Confidential Patient Case History

Dear Patient: Please complete this questionnaire. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. Thank you.

NAME____________________ DATE __________ HOME PHONE __________
ADDRESS____________________ WORK PHONE __________
CITY ____________ STATE ______ ZIP ______ FAX # __________
DATE OF BIRTH _____/_____/_____ AGE ____ M ☐ F ☐ MARITAL STATUS ______ NO. CHILDREN ______
OCCUPATION __________ SS # __________ SPOUSE ________ E-MAIL __________
WHO IS RESPONSIBLE FOR THIS ACCOUNT? __________ REFERRED BY: __________

Please check the appropriate box for any of the following symptoms which you now have or have had in the past. We want all the facts about your health before we accept your case. THIS IS A CONFIDENTAIL HEALTH REPORT.

O - OCCASSIONAL
F - FREQUENT
C - CONSTANT

O	F	C	**GENERAL**
☐	☐	☐	Allergy
☐	☐	☐	Chills
☐	☐	☐	Convulsions
☐	☐	☐	Dizziness
☐	☐	☐	Fainting
☐	☐	☐	Fatigue
☐	☐	☐	Fever
☐	☐	☐	Headache
☐	☐	☐	Loss of sleep
☐	☐	☐	Loss of weight
☐	☐	☐	Nervousness/Depression
☐	☐	☐	Neuralgia
☐	☐	☐	Numbness
☐	☐	☐	Sweats
☐	☐	☐	Tremors
			MUSCLE & JOINT
☐	☐	☐	Arthritis
☐	☐	☐	Bursitis
☐	☐	☐	Foot trouble
☐	☐	☐	Hernia
☐	☐	☐	Low back pain
☐	☐	☐	Lumbago
☐	☐	☐	Neck pain or stiffness
☐	☐	☐	Pain between shoulders
			Pain or numbness in:
☐	☐	☐	Shoulders
☐	☐	☐	Arms
☐	☐	☐	Elbows
☐	☐	☐	Hands
☐	☐	☐	Hips
☐	☐	☐	Legs
☐	☐	☐	Knees
☐	☐	☐	Feet
☐	☐	☐	Painful tailbone
☐	☐	☐	Poor posture
☐	☐	☐	Sciatica
☐	☐	☐	Spinal curvature
☐	☐	☐	Swollen joints

O	F	C	**GASTRO-INTESTINAL**
☐	☐	☐	Belching or gas
☐	☐	☐	Colitis
☐	☐	☐	Colon trouble
☐	☐	☐	Constipation
☐	☐	☐	Diarrhea
☐	☐	☐	Difficult digestion
☐	☐	☐	Distension of abdomen
☐	☐	☐	Excessive hunger
☐	☐	☐	Gall bladder trouble
☐	☐	☐	Hemmorrhoids
☐	☐	☐	Intestinal worms
☐	☐	☐	Jaundice
☐	☐	☐	Liver trouble
☐	☐	☐	Nausea
☐	☐	☐	Pain over stomach
☐	☐	☐	Poor appetite
☐	☐	☐	Vomiting
☐	☐	☐	Vomiting of blood
			EYES, EARS, NOSE & THROAT
☐	☐	☐	Asthma
☐	☐	☐	Colds
☐	☐	☐	Crossed eyes
☐	☐	☐	Deafness
☐	☐	☐	Dental decay
☐	☐	☐	Earache
☐	☐	☐	Ear discharge
☐	☐	☐	Ear noises
☐	☐	☐	Enlarged glands
☐	☐	☐	Enlarged thyroid
☐	☐	☐	Eye pain
☐	☐	☐	Failing vision
☐	☐	☐	Far sightedness
☐	☐	☐	Gum Trouble
☐	☐	☐	Hay fever
☐	☐	☐	Hoarseness
☐	☐	☐	Nasal obstruction
☐	☐	☐	Near sightedness
☐	☐	☐	Nosebleeds
☐	☐	☐	Sinus infection
☐	☐	☐	Sore throat
☐	☐	☐	Tonsillitis

O	F	C	**CARDIO-VASCULAR**
☐	☐	☐	Hardening of arteries
☐	☐	☐	High blood pressure
☐	☐	☐	Low blood pressure
☐	☐	☐	Pain over heart
☐	☐	☐	Poor circulation
☐	☐	☐	Rapid heart beat
☐	☐	☐	Slow heart beat
☐	☐	☐	Swelling of ankles
			RESPIRATORY
☐	☐	☐	Chest pain
☐	☐	☐	Chronic cough
☐	☐	☐	Difficult breathing
☐	☐	☐	Spitting up blood
☐	☐	☐	Spitting up phlegm
☐	☐	☐	Wheezing
			SKIN
☐	☐	☐	Boils
☐	☐	☐	Bruise easily
☐	☐	☐	Dryness
☐	☐	☐	Hives or allergy
☐	☐	☐	Itching
☐	☐	☐	Skin eruptions (rash)
☐	☐	☐	Varicose veins
			GENITO-URINARY
☐	☐	☐	Bed-wetting
☐	☐	☐	Blood in urine
☐	☐	☐	Frequent urination
☐	☐	☐	Inability to control kidneys
☐	☐	☐	Kidney infection or stones
☐	☐	☐	Painful urination
☐	☐	☐	Prostate trouble
☐	☐	☐	Pus in urine
			FOR WOMEN ONLY
☐	☐	☐	Congested breasts
☐	☐	☐	Cramps or backache
☐	☐	☐	Excessive menstrual flow
☐	☐	☐	Hot flashes
☐	☐	☐	Irregular cycle
☐	☐	☐	Menopausal symptoms
☐	☐	☐	Painful menstruation
☐	☐	☐	Vaginal discharge
☐	Yes	☐	No Are you pregnant?

CHECK THE FOLLOWING CONDITIONS YOU HAVE OR HAVE HAD:

☐ Alcoholism	☐ Cold sores	☐ Goiter	☐ Measles	☐ Rheumatic fever
☐ Anemia	☐ Diabetes	☐ Gout	☐ Miscarriage	☐ Scarlet fever
☐ Appendicitis	☐ Diptheria	☐ Heart disease	☐ Multiple Sclerosis	☐ Stroke
☐ Arteriosclerosis	☐ Eczema	☐ HIV/AIDS	☐ Mumps	☐ Tuberculosis
☐ Arthritis	☐ Emphysema	☐ Influenza	☐ Pleurisy	☐ Typhoid fever
☐ Cancer	☐ Epilepsy	☐ Lumbago	☐ Pneumonia	☐ Ulcers
☐ Chorea	☐ Fever blisters	☐ Malaria	☐ Polio	☐ Venereal disease
				☐ Whooping cough

Have you had previous chiropractic care? __________ If yes, date of last care __________
Do you have health and accident insurance? __________ If yes, with what company? __________
Is this an Industrial Accident Case? ☐ Yes ☐ No

NAME ______________________ DATE __________ HOME PHONE __________

PLEASE PRINT

What is your major complaint? ______________________

____

Other complaints ______________________

How long have you had this condition? __________ Have you had this or similar conditions in the past? __________

What activities agravate your condition? ______________________

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Constant ☐ Comes and goes

Is this condition interfering with your: ☐ Work ☐ Sleep ☐ Daily routine ☐ Other __________

How long has it been since you really felt good? ______________________

List previous diagnosis and treatments you have received for present condition __________

____

What do you believe is wrong with you? ______________________

List surgical operations and years: ______________________

____

Drugs you now take: ☐ Nerve pills ☐ Pain killers ☐ Muscle relaxers ☐ "Pep" pills ☐ Tranquilizers
☐ Birth control ☐ Other __________

Dental visits: ☐ 6 months ☐ Yearly ☐ Toothache only ☐ Complete dentures

Age of mattress: __________ ☐ Comfortable ☐ Uncomfortable Do you use a bed board? __________

Are you wearing: ☐ Heel lifts ☐ Sole lifts ☐ Inner soles ☐ Arch supports

Have you ever been in an auto accident? ☐ Past year ☐ Past 5 years ☐ Over 5 years ☐ Never

Describe: ______________________

Have you ever had any mental or emotional disorders? ☐ Yes ☐ No When __________

Have others in your family had such disorders? ☐ Yes ☐ No When __________

FAMILY HEALTH INFORMATION (Many health problems are the result of heredity spinal weaknesses; thus information about your family members will give us a better picture of your total health picture).

NAME	RELATION	PAST AND PRESENT HEALTH PROBLEMS

HAVE YOU EVER:	YES	NO	
Been knocked unconscious?	☐	☐	__________
Used a cane, crutch or other support?	☐	☐	__________
Been treated for a spine or nerve disorder?	☐	☐	__________
Had a fractured bone?	☐	☐	__________
Been hospitalized for other than surgery?	☐	☐	__________

DO YOU:	YES	NO	
Now take vitamins or minerals?	☐	☐	__________
Think you may need vitamins or minerals?	☐	☐	__________
Have an allergy to any drug?	☐	☐	__________

DATE OF LAST:	Less than 6 months	6 - 18 months	Over 18 months	Never
Spinal examination	☐	☐	☐	☐
Physical examination	☐	☐	☐	☐
Blood test	☐	☐	☐	☐
Chest X-Ray	☐	☐	☐	☐
Spinal X-Ray	☐	☐	☐	☐
Dental X-Ray	☐	☐	☐	☐
Urine test	☐	☐	☐	☐

HABITS	Heavy	Moderate	Light	None
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐

List below all conditions for which you have been treated in the past 10 years.

____

____

____

____

____

____

IN CASE OF EMERGENCY: (Name of relative or close friend not living in your home?:

NAME: ______________________ Phone __________

PRIMARY CARE PHYSICIAN ______________________

New Smyrna Spine & Injury Center Informed Consent

Patient Name: ____ File #: _________________ Date: _____________

Chiropractic Healthcare is an art and a science that is primarily concerned with the relationship between structure (primarily of the spine) and function (primarily of the nervous system). The doctor of chiropractic evaluates the patient using standard examination and testing procedures (such as orthopedic and neurological evaluation, labs, x-rays) along with specialized chiropractic evaluation. The chiropractic evaluation focuses on structural and/or functional abnormalities called subluxation". Subluxation exists when one or more vertebrae in the spine or bones in the extremity are misaligned sufficiently enough to result in damage or irritation to either the nearby nerves, joints and/or tissues. The primary goal of chiropractic treatment is the removal of sublaxation(s). This is accomplished by performing a procedure unique to the chiropractic profession called an "adjustment". A chiropractic adjustment involves the application of a quick, precise force directed over a very short distance to a specific vertebrae or bone. There are a number of different techniques that may be used to deliver the adjustment, some of which utilize specially designed equipment. Adjustments are performed by hand and also by hand-guided instruments. In addition to adjustments, other treatments used by chiropractors include physiotherapy modalities (e.g. heat, ice, soft-tissue manipulation), nutritional recommendations and rehabilitative procedures.

As is the case with all health care interventions, the benefits of care must be weighed against the inherent risks and limitations of receiving treatment. Chiropractic treatments are one of the safest interventions available to the public as evidenced by malpractice statistics. While there are risks involved with treatment, these are seldom great enough to contraindicate care. Nonetheless, they must be considered when making the decision on whether or not to receive chiropractic care. Listed below are summaries of some key research articles that have addressed both common and rare side-effects/complications associated with chiropractic care.

One research study indicated that within the first 2 months of care, approximately half of patients report some "reaction" to chiropractic treatment. Of those who reported a reaction, the following were the most commonly reported reactions to initial chiropractic care(1).

- Local discomfort (53%)
- Headache (12%)
- Tiredness (11%)
- Radiating discomfort (10%)

Most appeared within 4 hours of treatment and resolved within 24 hours.

Rare, Yet Possible Side-Effect Complications

- Rib Fracture
- Burns (if certain types of physiotherapy are used)
- Disc herniation
- Cauda Equina Syndrome (2) (1 case per 100 million adjustments)
- Compromise of the vertebrobasilar artery (i.e. stroke) (1 case per 400,000 to 1,000,000 cervical spine adjustments)(3)

In addition to national guidelines (4), we have set criteria for how we manage our patients. Through questioning and examination, we will do our best to determine what risk, if any, chiropractic care may pose to you and advise you of those risks as well as the possible need for medical referral. We may also suggest alternate chiropractic or medical approaches if we detect absolute of relative contraindications to the standard chiropractic treatment.

1. Senstad O, et al. Frequency and characteristics of side effects of spinal manipulative thereapy. Spine 1997;22:435-41
2. Shekelle PG, et al. Spinal manipulation for low back pain. Ann Intern Med 1992;117(7):590-8
3. Haldeman S, et al. Risk factors and precipitating neck movements causing vertebroasilar artery dissection after cervical trauma and spinal manipulation. Spine 1999;(24):785-94
4. Haldeman S, et al. Guidelines for chiropractic quality assurance and practice parameters. Aspen Publishers, 1997

PLEASE SIGN THIS FORM AFTER YOUR TREATMENT PLAN HAS BEEN REVIEWED WITH YOU BY YOUR DOCTOR AND BEFORE ANY CARE OR TREATMENT IS RENDERED.

I have read the previous information regarding risks of chiropractic care and my clinician has explained my risks (if any) to me and suggested alternatives when those risks exist. I understand the purpose of my care and have been given an explanation of the treatment, the frequency of care, and alternatives to this care. All of my questions have been answered to my satisfaction. I agree to this plan of care understanding any perceived risk(s) and alternatives to this care.

PATIENT'S SIGNATURE **X** ______________________________ Date ____________________

PARENT/GUARDIAN'S SIGNATURE **X** ______________________________ Date ____________________

DOCTOR'S SIGNATURE **X** ______________________________ Date ____________________

RECORD RELEASE AUTHORIZATION

DOCTOR / HOSPITAL ____

ADDRESS ____

____

____

I hereby authorize and request the release of my medical records to:

Synergy Chiropractic and Wellness Solutions, LLC
dba New Smyrna Spine & Injury Center
140 Wallace Road
New Smyrna Beach, FL 32168
Phone: 386-423-2415
Fax: 386-423-2417

Thank you in advance for your cooperation.

Patient's Signature	Date
Patient's Name (Please Print)	DOB
If Patient is a Minor Signature of Parent or Legal Guardian	Relationship to Patient
Witness to the Above Signatures	Please Print Name

Treatment Scheduling Agreement

By accepting Dr. Walsh as your chiropractic and acupuncture health care provider, you are participating in a tradition of exceptional chiropractic and acupuncture care established years ago. As part of our family of patients, it is vital that we have an open line of communication. Your access to us and our access to you is the foundation of a long lasting relationship.

Trying to accommodate every patient's individual needs and work schedules can be a difficult task but we always do our best. We work very hard to stay on schedule so that you will not spend unnecessary time waiting for your appointment. To us, a scheduled appointment is a commitment of time between you and our practice. We have reserved that time just for you. When you miss an appointment the result is a permanent loss of that time which could have been used to treat other patients in need.

We ask that when you schedule an appointment you make every effort to keep that commitment. Since various circumstances or personal emergencies may keep you from your commitment with us, we always take that into consideration when receiving a last minute schedule change. If however, you must cancel on short notice you will be asked to pay for your chiropractic or acupuncture care prior to making your next appointment. If you cancel the prepaid appointment on short notice you will forfeit a minimum charge of 50% of the procedure fee. If you arrive more than 10 minutes late for your appointment it may be necessary to reschedule your appointment. The same forfeiture penalties apply if we must reschedule due to tardiness.

When you find that you cannot keep your scheduled appointment, we ask that you provide a minimum notice of one full business day. Your cooperation will allow us to schedule other patients in need of our care. For your convenience we have a scheduling coordinator available to you Monday through Friday.

Financial Philosophy

We are committed to providing you with the highest quality of chiropractic and acupuncture care utilizing only the best equipment, materials and education available. In order to continue to provide excellent service and care to you, we have formulated this financial policy.

Our office accepts cash, personal checks, Mastercard, Visa and Discover. Outside financing is available upon request and approved credit.

For those of you with insurance, as a courtesy, we will assist you in processing your insurance claims. In order for our office to file your insurance claim, you must bring proof of insurance at your first appointment and then once a year thereafter. You will be responsible for the entire cost of your first visit and thereafter for your uninsured portion at the time treatment is rendered.

All incurred charges are ultimately the responsibility of the patient regardless of insurance coverage. We must emphasize that as your chiropractic and acupuncture provider, our relationship is with you, our patient, and not with your insurance company. Your insurance plan is a contract between you, your employer and/or the insurance company. Our office is not a party to that contract or any possible restrictions.

Returned checks are subject to a service charge. Additionally, charges may be incurred for broken appointments and appointments cancelled or rescheduled without one full business day advance notice.

I, the patient, agree to pay any and all collection costs and attorney's fees associated with collection of any account that becomes delinquent.

If you have any questions regarding our financial policy or our appointment scheduling policy, please do not hesitate to ask. We are committed to providing you with the highest level of service and excellence in chiropractic and acupuncture care.

____ ____________________

Signature of patient/responsible party Date

NOTICE OF INFORMATION PRACTICES

Protecting the privacy of your personal health information is important to us. This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent. You may request restrictions on disclosures.

Disclosures of protected health information are limited to the minimum necessary for the purpose of disclosure. This provision does not apply to the transfer of medical records for treatment.

You may inspect and receive copies of your records within 30 days of a request to do so. There may be a reasonable cost-based fee for photocopying, postage and preparation.

You may request to change your records. Our practice has the right to accept or deny your request.

We may maintain a history of protected health information disclosures that is accessible to you.

In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and our staff.

Our practice is required to abide by this notice. We have the right to change this notice in the future. Any revisions will be prominently displayed in a clearly visible location in our office.

You may file a complaint about privacy violations by contacting our Office Manager.

The effective date of this Notice of Information Policy is August 1, 2007.

Name____ Date______________________________

New Smyrna Spine & Injury Center
140 Wallace Road, New Smyrna Beach, FL 32168, 386-423-2415
www.newsmyrnaspine.com