Adult Initial Paperwork

3082 Dyer Blvd, Kissimmee, FL 34741
Office 407.329.3747/ Fax 407.264.6167

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

PATIENT DEMOGRAPHICS

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

Address: _____City: _____State_____ Zip: _____

E-mail: _____ Home Phone: _____ Mobile Phone: _____

□ I understand that Achieve Wellness will communicate with me as needed through email and texts in regards to information regarding appointments or clinic updates.

Employer: _____ Work Phone: _____ Occupation: _____

Marital Status: ❑ Single ❑ Married

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: _____

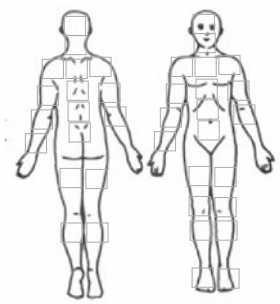
Condition(s) ever been treated by anyone in the past? ☐ Yes ☐ No

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 regardless of timeframe:

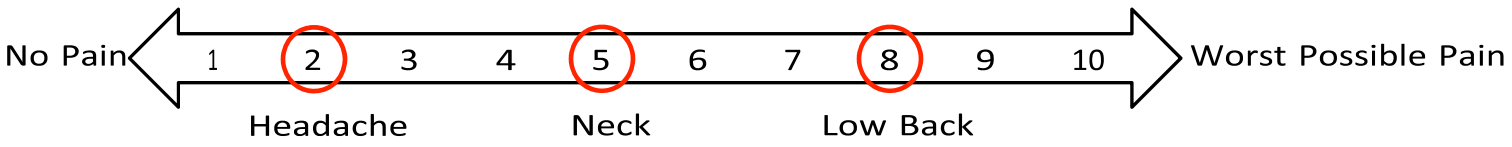
Identify any other injury(s), surgery(s), minor or major, that the doctor should know about regardless of time frame:

INTENSITY RATING

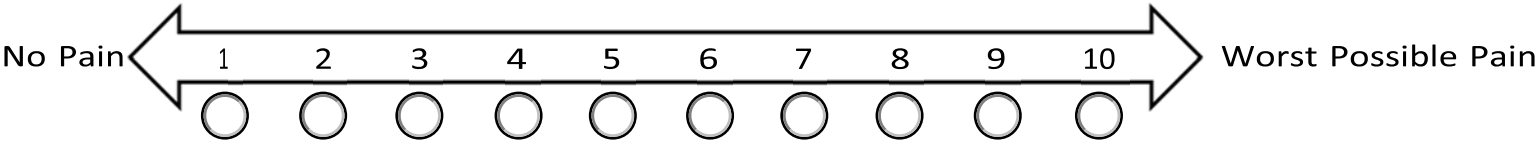
Instructions: Please circle the number that best describes the question being asked.

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.

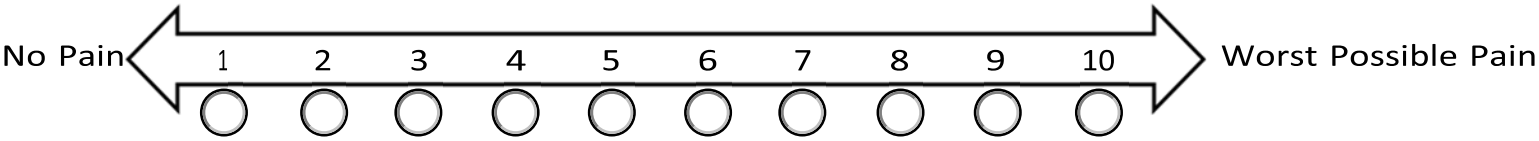
Example



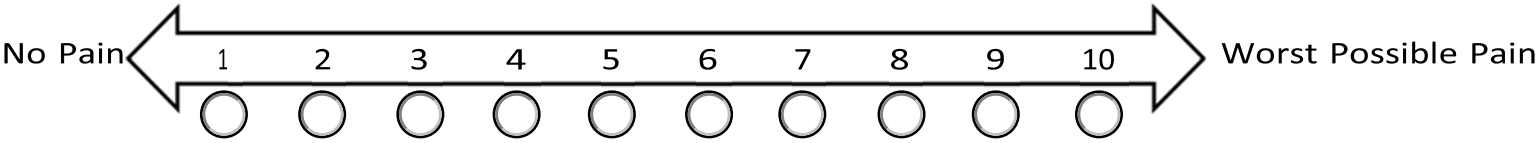
1. What is your pain **RIGHT NOW**?



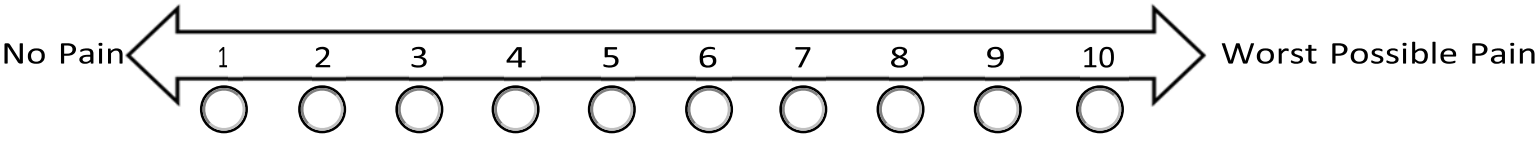
2. What is your **TYPICAL** or **AVERAGE** pain?



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 OR SUPPLEMENTS YOU TAKE:

_____

_____

_____

_____

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	
Bathing	◉ 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	
Other	◉ No Effect	○ Painful (can do)	○ Painful (Limits)	○ Unable to Perform	

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 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**

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

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: _____

_____ **_____ / _____ / _____**

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

_____ **_____ / _____ / _____**

Doctor's Signature **Date Form Reviewed**

Achieve Wellness 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 is most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at **Achieve Wellness** 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.

_____ _____

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

_____ ___/___/___ _____

Patient or Authorized Signature **Date** ***Witness***

Achieve Wellness 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 means 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 worker's 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 apprise 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.

COMPLAINTS:
If you wish to make a formal complaint about how we handle your health information, please call Yasmin at 407.329.3747. If she is unavailable, you may make an appointment with our receptionist to see her within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

Centralized Case Management Operations
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F HHH Bldg.
Washington, D.C. 20201

I have received a copy of Achieve Wellness Patient Privacy Notice. I understand my rights as well as the practice's 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**