COLLIER CHIROPRACTIC AND ACCIDENT REHABILITATION CENTER

PLEASE PRINT

GENERAL INFORMATION

PATIENT LAST NAME______________________ FIRST NAME______________________

ADDRESS______________________________ CARE OF______________________
(Parent or financially responsible person)

CITY__________________ STATE_____ ZIP________ PHONE (WORK)______________

DRIVER'S LIC.#______________ NO. CHILDREN________ PHONE (HOME)______________

OUT OF STATE ADDRESS__________________________ PHONE______________________

SPOUSE'S NAME__________ SPOUSE'S EMPLOYER____________ NATIVE LANGUAGE______

SEX M F MARRIED SINGLE WIDOWED DIVORCED DATE OF BIRTH SSN______________
(please circle) / /

EMAIL ADDRESS____

We will never sell or rent your email address to anyone. We value your privacy. Used for internal communication purposes only.

PATIENTS EMPLOYER'S NAME__________________________________

ADDRESS____

CITY__________________ STATE________ ZIP__________________

PHONE__________________ OCCUPATION______________________

EMPLOYED

FULL TIME PART TIME RETIRED NOT EMPLOYED

STUDENT

FULL TIME PART TIME NON STUDENT

INSURANCE INFORMATION

PRIMARY INSRUANCE COMPANY NAME__________________________

MEMBERSHIP/CERT #______________________ POLICY/GROUP#______________________

NAMES ON CARD_________________________ RELATIONSHIP TO INSURED________________

SECONDARY INSRUANCE COMPANY NAME________________________

MEMBERSHIP/CERT #______________________ POLICY/GROUP#______________________

NAMES ON CARD_________________________ RELATIONSHIP TO INSURED________________

RELEASE AND ASSIGNMENT

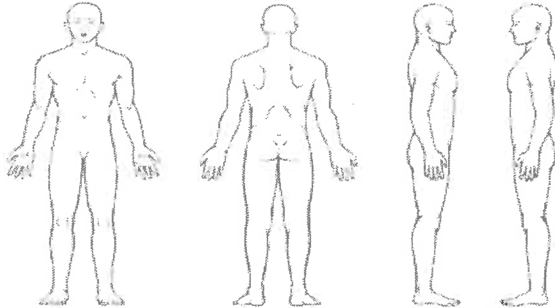
I authorize release of any information necessary to process my insurance claims and assign and request payment directly to my physicians.

PATIENT'S SIGNATURE______________________________ DATE____________

Patient Name:__________________

Collier Chiropractic Patient History

Please mark the exact location of your pain/discomfort on the diagram below



Major complaint ____

____

How did this condition develop (What caused it? How did it start? Have you had it previously)____

____

What makes this condition better and worse____

____

Have you received treatment for this condition? Yes or No (circle one) If yes, where, and what were the results?____

____

Type of pain experienced? (circle all that apply). Numbness Tingling Burning Radiating Throbbing

When is your pain at its worst Morning Afternoon Night Constant

When is your pain at its best Morning Afternoon Night Constant

Any other associated symptoms with your current condition (Eg headaches)____________________

____

Any previous surgeries, hospitalizations, infections/immunizations, trauma, allergies____________

____

Family history of current condition, cancer, diabetes and cardiovascular disease________________

____

Signed__________________________________ Date___________

Do you smoke, and how much?____

Current Occupation____

____

Sleep habits, number of hours?____

Sexual activity/STD's?____

Do you take any prescription, over the counter or recreational drugs yes/no____________________

____

Do you consume alcohol, how much?____

Diet (all american, vegan, food intolerances)_____________________________________

Exercise (how much and how often)____

Have you ever been in an automobile accident?_____________________________

Any chiropractor consulted in the past? Yes or No (circle one) If yes who, when and what for?_____

____

Signed_______________________________ Date___________

Collier Chiropractic And Accident Rehabilitation Center
2180 Immokalee Road Suite 201
Naples FL 34110

New Patient Questionnaire/ Medical History

Name:__________________________ **Date:**____________________

Comprehensive Review of Systems: Circle all those that apply

Constitutional: Fevers, night sweats, poor appetite, unexplained weight loss or gain, insomnia, fatigue, excessive daytime sleepiness **NONE**

Current weight:______________ **Weight 1 year ago**_____________

Height:_________ **Height Loss?** Yes or No

Eyes: Glasses or contact lenses, eye pain, dry eyes, excessive tearing, double vision, light sensitivity, cataracts, glaucoma, other visual disturbances. **NONE**

Ears: Hearing loss, hearing aid right ear_____ left ear____, ringing in ears, sensitivity to noise, ear ache, balance disturbance, dizziness, vertigo, recurrent ear infections, excessive ear wax. **NONE**

Nose: Frequent colds, nasal congestion, recurrent or chronic sinusitis, nosebleeds, deviated septum, nasal polyps, loss of sense of smell **NONE**

Mouth: Dry mouth, bleeding gums, dentures, mouth ulcers, altered taste, loss of sense of taste. **NONE**

Throat: Frequent sore throats, hoarseness, difficulty swallowing. **NONE**

Cardiovascular: High blood pressure, low blood pressure, heart murmur, rheumatic fever, mitral valve prolapse, palpitations, shortness of breath, leg cramps, swelling of feet or ankles, varicose veins, thrombophlebitis, chest pain, angina, heart attack, congestive heart failure, heart surgery. **NONE**

Respiratory: Asthma, wheezing, bronchitis, pneumonia, chronic cough, emphysema/COPD, excessive phlegm production, coughing blood, shortness of breath on minimal exertion, sleep apnea, pain with deep breathing. **NONE**

Gastrointestinal: Chronic heartburn/indigestion, nausea, vomiting, food intolerance, hiatal hernia, gastric reflux, ulcer, gallstones, jaundice, cirrhosis, abdominal or umbilical hernia, hemorrhoids, blood in stool, irritable bowel syndrome, diverticulitis, abdominal pain, bloating, constipation, laxative or enema dependence, chronic diarrhea, fecal incontinence. **NONE**

Urinary: Excessive or frequent urination, painful urination, blood in urine, recurrent urinary infections, urethral discharge, difficulty starting or stopping stream, incontinence, kidney or bladder stones, kidney disease, prostate. **NONE**

Genitoreproductive: Impotence, sexually transmitted diseases, pregnant or possibly pregnant, premenstrual syndrome, endometriosis, irregular menses, last menstrual period__/__/__. Menopausal symptoms, age oat menopause, post-menopausal bleeding, discharge, itching, sores, painful intercourse, decreased libido, number of pregnancies___. Miscarriages or abortions, last PAP smear __/__/__ **NONE**

Collier Chiropractic and Accident Rehabilitation Center
2180 Immokalee Road Suite 201
Naples FL 34110

New Patient Questionnaire:

Name:___________________________ **Date:**_____________________

Comprehensive Review of Systems: Circle all those that apply

Musculoskeletal: Neck pain, back pain, painful limb, generalized muscle aches, muscle spasms, joint pain, swelling or stiffness, fractures, dislocations, arthritis, gout, restricted joint motion, weakness. **NONE**

Breasts: Nodule or mass, thickening, dimpling, redness, pain or discomfort, nipple discharge, fibrocystic disease, breast biopsy or breast cancer, mastectomy ___right,___left.
Breast reduction/augmentation. **NONE**

Skin: Rashes, recurrent lesions, rosacea, chronic ulcer, pressure sore, psoriasis, itching, pigment changes, nail changes, thinning hair, hair loss, photosensitivity, Raynaud's Phenomenon, skin cancer. **NONE**

Neurologic: Fainting spells, dizziness, incoordination, difficulty walking, falls, tremor, involuntary movements, slurred speech, tingling/numbness, paralysis, stroke, spinal cord injury, head injury or concussion, confusion, changes in memory, change in behavior or personality, headaches, seizures. **NONE**

Psychiatric: Nervousness, anxiety, panic disorder, claustrophobia, agoraphobia, post-traumatic stress disorder, victim of abuse, attention deficit disorder, hyperactivity, compulsive behavior, uncontrollable anger, depression, hallucinations, suicidal or homicidal thoughts, psychiatric treatment or hospitalizations. **NONE**

Current or past use:
Recreational drug use:____
Prescription drug dependence:____
Alcohol dependence withdrawal or treatment:____

Endocrine: Heat or cold intolerance, excessive thirst or hunger, thyroid problem, diabetes, hypoglycemia, excessive sweating. **NONE**

Hematologic: Anemia, easy bruising, prolonged bleeding, history of transfusion, cancer, chemotherapy, radiation therapy, swollen glands/lymph nodes. **NONE**

Allergy/Immunology: food allergies_________________, lactose intolerance, seasonal allergies, latex allergy, dermatitis, eczema, adverse reaction to vaccination, contrast, antibiotics or other drugs__________________________, impaired immunity, herpes, shingles.
NONE

Surgical History:

____
____
____
____

RELEASE OF PATIENT RECORDS AUTHORATZION

I hereby authorize ____ to release a copy of my patient records, x-rays or other diagnostic imaging containing protected health information to:

COLIER CHIROPRAXTIC AND ACCIDENT REHABILATION CENTER INC.

FAX # (239) 594-9976

This Authorization is given pursuant to Florida Statue 456.057 and HIPPAA regulations. I understand that Florida Statue 456.057 (12) makes clear that any third party to whom records are disclosed is prohibited from further disclosing any information in the medical record without the expressed written consent of the patient or the patients' legal representatives.

________________________________ ____________________

Patient's or Patient Legal Representative's Name – PRINT CLEARLY **Patient's Date of Birth**

____

Patient's or Patient Legal Representative's Signature

____

Date Signed

Specific description of information to be disclosed:

____

____

____

COLLIER CHIROPRACTIC AND ACCIDENT REHABILITAION CENTER, INC.
(CCARC)
2180 IMMOKLAEE RD SUITE 201
NAPLES, FL 34110
(239) 594-8995 TAX ID 45-0522823

Patient Name: ____

Assignment of Insurance Benefits:

I hereby authorize payment to be made directly to CCARC of all benefits which may be due and payable under insurance coverage for the above-named patient. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments. I further acknowledge that this assignment of benefits does not in any way relieve me of liability and that I will remain financially responsible to CCARC.

Furthermore, I hereby IRREVOCABLY ASSIGN to CCARC. the rights and benefits under any policy of insurance, indemnity agreement, or any other collateral source as defined in Florida Statutes for any service and or charges provided by CCARC.

Signature of Witness: ____

Signature of patient or responsible party: ______________________________

INFORMED CONSENT DOCUMENT

PATIENT NAME: ______________________________

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment.

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or " click" much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis/ Examination/ Treatment

As a part of the analysis, examination, and treatment, you are consenting to the following procedures:

___ Spinal manipulative therapy
___ Palpation
___ Vital signs
___ Range of motion testing
___ Orthopedic testing
___ Basic neurological
___ Muscle strength testing
___ Postural analysis testing
___ Ultrasound
___ Hot/Cold Therapy
___ Laser
___ Radiographic studies
___ Electrical Muscle Stim
___ Other (please explain)

____

Patient should initial each procedure they are consenting to.

The material risks inherent in chiropractic adjustment.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, burns, orbital hemorrhage/retinal detachment. 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 will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and

X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options.

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
- Hospitalization
- Surgery

If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated.

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.
PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW
I have read [ ] or have read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Bradley Frick/ Dr. Kayla Smith and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated :________________ **Dated :** ______________

____

Patient's Name

____

Doctor's Name

____

Signature (Parent or Guardian)

____

Signature

Collier Chiropractic Accident and Rehabilitation Center **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

OTHER COMMENTS: ______________________

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.

Collier Chiropractic Accident and Rehabilitation Center
Lower Extremity Functional Index

We are interested in knowing whether you are having any difficulty at all with the activities listed below <u>because of your lower limb</u> problem for which you are currently seeking attention. Please provide an answer for each activity.

Today, <u>do you</u> or <u>would you</u> have any difficulty at all with:

(Circle one number on each line)

Activities	Extreme Difficulty or unable to perform activity	Quite a bit of difficulty	Moderate difficulty	A little bit of difficulty	No difficulty
a. Any of your usual work, housework or school activities.	0	1	2	3	4
b. Your usual hobbies, recreational or sporting activities	0	1	2	3	4
c. Getting into or out of the bath.	0	1	2	3	4
d. Walking between rooms.	0	1	2	3	4
e. Putting on your shoes or socks.	0	1	2	3	4
f. Squatting.	0	1	2	3	4
g. Lifting an object, like a bag of groceries from the floor.	0	1	2	3	4
h. Performing light activities around your home.	0	1	2	3	4
i. Performing heavy activities around your home.	0	1	2	3	4
j. Getting into or out of a car.	0	1	2	3	4
k. Walking 2 blocks.	0	1	2	3	4
l. Walking a mile.	0	1	2	3	4
m. Going up or down 10 stairs (about 1 flight of stairs).	0	1	2	3	4
n. Standing for 1 hour.	0	1	2	3	4
o. Sitting for 1 hour.	0	1	2	3	4
p. Running on even ground.	0	1	2	3	4
q. Running on uneven ground.	0	1	2	3	4
r. Making sharp turns while running fast.	0	1	2	3	4
s. Hopping.	0	1	2	3	4
t. Rolling over in bed.	0	1	2	3	4
COLUMN TOTALS					

Score variation ± 6 LEFTS points
MDC & MCID = 9 LEFS points

Score _____/80

Patient Signature________________

Doctor Signature________