TOTAL BACK AND BODY CENTER
1228 SE Port St Lucie Blvd. Port St Lucie, FL 34952 **Date:**

Name:________________________________ **Sex**: **Male** **Female** **Height**______**Weight**______
Address:________________________________ **Birth Date**:_____/______/_____ **Age**________
City:____________________ **ST**_______ **Zip**__________ **Social Security #**:_______-______-_________
Home Number:(_______)________________ **Cell Phone**: (_______)__________________**Email**:______________@___________
Would you like to get reminded of appointments? No Text to Cell Phone Email Phone Call **Primary Language:** __________________
Martial Status: Single Married Separated Divorced Widowed **Children #:**____ **Race: White Black Hispanic Asian Native American Other:** __________
Occupation:____________________________**Employer**: ___________________________**Work#**:(______)______________
Spouse: N/A Name:____________________________________ **Occupation**:____________________________
Emergency Contact:______________________________ **Relationship to you?** ____________ **Phone#:** (_______)________________

Whom should we thank for referring you into our office?

Insurance Information: **Do you have insurance**? Yes No Name of Plan__________________**Relation to insured** : Self Spouse
Primary Care Physician Name:________________________________ Last Visit ______________Phone #:(______)_______________

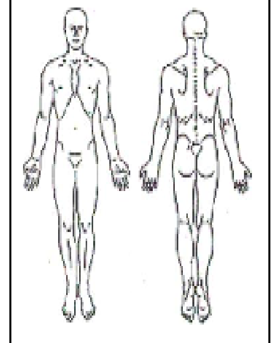
COMPLAINTS: (Please answer complaints from worst symptoms to least amount of symptoms)

First area of complaint?____ **When did symptoms begin**?______________________
How did symptoms begin?____ **Have you had complaints previous? Yes No**
Rate Pain Level 1 (least) to 10 (severe): **Pain Now: 0 1 2 3 4 5 6 7 8 9 10** **Typical Average Pain: 0 1 2 3 4 5 6 7 8 9 10**
Is the condition getting worse? Yes No **Pain at best: 0 1 2 3 4 5 6 7 8 9 10** **Pain at worst: 0 1 2 3 4 5 6 7 8 9 10**
The pain is? Constant (76-100%) Frequent (51-75%) Occasional (26-50%) Infrequent (1-25%) Comes and Goes Vary with intensity and frequency
The symptoms are: **Same all day** **Better in the:** morning /afternoon /night /sleeping **Worse in the:** morning /afternoon /night /sleeping
Type of symptoms you are experiencing: (mark all that apply):
❑Dull ❑ Sharp ❑ Throbbing ❑Burning ❑Deep ❑Aching ❑ Tingling ❑Stabbing ❑Cramping ❑Soreness
❑ Numbness ❑Stiffness ❑Spasm ❑ Grabbing ❑Swelling ❑Pounding ❑Tightness ❑Shooting to ____________

Activities that aggravate the pain: ❑ Sitting ❑Standing ❑Walking ❑ Bending ❑ Stooping ❑ Lifting ❑Sleeping
❑Straining ❑Reaching ❑Twisting ❑Looking Up/Down ❑Movements ❑Resting ❑Driving ❑Stairs ❑ Computer
❑Housework ❑Exercise ❑Working ❑Sitting to Standing ❑Standing to Sitting ❑Traveling ❑Recreational activities

What improves the pain: ❑Nothing ❑Sitting ❑Standing ❑Lying ❑Knees Bent ❑Support (cane) ❑Movement
❑No Movement ❑ Heat ❑ Ice ❑ Topical Rub ❑Resting ❑Stretching ❑Exercising ❑Back Brace ❑Massage
❑ Over the counter Medication ❑ Prescription medication ❑Hot Showers ❑Jacuzzi ❑Tens Unit ❑Other______

Mark All Pain Areas

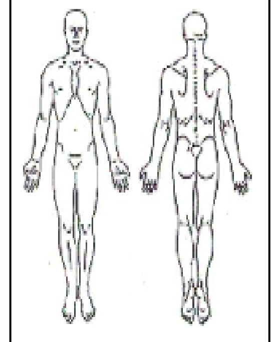


Second area of complaint?____**When did symptoms begin**?______________________
How did symptoms begin?____**Have you had complaints previous? Yes No**
Rate Pain Level 1 (least) to 10 (severe): **Pain Now: 0 1 2 3 4 5 6 7 8 9 10** **Typical Average Pain: 0 1 2 3 4 5 6 7 8 9 10**
Is the condition getting worse? Yes No **Pain at best: 0 1 2 3 4 5 6 7 8 9 10** **Pain at worst: 0 1 2 3 4 5 6 7 8 9 10**
The pain is? Constant (76-100%) Frequent (51-75%) Occasional (26-50%) Infrequent (1-25%) Comes and Goes Vary with intensity and frequency
The symptoms are: **Same all day** **Better in the:** morning /afternoon /night /sleeping **Worse in the:** morning /afternoon /night /sleeping
Type of symptoms you are experiencing: (mark all that apply):
❑Dull ❑ Sharp ❑ Throbbing ❑Burning ❑Deep ❑Aching ❑ Tingling ❑Stabbing ❑Cramping ❑Soreness
❑ Numbness ❑Stiffness ❑Spasm ❑ Grabbing ❑Swelling ❑Pounding ❑Tightness ❑Shooting to ____________

Activities that aggravate the pain: ❑ Sitting ❑Standing ❑Walking ❑ Bending ❑ Stooping ❑ Lifting ❑Sleeping
❑Straining ❑Reaching ❑Twisting ❑Looking Up/Down ❑Movements ❑Resting ❑Driving ❑Stairs ❑ Computer
❑Housework ❑Exercise ❑Working ❑Sitting to Standing ❑Standing to Sitting ❑Traveling ❑Recreational activities

What improves the pain: ❑Nothing ❑Sitting ❑Standing ❑Lying ❑Knees Bent ❑Support (cane) ❑Movement
❑No Movement ❑ Heat ❑ Ice ❑ Topical Rub ❑Resting ❑Stretching ❑Exercising ❑Back Brace ❑Massage
❑ Over the counter Medication ❑ Prescription medication ❑Hot Showers ❑Jacuzzi ❑Tens Unit ❑Other______

Mark All Pain Areas



Since your symptoms began, have you had changes with: ❑None ❑Bowel ❑Sexual functions ❑Bladder

******More than 2 complaint area - Please ask for additional sheet******

Have you had treatment already for your condition? ❑ Yes ❑ No ❑ Self Treatment Only
Who treated with for this Condition?______________________Specialty?______________________
Date of consultations_______ **What was treatment recommendation**? ❑Muscle Relaxors ❑Anti-Inflammatories ❑Antibiotic
❑ Pain Medication ❑ Physical Therapy ❑ Surgery ❑ Chiropractic Care Other______________________
Did Treatment help? ❑ No, Aggravated problem ❑ Yes, helped a little ❑ Yes, helped a lot ❑ No Symptoms
Were you referred to anyone from your doctor? ❑ No ❑ Yes Referred to:______________________
For ______________________
Diagnostic Test and areas of tests that have been performed in past 5 years:
❑ X-Rays of the ______________ ❑ MRI of the ______________ ❑ CT scan of the______________
❑Bone Scan of ______________ ❑ Bone Density test ______________ ❑ Blood Work for______________
❑ EMG of ______________ ❑ Nerve Conduction of______________Other:______________

CHIROPRACTIC CARE

Have you been to a Chiropractor before? ❑ No ❑ Yes Who?______________________
How long ago was the last chiropractic treatment?______________**What was the treatment for**?______________
How were your results with chiropractic previously? ❑ Good ❑ Okay ❑ Bad Why?______________________

HEALTH HISTORY (**P** = In The Past Only **H** = Have Right Now)

General	P H
Bronchitis	❑❑
Chills	❑❑
Convulsions	❑❑
Dizziness	❑❑
Fainting	❑❑
Fever	❑❑
Loss of Sleep	❑❑
Loss of Weight	❑❑
Nervousness	❑❑
Parkinson's DX	❑❑
Night Sweats	❑❑
Wheezing	❑❑
Headaches	❑❑
Heat Intolerance	❑❑
Tremors	❑❑
Fatigue	❑❑
AIDS/ HIV	❑❑
Cancer	❑❑
Allergies	❑❑
Females Only	
Painful Cramps	❑❑
Vaginal Discharge	❑❑
Irregular Cycle	❑❑
Abnormal Bleeding	❑❑
Hot Flashes	❑❑
Miscarriages	❑❑
Pregnancy	❑❑
Last Pap_________	❑❑
Breast Lumps	❑❑

Skin	P H
Rash	❑❑
Redness	❑❑
Itching	❑❑
Dryness	❑❑
Easily Bruise	❑❑
Eczema	❑❑
Hives/ Allergies	❑❑
Sensitive Skin	❑❑
Hair Changes	❑❑
Nail Changes	❑❑
Lung	
Chest Pain	❑❑
Cough	❑❑
Difficult Breathing	❑❑
Spitting up Blood	❑❑
Asthma	❑❑
Emphysema	❑❑
Psychological	
Anxiety	❑❑
Depression	❑❑
Mood Swings	❑❑
Memory Loss	❑❑
Phobias	❑❑
Others_________	❑❑
Anorexia	❑❑
Drug Addiction	❑❑

Muscle & Joints	P H
Back Pain	❑❑
Shoulder Pain	❑❑
Neck Pain	❑❑
Foot Trouble	❑❑
Herniated Discs	❑❑
Rheumatoid Arthritis	❑❑
Scoliosis	❑❑
Osteoporosis	❑❑
Cardio-vascular	
Swollen Extremities	❑❑
Murmur	❑❑
Palpitations	❑❑
High Blood Pressure	❑❑
Low Blood Pressure	❑❑
Stroke	❑❑
Prev Heart Trouble	❑❑
High Cholesterol	❑❑
Anemia	❑❑
Diabetes	❑❑
Thyroid Problems	❑❑
Genito-Urinary	
Frequent Urination	❑❑
Blood in Urine	❑❑
Unable to Hold Urine	❑❑
Kidney Problems	❑❑
Prostate Problems	❑❑
Bedwetting	❑❑
Gout	❑❑
Sterility	❑❑

Gastro-intestinal	P H
Decreased Appetite	❑❑
Increased Appetite	❑❑
Abdominal Pain	❑❑
Excessive Gas	❑❑
Vomiting	❑❑
Diarrhea	❑❑
Constipation	❑❑
Gallbladder Trouble	❑❑
Jaundice	❑❑
Liver Trouble	❑❑
Nausea	❑❑
Colon Trouble	❑❑
Hemorrhoids	❑❑
Pain over Stomach	❑❑
Excessive Hunger	❑❑
Poor Digestion	❑❑
Ulcers	❑❑
Alcoholism	❑❑
Eyes	
Pain R L	❑❑
Discharge R L	❑❑
Vision Trouble R L	❑❑
Cataracts R L	❑❑
Ears	
Pain R L	❑❑
Discharge R L	❑❑
Ringing R L	❑❑
Hearing trouble R L	❑❑

ANY OTHERS NOT LISTED ABOVE? ______________________________________

Are You PREGNANT? ❑ NO ❑ YES Due Date:______________ **Do you have a PACEMAKER? ❑ NO ❑ YES**

MEDICATIONS: Are you currently taking Medications? ❑ No (Please put the name of medication & dosage)

Medical Issue	Medication Name	Medical Issue	Medication Name	Medical Issue	Medication Name
❑ Cholesterol	______________	❑ Diabetes	______________	❑ High Blood Pressure	______________
❑ Heart	______________	❑ Thyroid	______________	❑ Birth control	______________
❑ Cortisone	______________	❑ Inhalers	______________	❑ Stomach	______________
❑ Hormones	______________	❑ Pain	______________	❑Anti-Depressants	______________
❑ Headache	______________	❑ Arthritis	______________	❑Osteoporosis	______________
❑ Anti-biotic	______________	❑ Anxiety	______________	❑ Muscle Relaxers	______________

❑ Any Other Medications being taken:______________________________________

ARE YOU ALLERGIC TO ANY MEDICATIONS? ❑NO ❑ YES ______________________

VITAMINS: ❑No Vitamins ❑ Multivitamin ❑Glucosamine ❑ Chondroitin ❑Calcium ❑ Fish Oil ❑ Flaxseed
❑Vit D ❑ Vit B ❑ Vit C ❑ Vit E ❑ Joint Formula ❑Digestive Enzymes ❑ CoQ10 ❑ Other ______________

PAST HISTORY:

SURGERIES: Have you had any type of surgeries? ❑ No

Surgery	When	Surgery	When	Surgery	When
❑ Tonsillectomy	___________	❑ Colon	____________	❑ Thyroid	____________
❑ Spine /Knee/ Hip	___________	❑ Appendix	____________	❑ Heart	___________
❑ Gall Bladder	___________	❑ Stomach	____________	❑ Kidney	___________
❑ Hernia	____________	❑ Sinus	____________	❑ Eye	____________

❑ Other Surgeries not listed:____

CANCER: Type _____________ When________ Outcome to date: ❑ Cancer Free ❑ Remission ❑Ongoing

FEMALE: ❑ Breast ___________ ❑ C-section ____________ ❑ Hysterectomy ______________

MALE: ❑ Prostate ___________ ❑ Other: ____

INJURIES:	**When**	**What was Injured**		**When**	**What was Injured**
❑ Auto Accident	__________	_______________	❑ Slip/Fall	____________	______________
❑ Work Related	___________	_______________	❑ Other:	____________________________________	

HOSPITALIZATIONS:

Have you ever been hospitalized? ❑ No ❑ Only with Surgeries ❑ Childbirth

Other Hospitalizations:____

EXERCISE: ❑ **No Exercise** ❑ **Few times a year** ❑ **Sporadic**

❑ **Walking** __________x a wk/mth ❑ **Biking** _______________x wk/mth ❑ **Yoga/Pilates** _____________x wk/mth

❑ **Weights** ____________x wk/mth ❑ **Golfing** _______________x wk/mth ❑ **Swimming** ______________x wk/mth

❑ **Hiking** _____________x wk/mth ❑ **Dancing** ______________x wk/mth ❑ **Stretching** ______________x wk/mth

❑ **Tennis** _____________x wk/mth **Other:**____

Hobbies? ❑ Reading ❑ Fishing ❑ Gardening ❑Sewing ❑Cooking ❑Computers Others:__________________

Work Type? ❑ No ❑ Student FT / PT ❑ Retired ❑ PT Work ❑ FT Work ❑ Stay at home Parent ❑ Other

Work Type Activities? ❑ Standing ❑Sitting ❑Light Activities ❑Heavy Activities ❑Repetitive Activities

❑Driving ❑Lifting ❑Bending ❑Carrying ❑Pushing ❑Pulling ❑Arms over head ❑Kneeling Other__________

Habits? ❑ Smoking, packs a day____ ❑ Alcohol, drinks per week____ ❑ Coffee, cups per day ________

❑ High Stress, reason__________________________________ ❑ Recreational Drugs use, per month___________

Sleeping Habits? ❑ Side Sleeper- Right / Left / Both ❑ Back Sleeper ❑ Stomach Sleeper ❑ Pillow between Leg

# of Pillows ____ Hours of sleep per night?____ How do you sleep? ❑Restful ❑ Wake up every __hr ❑ Insomnia

FAMILY HISTORY: Has any one in your family had any of the following?

Please use these codes for answers: **M**= Mother **F**= Father **S**= Siblings **C**= Children **G**=Grandparents

Cancer___________	Diabetes__________	Heart Trouble___________	Stroke_____________
Ulcers____________	Arthritis__________	Headaches_______________	Asthma____________
Anemia__________	Hepatitis__________	Glaucoma_______________	Suicide_____________
Allergies_________	Epilepsy__________	Birth Defects___________	Alcoholism________

High Blood Pressure__________ Multiple Sclerosis___________ Mental Illness ____________

Good Health? M F S C G Still Living?❑ Yes M F S C G ❑ No M F S C G

Are there are any other complaints that may not have been addressed? _________________________________

____

All the information above is accurate and true as can be recalled at this time. The doctors cannot be held responsible for information that is not discussed on this form.

❑ **I choose to decline receipt of my clinical summary after every visit (These summaries are often blank as a result of the nature and frequency of chiropractic care.)**

PATIENT SIGNATURE:____ DATE:__________

WITNESS SIGNATURE:____ DATE:__________

OFFICE POLICY

If the doctor accepts you as a patient, a specific treatment plan designed to meet your needs will be prescribed. It is important for you to follow your treatment plan to maximize your results and achieve healing.
If you must cancel a scheduled appointment, please give 24 hours' notice if possible, as this time has been reserved for you. If you do miss an appointment, please make up the visit during the same treatment week, as not to disturb your progress. There may be a $20.00 charge for appointments that are missed without cancellation for people who continually abuse of this policy, as per our discretion.
I clearly understand and agree that all services rendered to me are my responsibility for payment even if my insurance fails to pay. Insurance is between the patient and the insurance company. This office will make its best effort in collecting outstanding balances, but ultimately I, the patient is responsible for all outstanding medical bills.

DOCTOR-PATIENT RELATIONSHIP IN CHIROPRACTIC INFORMED CONSENT

It is important to acknowledge the difference between the health care specialties of Chiropractic, Osteopathy and Medicine. Chiropractic health care seeks to restore health through natural means without the use of medicine or surgery. This gives the body maximum opportunity to utilize inherent recuperative powers. The success of the Chiropractic Doctor's procedures often depends on environment, underlying causes, physical and spinal conditions. It is important to understand what to expect from Chiropractic Healthcare Services. The Doctor of Chiropractic will use hers hands or mechanical device in order to adjust your spine. You may feel a "click" or "pop", such as the noise you hear if your knuckles are "cracked", and you may feel movement in the joints at that time. The doctor may use various ancillary procedures such as trigger points (arthrostim electric adjusting machine), hot or cold packs, electric muscle stimulation, therapeutic ultrasound, intersegmental traction, or cervical/lumbar mechanical traction, assisted manual traction, or manual traction.

Informed Consent

I hereby consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy, physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic and /or whomever she may designate as her assistant who now or in the future work at the office listed below or any other office or clinic. I will discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures.

Probability of any risk occurring: The risks of complication due to a chiropractic treatment may be described as "rare", about as often as complications from being hit by lightning or winning the lottery. The risk of cerebrovascular injury or stroke has been estimated at one in one million to one in twenty million. We take great care in making sure through proper screening that we reduce your risks even more than that. And the risk of adverse reactions due to the Ancillary procedures is also extremely "rare".

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fracture of bone, muscle strain, ligamentous sprain, dislocation of joints, or injury to the discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to the arteries of the neck. Some patients may have some soreness and stiffness after the first few days of treatment. The Ancillary procedures could produce skin irritation, burns or minor complications. As it is stated above all these things could happen but the doctor doesn't expect them to for careful evaluation and screening procedures are in place to insure your safety. The doctor, of course, will not give a Chiropractic adjustment, or health care, if she is aware that such care may be contraindicated. Again, if is the responsibility of the patient to make it known or to learn through healthcare procedures whatever he/she is suffering from: latent pathology defects, illnesses, if deformities which would otherwise not come to the attention of the Doctor of Chiropractic. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

Results

The purpose of Chiropractic services is to promote natural health care through the reduction of the vertebral subluxation complex. Since there are so many variables, it is difficult to predict the time schedule or efficacy of the Chiropractic procedure. Sometimes the response is phenomenal. In most cases there is a more gradual, but quite satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same Chiropractic care. Many medical failures find quick relief through Chiropractic. In turn, we must admit that conditions, which do not respond to Chiropractic care, may come under the control or be helped through medical science. The fact is that the science of Chiropractic and medicine may never be so exact as to provide definitive answers to all problems. Both have great strides in alleviating pain and controlling disease.

Risk of remaining untreated: Delay in treatment allows for formation of adhesions, scar tissue, and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. This can further complicate your condition and prolong treatment at another date and time.

TO THE PATIENT: Please discuss any questions with the Doctor before signing this statement of policy.

I have read the explanations above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated my risks and benefits of undergoing treatment, and hereby give my full consent to treatment.
I agree to the above-named procedures. 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.

***** I acknowledge that a copy of the NOTICE OF PRIVACY is on display and is available for me at the front desk upon request. I understand that if I have any questions, I am free to ask for assistance in reviewing the document to understand my privacy rights.**

PATIENT SIGNATURE____**DATE**________________

WITNESS SIGNATURE____**DATE**________________

Third area of complaint?____**When did symptoms begin**?______________________

How did symptoms begin?____**Have you had complaints previous? Yes No**

Rate Pain Level 1 (least) to 10 (severe): Pain Now: 0 1 2 3 4 5 6 7 8 9 10 Typical Average Pain: 0 1 2 3 4 5 6 7 8 9 10

Is the condition getting worse? Yes No **Pain at best: 0 1 2 3 4 5 6 7 8 9 10 Pain at worst: 0 1 2 3 4 5 6 7 8 9 10**

The pain is? Constant (76-100%) Frequent (51-75%) Occasional (26-50%) Infrequent (1-25%) Comes and Goes Vary with intensity and frequency

The symptoms are: **Same all day Better in the:** morning /afternoon /night /sleeping **Worse in the:** morning /afternoon /night /sleeping

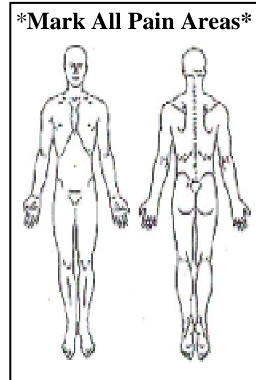
Type of symptoms you are experiencing: (mark all that apply):

❑Dull ❑ Sharp ❑ Throbbing ❑Burning ❑Deep ❑Aching ❑ Tingling ❑Stabbing ❑Cramping ❑Soreness
❑ Numbness ❑Stiffness ❑Spasm ❑ Grabbing ❑Swelling ❑Pounding ❑Tightness ❑Shooting to ____________

Activities that aggravate the pain: ❑ Sitting ❑Standing ❑Walking ❑ Bending ❑ Stooping ❑ Lifting ❑Sleeping
❑Straining ❑Reaching ❑Twisting ❑Looking Up/Down ❑Movements ❑Resting ❑Driving ❑Stairs ❑ Computer
❑Housework ❑Exercise ❑Working ❑Sitting to Standing ❑Standing to Sitting ❑Traveling ❑Recreational activities

What improves the pain: ❑Nothing ❑Sitting ❑Standing ❑Lying ❑Knees Bent ❑Support (cane) ❑Movement
❑No Movement ❑ Heat ❑ Ice ❑ Topical Rub ❑Resting ❑Stretching ❑Exercising ❑Back Brace ❑Massage
❑ Over the counter Medication ❑ Prescription medication ❑Hot Showers ❑Jacuzzi ❑Tens Unit ❑Other______

Mark All Pain Areas



Forth area of complaint?____**When did symptoms begin**?______________________

How did symptoms begin?____**Have you had complaints previous? Yes No**

Rate Pain Level 1 (least) to 10 (severe): Pain Now: 0 1 2 3 4 5 6 7 8 9 10 Typical Average Pain: 0 1 2 3 4 5 6 7 8 9 10

Is the condition getting worse? Yes No **Pain at best: 0 1 2 3 4 5 6 7 8 9 10 Pain at worst: 0 1 2 3 4 5 6 7 8 9 10**

The pain is? Constant (76-100%) Frequent (51-75%) Occasional (26-50%) Infrequent (1-25%) Comes and Goes Vary with intensity and frequency

The symptoms are: **Same all day Better in the:** morning /afternoon /night /sleeping **Worse in the:** morning /afternoon /night /sleeping

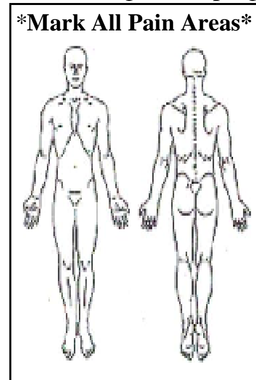
Type of symptoms you are experiencing: (mark all that apply):

❑Dull ❑ Sharp ❑ Throbbing ❑Burning ❑Deep ❑Aching ❑ Tingling ❑Stabbing ❑Cramping ❑Soreness
❑ Numbness ❑Stiffness ❑Spasm ❑ Grabbing ❑Swelling ❑Pounding ❑Tightness ❑Shooting to ____________

Activities that aggravate the pain: ❑ Sitting ❑Standing ❑Walking ❑ Bending ❑ Stooping ❑ Lifting ❑Sleeping
❑Straining ❑Reaching ❑Twisting ❑Looking Up/Down ❑Movements ❑Resting ❑Driving ❑Stairs ❑ Computer
❑Housework ❑Exercise ❑Working ❑Sitting to Standing ❑Standing to Sitting ❑Traveling ❑Recreational activities

What improves the pain: ❑Nothing ❑Sitting ❑Standing ❑Lying ❑Knees Bent ❑Support (cane) ❑Movement
❑No Movement ❑ Heat ❑ Ice ❑ Topical Rub ❑Resting ❑Stretching ❑Exercising ❑Back Brace ❑Massage
❑ Over the counter Medication ❑ Prescription medication ❑Hot Showers ❑Jacuzzi ❑Tens Unit ❑Other______

Mark All Pain Areas



Fifth area of complaint?____**When did symptoms begin**?______________________

How did symptoms begin?____**Have you had complaints previous? Yes No**

Rate Pain Level 1 (least) to 10 (severe): Pain Now: 0 1 2 3 4 5 6 7 8 9 10 Typical Average Pain: 0 1 2 3 4 5 6 7 8 9 10

Is the condition getting worse? Yes No **Pain at best: 0 1 2 3 4 5 6 7 8 9 10 Pain at worst: 0 1 2 3 4 5 6 7 8 9 10**

The pain is? Constant (76-100%) Frequent (51-75%) Occasional (26-50%) Infrequent (1-25%) Comes and Goes Vary with intensity and frequency

The symptoms are: **Same all day Better in the:** morning /afternoon /night /sleeping **Worse in the:** morning /afternoon /night /sleeping

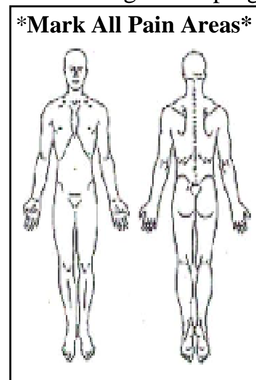
Type of symptoms you are experiencing: (mark all that apply):

❑Dull ❑ Sharp ❑ Throbbing ❑Burning ❑Deep ❑Aching ❑ Tingling ❑Stabbing ❑Cramping ❑Soreness
❑ Numbness ❑Stiffness ❑Spasm ❑ Grabbing ❑Swelling ❑Pounding ❑Tightness ❑Shooting to ____________

Activities that aggravate the pain: ❑ Sitting ❑Standing ❑Walking ❑ Bending ❑ Stooping ❑ Lifting ❑Sleeping
❑Straining ❑Reaching ❑Twisting ❑Looking Up/Down ❑Movements ❑Resting ❑Driving ❑Stairs ❑ Computer
❑Housework ❑Exercise ❑Working ❑Sitting to Standing ❑Standing to Sitting ❑Traveling ❑Recreational activities

What improves the pain: ❑Nothing ❑Sitting ❑Standing ❑Lying ❑Knees Bent ❑Support (cane) ❑Movement
❑No Movement ❑ Heat ❑ Ice ❑ Topical Rub ❑Resting ❑Stretching ❑Exercising ❑Back Brace ❑Massage
❑ Over the counter Medication ❑ Prescription medication ❑Hot Showers ❑Jacuzzi ❑Tens Unit ❑Other______

Mark All Pain Areas



TOTAL BACK AND BODY CENTER

1228 SE PORT ST LUCIE BLVD
PORT ST LUCIE, FL 34952
(772)878-9355 Fax (772)398-4988

Patient Name: ____ Date:_____________

Authorization to Pay Physician

I hereby authorize my insurance company______________________ to pay by check or electronic funds made out and mailed to or electronically sent to:
Total Back and Body Center, PLLC and /or Dr. Kelly M. Meredith, DC at 1228 SE Port St Lucie Blvd., Port St Lucie, FL 34952-5330. The medical expense benefits allowable and otherwise payable to me under current insurance policy, as payment toward the total charge for professional services rendered. This payment will not exceed the indebtedness to the above mentioned assignees, and I agree to pay, in the current manner, any balances of the said professional service charges over and above the insurance payment. If my policy prohibits direct payment to the doctor then I hereby authorize you to make the check payable to me but send it directly to Total Back and Body Center, PLLC at the above address. I agree that his office be given limited power of attorney to endorse/sign my name on any and all drafts for payment of my bill. This is a direct assignment of my rights and benefits under this policy. (a photocopy of this Assignment shall be considered as effective and valid as the original. I authorize the release of any information pertinent to my case to any insurance company, adjuster and or attorney involved in the case

____

Patient Signature Date Witness

Patient Record of Disclosure

In general the HIPAA privacy rule gives individuals the right to request a restriction on uses of disclosure of their protected health information (PHI). The individual is also provided to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of home. I will be contacted in the following manner: Home: Leave a message with name of office and call back information. Work: Leave a message with name of office and call back information. Written communication: Send to home

I give the office the right to disclose information to _______________________________ on my behalf.

____

Patient Signature Date Witness

*******Must Sign Above This Line*******

ADDITIONAL RELEASES:

Attorney Representative and Protection of Balance

I the undersigned patient, am directing my attorney, ___________________________ to pay any outstanding bills out of my settlement and, in effect, protecting any such balance. I hereby make and declare the instructions herein contained to be irrevocable. I fully understand that I am directly responsible for any and all medical bills and this agreement solely for the doctor's additional protection and consideration of his awaiting payment. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee. I have been advised that if my attorney does not wish to cooperate in protecting my doctor's interest, the doctor will not await payment but will require me to make payments on a current status of treatment.

____

Patient Signature Date Witness

Consent for the Treatment of Minors

I hereby authorize Dr. Kelly M. Meredith, DC and whomever she may designate as her assistant to perform diagnostic test, including not limited to radiographs, and to administer treatment as she deems necessary to my child. I give my informed consent to the child listed to receive chiropractic adjustments, and/or physiotherapy.

The child may be treated with or without my presence in the office.

____

Childs Name Parent/Guardian Name Signature Date

Authorization to Release Medical Records/X-rays

I hereby authorize Dr. Kelly Meredith to release all my medical records and /or x-rays to____________ ____ .

____

Patient Signature Date Witness