30-A Chiropractic/30-A Medical

4164 W. County Hwy 30-A • Santa Rosa Beach, FL 32459 • Ph (850) 622-2313 Fax (850) 622-2718

PATIENT PERSONAL HISTORY

Name:	Place of Employment:
Address:	Work Ph:
City, State, Zip	Spouse Name:
SS#:	Spouse Ph:
DOB:	Release Medical Records to:
Home Ph:	Custodian (if child):
Cell Ph:	Emergency Contact Name:
Email:	Emergency Contact Ph:

Social History

Yes	No	Have you been seen at Coastal Skin & Dermatology within the last 2 years?	
Yes	No	Do you Smoke? How many packs a day?	_____
Yes	No	Do you drink alcohol? Quantity/day?	_____
Yes	No	Do you have children? Children(s) age(s)	_____
Yes	No	Have you been seen at this office within the last three years?	_____

PAYMENT POLICY – INSURANCE COMPANY

1. I agree to pay in full for services received today and I will be responsible for filing my own insurance if 30-A Chiropractic/30-A Medical is not a participating provider with my insurance company. I am also financially responsible for any non-covered services as well as any collection fees if my account were to become delinquent.
2. I authorize and assign all payments of benefits directly to 30-A Chiropractic/30-A Medical for claims filed.
3. I understand that if I discontinue care prior to being discharged, my account is payable in full.
4. I authorize release of any information to my insurance provider that they may need to process my claims, whether filed by me, or 30-A Chiropractic/30-A Medical. (NOTE: This applies to claims accepted for submission and assignment to 30-A Chiropractic/30-A Medical.)
5. If services are not payed for at the time of visit there will be an additional $50.00 fee added to your balance due. This includes checks that do not clear due to insufficient funds.

AGREEMENT TO BRING IN PAYMENT(S) ON ACCOUNT FOR SERVICES RENDERED

I understand that there may be times when my insurance company may erroneously send payments to me rather than directly to 30-A Chiropractic/30-A Medical for services rendered at their office. I understand and agree to bring in these checks within three days of receipt. I also understand that if payment is deposited in my account, that I am responsible to reimburse 30-A Chiropractic/30-A Medical.

X-RAY POLICY

I understand that the fee for x-rays is for taking, developing and interpretation of these films and that the films will remain the property of 30-A Chiropractic/30-A Medical. If I need to use these films, they can be made available to me for a maximum of 30 days by signing the appropriate forms. I also understand there may be a charge for use of the films.

Signature:_____ **Date:**_____

Note: It is mandatory that the patient provide all of the information indicated above prior to receiving any care or treatment. Failure to provide all of the information may result in additional service fees (PKT 101).

Agreement for Controlled Substance Prescription

The purpose of this agreement is to clarify and prevent misunderstanding about medications you may be taking for acute or chronic pain. It is not the intent of this facility to treat long term or chronic pain, we refer to pain management physicians as that is their field of expertise. Occasionally our patients require controlled substance (pain medication) for acute pain on a short term basis, this clarification will help us and you comply with the law regarding controlled medications for pain.

Controlled substance medication prescriptions (opiods, tranquilizers, barbiturates, sedatives and certain muscle relaxers) are closely by the State of Florida, all other states and the Federal Government. Providers who prescribe these medications are closely monitored by these governmental agencies as well. In order to receive controlled substance medications from our office, you must agree to the following.

1. I am responsible for safekeeping of controlled substances prescribed for me. Lost or stolen prescriptions or medications will not be replaced. I will take medications only as prescribed and not exceed the prescribed dose. I will not share, trade or sell or trade any medication with/or to anyone. No early refills will be given if I run out of medications before the prescribed time.

2. I will be required to schedule monthly office visits to receive medication refills.

3. I agree to not receive narcotics or other controlled substance medications from other providers. Exceptions would be for acute emergency condition or surgical procedure. Receiving controlled substances from other sources (commonly referred to as "doctor shopping"), outside of the noted exceptions, will result in dismissal from this practice.

4. Pain management referrals, when appropriate, will be made by the attending medical person.

5. I will not operate heavy machinery or automobiles when under the influence of a controlled substance.

6. I will refrain from using any illegal substances or abusing alcohol while receiving controlled medications.

7. I will NOT share, trade or sell any medication with/or to anyone.

8. I give my permission to 30-A Chirporactic/30-A Medical to obtain information about my medications from other physicians, any pharmacy, and the Drug Enforcement Administration or State agency regulation controlled substances.

9. I understand that State law prohibits driving or operating dangerous equipment while taking any sedating medication or narcotic, even if I do not feel sedated.

By signing below, I acknowledge that I have read and agree with the terms of this agreement and will abide by it. If I do not abide by this agreement, I understand that I will be immediately dismissed from the 30-A Chirporactic/30-A Medical practice and receive no further medical care from it or it's physician(s).

_____ _____

Patient Signature Date

Copy of agreement given to pt. _____ initial

Domestic Violence Questionnaire

Have "**YOU**"

Refers to your husband/wife, partner, ex-husband/wife, ex-partner, ever been exposed to any form and/or physical abuse and/or been placed in a life-threatening situation?

Yes ☐ No ☐

Signature _____ **Date** _____

Thank you. Please talk to your nurse, or doctor about having a Danger Assessment consultation.

INFORMED 2011/2012 Florida Physician Update

Danger Assessment
Jacquelyn C. Campbell, PhD, RN
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School of Nursing
www.dangerassessment.org

Pharmacy Preference

Name _____ Address _____

Phone _____

VITAL SIGNS

(FOR OFFICE USE ONLY)

Patient Name:			Allergies:	
Date	Blood Pressure	Pulse	Height	Weight
	/			
	/			
	/			
	/			

PAIN CHART

To help us understand your pain in location and intensity, please fill out the following information to the best of your ability. Please grade your pain on a scale from 0 to 10, where zero is no pain and ten being pain that would cause you to seek emergency care. Circle the number that applies to your area of pain, leaving blank those that do not. If specific areas of pain are not covered by the questions, please describe your pain felt in other areas in the space provided for additional comments.

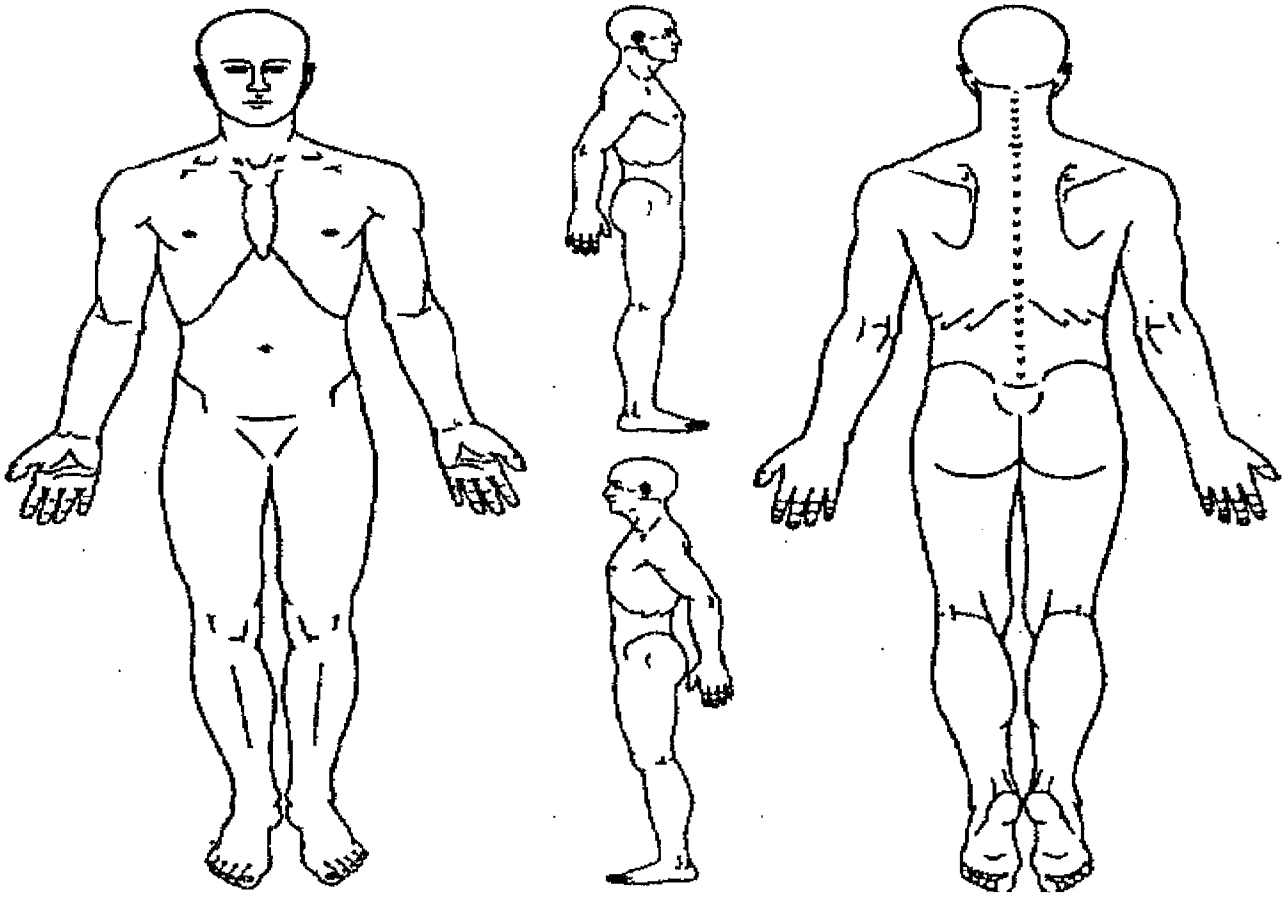
Neck Pain	(0 1 2 3 4 5 6 7 8 9 10)	Headache	(0 1 2 3 4 5 6 7 8 9 10)
Arm Pain	(0 1 2 3 4 5 6 7 8 9 10)	Mid Back	(0 1 2 3 4 5 6 7 8 9 10)
Low Back	(0 1 2 3 4 5 6 7 8 9 10)	Leg Pain	(0 1 2 3 4 5 6 7 8 9 10)

Please provide additional information as to the quality and type of pain in terms of Numbness, Pins & Needles, Burning or Stabbing sensations indicating the areas involved.

_____

_____

Please shade in your areas of pain on the drawings below. Be as specific as possible.



Patient Signature: _____ Date: _____

30-A Chiropractic/30-A Medical

Please check all conditions you currently have, or have had

General Questions	Cardiovascular	Kidneys & Urinary Tract	Musculoskeletal
Weight loss	Angina Chest Pain	Blood in urine	Anemia Arthritis
Weight gain	Leg cramps Murmurs	Brown urine	Back pain Bursitis
Change in sleep patterns	Ankle swelling	Dribbling after urination	Gout Joint aches
Change in activity capacity	Awakening at night short of breath & getting out of bed	Painful urination	Neck pain Tendinitis
Neurologic & Psychiatric	Cardiac catheterization	Excessive thirst	Abnormal blood counts
Anxiety	Cold hands or feet	Involuntary urination/incontinence	Blood clots in legs/lungs
Headaches	Congenital heart defects	Urinating frequently (day)	Bone marrow biopsy
Depression	Dizziness when standing up quickly	Urinating frequently (night)	Easy bleeding
Meningitis	Heart attacks	Urine hesitancy	Easy bruising
Paralysis	Heart failure	Weak flow	Joint swelling
Seizure	High/low blood pressure	Frequent bladder infections	Morning stiffness
Stroke	Irregular heart rates	Kidney disease	Muscle aches
Tingling	Purple fingers or lips	Kidney Stone	Scoliosis
Tremors	Leg pain that resolves with rest	**Endocrine**	**Gastro-intestinal**
memory loss	Heart palpitations	Diabetes Sickle cell	Diarrhea Gallstones
Fainting spells, dizziness	Varicose veins	Abnormal body hair	Reflux Vomiting
Head Injuries	**Respiratory**	Changes in skin texture	Ulcers Heartburn
Blackouts, or near blackouts	Pleurisy Wheezing	Cold intolerance	Hepatitis Indigestion
Change in sensation anywhere to your body	Asthma	Heat intolerance	Abdominal pain
Localized weakness or numbness	Breathlessness when laying flat	History - borderline diabetes	Anal fissures
Ears, Eyes, Nose & Throat	Prolonged cough	Increased loss of hair	Black tarry stools
Hay fever	Coughing up blood	Rheumatism	Vomiting blood
Glaucoma	Emphysema	Thyroid disease	Constipation
Polyps	Shortness of breath	**Male & Female**	Nausea
Allergy	Tuberculosis	Painful sexual intercourse	Problems swallowing
Cataracts	Pneumonia	Loss of sexual interest	Hiatal hernia
Goiter	Frequent infections (bronchitis)	Unprotected sex	Intestinal obstruction
Hoarseness	**Skin**	Groin itching	Liver disease
Double vision	Abscess Dandruff	Sexually transmitted disease	Hemorrhoids
Gum problems	Acne Oily skin	**Males Only**	Red blood
Eye problems	Boils Rashes	Hernia Sterility	
Ear infections	Hives Dry skin	Bloody ejaculation	
Glasses/contacts	Lumps Psoriasis	Inability to complete intercourse	
hearing loss	Jaundice	Lumps on testicles	
Ear discharge/pain	Athlete's foot	Penile discharge	
Frequent nosebleeds	Excessive body odor	Premature ejaculation	
Ringing in your ears	Excessive sweating	Problems in maintaining or Maintaining an erection	
Sinus infection	Fungal infections	Prostate disease	
Swollen glands	nail problems	Sores or worts on penis	
	moles - irregular	Testicular pain	
	Moles change/new	Testicular swelling	

Providers Notes: _____

_____

Providers Signature: _____ Date: _____

COMPREHENSIVE MEDICAL HISTORY

This information is confidential and no one other than your healthcare provider will have access to it without your written consent. Completion of this history allows us to provide you the most complete medical care possible and will be reviewed with you during your visit.

General Information

Name: **Birthdate:** **SS#:**

Date of your last complete physical exam?	Date of your last chest x-ray?
Date of your last cholesterol screening?	Date of you last dental exam?
Date of your last eye exam?	
Women:	*Men:*
Date of last mammogram?	Date of last PSA?
Date of last pap smear?	Date of last rectal/prostate exam?

Immunizations

Pneumonia	Date:	Measles-Mumps-Rubella (MMR)	Date:
Hepatitis B	Date:	Tetanus & Diphtheria Toxoids (Td)	Date:
Influenza	Date:		

Past Medical History (check those that apply)

	AIDS or HIV+		Chicken Pox		Measles		Rheumatic Fever
	Epilepsy		Blood/Plasma Transfusions		Mumps		Scarlet Fever
	Cancer		Infectious Mononucleosis		Polio		Whooping Cough

Hospital/Surgical History

Illness or Operation	Date	Illness or Operation	Date
1.		3.	
2.		3.	

Allergies

Please list any drug, food, contact or environmental substances to which you have had an allergic or bad reaction.

Medications

Please list any prescription medications, over the counter medications, vitamins, herbs or nutritional supplements that you are now taking. Please include the dosage amount and the times a day you take them.

1.	3.	5.
2.	3.	6.

Social History

Occupation:	Marital Status:	Do you wear seatbelts? Yes / No
Do you exercise regularly? Yes / No	If yes, what type?	How often?
Do you use illicit drugs? Yes / No	How often and how much?	
Do you have any risk factors for HIV infection? Yes / No		
Have you ever been exposed to anyone with tuberculosis? Yes / No		
Have you had excessive exposure to sun because of your work or recreation? Yes / No		
Are you currently experiencing unusual stress? Yes / No If yes, explain:		

Family History

Please check all that apply to family members and your relationship to them.

	Relationship		Relationship		Relationship
Anemia		Epilepsy		High Cholesterol	
Asthma		Glaucoma		Kidney Disease	
Obesity		Leukemia		Thyroid Disease	
Cancer		Depression		High Blood Pressure	
Diabetes		Heart Disease		Alcohol Problems	
Stroke		Lung Disease		Bleeding Tendency	

Present Age or Death

Mother:	Father:	Sibling:	Sibling:	Sibling:

Women Only

Age of first Menstrual Period:	Regular? Yes No		Date last period began:	
Age at Menopause:	Difficulty with periods? Yes No If yes, explain:			
Pregnancies: # of Children:	# Cesarean:	# Premature:	# Stillborn:	# Miscarriages: