointment. Tremendous progress has been made in the rehabilitating and correction of spinal problems. Where in the past, chronic spinal structural problems could not be reversed or corrected, today they can. Your doctor will outline a course of treatment that will take you beyond simple pain relief, through two distinct phases of care to make a structural correction to your spine that will enable your central nervous system to function optimally, thereby improving you overall health.

☐ FIRST THINGS FIRST- Prior to receiving chiropractic care at this office, a health history and examination will be completed. Imaging studies as well as any other necessary diagnostics may also be ordered, to confirm the true nature of your condition and exact location of subluxations. The results of these procedures will aid in assessing your presenting problem, your overall health and, in particular, the condition of your spine. They will also assist the doctor in determining the type and amount of care you will need. All relevant findings will be reported to you along with care plan recommendations so that you can make the best possible decision regarding your health care needs. Our gold standard for care is to ensure the reduction of subluxation while teaching patients what they need to do in addition to being adjusted to maintain their health for a lifetime.

☐ PATIENT'S REPORT OF FINDINGS – To enhance your understanding of the chiropractic approach that will be used to manage your health, immediately following your first adjustment, you will be scheduled for a 'Doctors Report of Findings'. The information you receive at this appointment will be both informative and clinically relevant to your case, therefore attendance is required for individuals who wish to become new patients of this practice. Because the results of your x-rays and all examinations as well as the doctors' recommendations for care, will be discussed at that time, we strongly urge new patients to invite their spouse or significant other to attend. We know from experience that when a patient's family understands the goals and objectives of chiropractic care and how restoring and maintaining good health can affect their lives as well, they become infinitely supportive and helpful in making important decisions concerning treatment options.

☐ **NO-SHOWS and CANCELATIONS** – We understand that life and emergencies happen, but we do ask that if you cannot keep your appointment, please call us within 24 hours to cancel and reschedule your appointment. You can leave a message on our answering machine or send us an email and one of our staff members will gladly reschedule your appointment for you. **If you do not show up for your appointment, and did not call within 24 hours in advance, you will be charged a $35 NO-SHOW FEE for existing patients and a $50 NO-SHOW FEE for new patients. *First offense* – No charge, graceful warning. *Second (+) offenses* - $35 NO-SHOW FEE.**

I hereby acknowledge receiving a copy of the practices 'Office Policies' that I have read and retained. This signature page will be retained by the practice as evidence of my receiving and understanding this 'Notice'. I further acknowledge that any concerns regarding these 'Policies 'as well as all my questions have been answered by a qualified member of the staff to my complete satisfaction.

_____ _____
Patient's Name DOB

_____ _____
Patient Signature Date

_____ _____
Witness Date