FILL OUT COMPLETELY – PLEASE PRINT

Name _____ Birth Date_____ Marital Status_____

Address_____ City_____ State_____ Zip _____

Phone Numbers: Home_____ Cell_____ Work_____

Cell Phone Carrier: ☐ATT ☐Sprint ☐Verizon ☐T-Mobile ☐MetroPCS ☐Virgin Mobile Other_____

Employer _____ Occupation _____ Email Address _____

Spouse's Name_____ Spouse's Birth Date_____ Ladies, are you pregnant? ☐Yes ☐No

Referred by: ☐Sign ☐Ad ☐My Web Site ☐On Insurance Plan ☐Newspaper ☐Phone book ☐Friend/Relative

If Friend or Relative, what is their name _____

Chiropractic Before ☐Yes ☐ No If yes, when? _____ Doctors Name _____

Were you happy with the DC's treatment? ☐ Yes ☐ No If No, why not? _____

_____

Briefly describe what's bothering you right now: _____

_____

Are your symptoms/complaints due to an auto accident? ☐Y ☐N If yes, ask for auto accident forms.

Check any problems you have ever been diagnosed as having or are currently suffering from:

☐ Broken bones or fracture	☐ Osteoarthritis	☐ Alcoholism	☐ Epilepsy
☐ Rheumatoid Arthritis	☐ Pace Maker	☐ Drug Addiction	☐ Tumors
☐ Seizures/Convulsions	☐ Strokes	☐ HIV Positive	☐ Depression
☐ A Congenital Disease	☐ Circulation Problems	☐ Gall Bladder	☐ Ruptures
☐ Excessive Bleeding	☐ Coughing Blood	☐ Head Problems	☐ Ulcers
☐ High/Low Blood Pressure	☐ Eating Disorders	☐ Cancer	☐ Other_____

Payment Arrangements: (✓) ☐ Cash/Check ☐ Credit Card ☐ Insurance (Must be verified in Advance)

READ CAREFULLY – IF YOU UNDERSTAND AND AGREE, SIGN BELOW

Authorization & Assignment: I hereby authorize and assign any and all insurance and/or third party benefits directly to this office. I authorize the release of any and all information this office deems necessary to anyone in order to process a claim for insurance or third party benefits on my behalf, and hereby release this office of any consequences thereof.

I hereby authorize the doctor(s) to treat my condition(s) as he/they deem(s) appropriate through the use of spinal adjustments (manipulation) and therapy throughout my spine/body. I understand and agree the amount paid the doctor for x-rays, is for the examination and analysis of the x-rays only and the x-ray negatives will remain the property of this office. The doctor will not be held responsible for any pre-existing medically diagnosed conditions or medical diagnosis. I understand and agree that I am responsible for any and all charges at this office whether paid by insurance or not.

I give all the doctor's in this office consent to treat me and or my minor children. I understand that no cures are promised (or implied) and any risks regarding care at this office will be explained to me upon my request. All information is true and accurate to the best of my knowledge.

Signature _____ Date _____
(Patient – Guardian)

(TURN OVER AND CONTINUE)

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and any other chiropractic procedures, including a comprehensive exam, diagnostic x-rays, physical therapy techniques, on me (or on the patient named below for which I am legally responsible) by the licensed doctors of chiropractic at this office.

I understand that, as with any health procedure, there are certain conditions that may arise during a chiropractic adjustment. Those complications include but are not limited to: fractures, dislocations, muscle strain, costovertebral strains and separations. Some types of manipulations of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. This is a very rare occurrence (a one in three million chance). We screen our patients for indications that they are candidates for chiropractic adjustments to the best of our ability. I do not expect the doctor to be able to anticipate all risk and complications during the course of the procedure(s) that the doctor feels at the time, based upon the facts then known, are in the best interest.

I have had an opportunity to discuss with the doctor the nature, purpose, and risk of chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed.

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. By signing below, I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the chiropractic treatment recommended. Having being informed of the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition (s) for which I seek treatment.

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, this office may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to our Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. This office reserves the right to revise its' Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to your doctor at 1340 Tuskawilla Rd. Suite 112, Winter Springs, FL 32708.

With my consent, The doctors at this office may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care.

With my consent, the doctors at this office may email me, mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminders, and patient statements as long as they are marked Personal and Confidential.

I have the right to request that my doctor restricts how he uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, is bound by this agreement. By signing this form, I am consenting to my chiropractor to have the right to use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do no sign this consent, the doctors at this office may decline to provide treatment to me.

Signature of Patient	Printed name of patient	Date

Signature of Patient's Representative
(if minor)

Patient Health History Worksheet - Pg 1 (PLEASE PRINT)

Patient Name:_____ Date:_____

Present Health History

When did your present condition begin?
☐ Gradual Onset (no specific date)
☐ Date:_____

What caused your present condition?
☐ No specific injury (gradual onset)
☐ Home injury ☐ Work injury
☐ Auto injury ☐ Sports Injury
☐ Other_____

What happened to cause your present problem(s)?
_____
_____
_____
_____

Ever had these symptoms/complaints before?
☐ No ☐ Yes: When:_____

What time of the day are your complaints BETTER?
☐ Morning ☐ Evening
☐ Afternoon ☐ None – constant pain

What time of the day are your complaints WORSE?
☐ Morning ☐ Evening
☐ Afternoon ☐ All times – constant pain

Have you missed any time from work/school?
☐ No ☐ Yes: Date_____

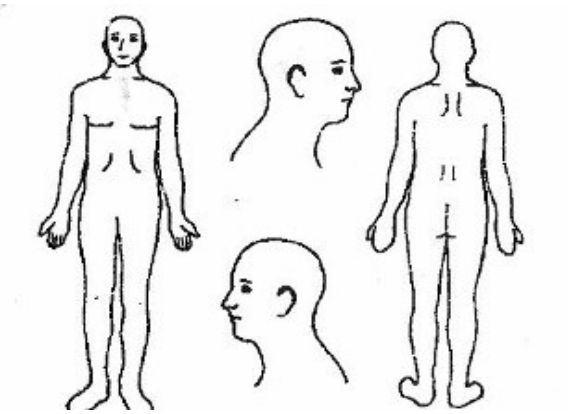
What makes your complaint/symptom BETTER?
☐ Rest
☐ Ice ☐ Heat ☐ Both
☐ Prescription Medications
☐ OTC Meds (aspirin, Advil, Tylenol, etc.)
☐ Other:_____

What makes your complaints/symptoms WORSE?
☐ Activity (work, school, repetitive motions)
☐ Ice ☐ Heat ☐ Both ☐ Driving (or riding in car)
☐ Sitting ☐ Standing ☐ Squatting ☐ Bending
☐ Lifting ☐ Pushing ☐ Pulling ☐ Stepping up-down
☐ Other_____

What home remedies have you tried so far?
☐ Rest ☐ Ice ☐ Heat ☐ OTC Meds ☐ Exercise

Have any of the home remedies helped so far?
☐ No ☐ Yes ☐ Yes to begin with, but not now.
☐ Other:_____

Please mark the area(s) where your problem(s) are:



_____
_____
_____
_____

Significant Past Health History

Have you ever been hospitalized?
☐ No ☐ Yes (If yes, list date and reason)
Date:_____ Reason:_____
Date:_____ Reason:_____
Date:_____ Reason:_____

Have you had any surgeries?
☐ No ☐ Yes (If yes, list date and reason)
Date:_____ Reason:_____
Date:_____ Reason:_____
Date:_____ Reason:_____

Do you have any significant health problems?
☐ No ☐ Yes Explain:_____
_____
_____

(TURN OVER AND CONTINUE)

Significant Past Medical History

Have you seen any other doctor(s) for this condition?
☐No ☐Yes, if yes give doctors name & date seen.
Name Date
_____ _____
_____ _____
_____ _____

Did this doctor recommend any treatment?
☐No ☐Yes If yes, list treatment recommended.
_____
_____

Are you taking any medications?
☐No ☐Yes If yes, list them and for what.
Medication For what?
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Are you taking any vitamins?
☐No ☐Yes If yes, list them and for what.
Vitamin For what?
_____ _____
_____ _____
_____ _____
_____ _____

Do you play any sports?
☐No ☐Yes If yes, list them.
_____
_____

Do you exercise regularly?
☐No ☐Yes If yes, how often: _____
_____

How many hours do you sleep at night? _____

How many hours a week do you work? _____

Significant Family Medical History

Did your father have any health problems?
☐No ☐Yes:_____

Did your mother have any health problems?
☐No ☐Yes:_____

Did your brother(s) have any health problems?
☐No ☐Yes:_____

Did your sister(s) have any health problems?
☐No ☐Yes:_____

Did your grandfarther have any health problems?
☐No ☐Yes:_____

Did your grandmother have any health problems?
☐No ☐Yes:_____

Health Risk Factors

Do you drink alcohol?
☐No ☐Yes Amount:_____

Do you smoke?
☐No ☐Yes Amount:_____

What is your height: _____ ft _____ in

What is you weight: _____ (try be accurate)

Anything else the doctor should know?
☐No ☐Yes Explain:_____
_____
_____
_____
_____
_____
_____
_____

All of the information I have provided on this Health History Worksheet is true to the best of my knowledge.

_____
Patient/Guardian Signature

CONSENT FOR TREATMENT OF A MINOR CHILD

I hereby authorize Dr. Van Syoc and whomever he may designate as his assistants to administer chiropractic care as he/she deems necessary to my _____(indicate relationship of child).

NAME OF CHILD_____

DATED_____

SIGNATURE OF PARENT OR GUARDIAN_____