Apex Health & Wellness
5110 S. Florida Ave. #103
Lakeland, Fl. 33805

Patient Information

Please allow our staff to photocopy your drivers license and all available insurance cards.

WELCOME! PLEASE PRINT!

Name: _____ Birth Date: _____-_____-_____

Age: _____ □ Male □ Female E-mail: _____

Address: _____ City: _____

State: _____ Zip: _____ Marital Status: □ Single □ Married SS# _____

Home Phone: _____Mobile Phone: _____

Health Insurance: _____Member ID #: _____

Auto Insurance: _____ Claim #: _____

Is your condition due to an car accident: □ Yes □ No

If yes, Date of Accident: _____

Emergency Contact:

Name: _____ Relationship: _____ Phone Number: _____

Parent or Guardian:

Name: _____ Relationship: _____ Phone Number: _____

Describe the major complaints that bring you in our office: _____

MR# _____

1. I authorize payment of medical benefits to this office.
2. I will allow this office to treat me, with other health care providers present, and to record my medical information, including consultation and examination for document purposes, if necessary.
3. I give this office the right to use my name for any office publications.
4. Authorization may be denied or retracted by notifying the office manager.

Patient's Signature: _____ Date: _____

Guardian's Signature: _____ Date: _____

Case History

Please answer the questions below concerning your health history. Be sure to list all conditions or symptoms, both past or present. An understanding of your health history will help us to determine appropriate care.

Name: _____ DOB: _____ MR#: _____

Height: _____ Weight: _____

Review of Systems

1. Do you have skin, hair or nail problems: ❑ Yes ❑ No _____
2. Do you have mouth and/or throat problems? ❑ Yes ❑ No _____
3. Do you have nose and/or sinus problems? ❑ Yes ❑ No _____
4. Do you have ear problems? ❑ Yes ❑ No_____
5. Do you have eye problems? ❑ Yes ❑ No _____
6. Do you have chest or lung (breathing) problems? ❑ Yes ❑ No _____
7. Do you smoke? ❑ Yes ❑ No Amount per day? _____ How Long? _____
8. Do you have heart and/or blood vessel problems? ❑ Yes ❑ No _____
9. Do you have blood or lymph node problems? ❑ Yes ❑ No _____
10. Do you have digestive problems? ❑ Yes ❑ No _____
11. Do you have genital problems (e.g. prostate; testicular, vaginal)? ❑ Yes ❑ No _____
12. Do you have urinary (including kidney or bladder) problems? ❑ Yes ❑ No _____
13. **Females**, have you had menstrual problems? ❑ Yes ❑ No _____

Have you ever taken birth control pills? ❑ Yes ❑ No For how long? _____

Is there any chance that you are currently pregnant? ❑ Yes ❑ No

Do you have any breast problems? ❑ Yes ❑ No _____

14. Do you have any nervous system diseases and/or mental health problems? ❑ Yes ❑ _____
15. Do you have any gland and/or-hormone problems? ❑ Yes ❑ No_____
16. Do you have allergy or immunity problems? ❑ Yes ❑ No _____
17. Do you have any muscle, tendon or ligament problems? ❑ Yes ❑ No _____
18. Do you have any bone or joint diseases (examples: bone = osteoporosis, joint arthritis? Yes ❑ No __

_____

Past History

19. List any diseases which you have had in the past, including childhood diseases: _____

_____

20. Tell us if you have ever been diagnosed as having a condition such as diabetes, cancer, AIDS, etc.: __

_____

21. Have you had any physical injuries such as falls or blows, automobile accidents, whiplash, concussion or head injury; lacerations, sprains, strains, dislocations, broken or cracked bones? ❑ Yes ❑ No_____

_____

22. List any surgeries you have had (don't forget appendix, tonsils, ear tubes, wisdom teeth):

_____ Date: _____

_____Date: _____

_____ Date: _____

_____ Date: _____

Case History (Continued)

23. Have you ever been hospitalized for any reason other than surgery? ❑ Yes ❑ No_____
24. **Medications:** Please list all medications (prescription & non-prescription) you are currently taking or take on an occasional basis: _____
25. Your diet is: 0 Balanced ❑ Fair ❑ Poor ❑ Excessive ❑ Restricted

Family History

26. Are there any diseases or conditions that are common among your family members (i.e. inherited diseases or conditions)? ❑ Yes ❑ No _____

Social History

27. In what position do you usually sleep, and how well? _____
28. Do you exercise on a regular basis? ❑ Yes ❑ No How? _____
29. How do you spend your spare time (hobbies, etc)? _____
30. Do you use: ❑ Caffeine? ❑ Tobacco? ❑ Nicotine? ❑ Recreational Drugs? ❑ Alcohol?
31. Please describe your work.

Type: ❑ Professional ❑ Physical Labor ❑ Driver ❑ Clerical ❑ Factory ❑ Homemaker

Physical Demands: ❑ Heavy ❑ Moderate ❑ Mild ❑ Sedentary

Stress Level: ❑ High ❑ Medium ❑ Low

Additional Questions

32. Do you have problems with recurring headaches? ❑ Yes ❑ No
33. Are you losing weight without trying? ❑ Yes ❑ No
34. Does your pain wake you up at night? ❑ Yes ❑ No
35. Have you had a change in bowel or bladder habits? ❑ Yes ❑ No_____
36. Have you had a sore that doesn't heal? ❑ Yes ❑ No _____
32. Have you recently had any unusual bleeding or discharge? ❑ Yes ❑ No _____
38. Do you have a thickening/lump in the breast or elsewhere? ❑ Yes ❑ No_____
39. Do you have indigestion or difficulty swallowing? ❑ Yes ❑ No _____
40. Have you had an obvious change in a wart or mole? ❑ Yes ❑ No _____
41. Do you have a nagging cough or hoarseness? ❑ Yes ❑ No _____
42. In the space below, please explain or give additional details regarding the information you have given above. Also, if there is any information about your health history which was not requested, please fill it in below. _____

_____

43. Please describe your current complaint. In other words, what brought you here?
44. Who is your:

Medical Doctor? _____

OB/GYN? _____

Dentist? _____

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Lakeland, FL 33813

Acknowledgement of receipt of notice of privacy practices and informed consent form

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

I hereby request and consent to the performance of chiropractic adjustment and other chiropractic/medical procedures, including various modes of physical therapy and diagnostic x-rays by Apex Health and Wellness. This consent is extended to other licensed chiropractic physicians, chiropractic assistants or licensed massage therapists, who now or in the future, are employed by, working with or associated with this office.

I certify that I have had the opportunity to discuss, with the Doctor of Chiropractic and/ or other office personnel, the nature and purpose of the care that is being provided. I understand that the results are not guaranteed. Further, I have been informed and I understand that, as in the practice of any of the healing arts, in the practice of chiropractic, there are some risks and complications. I will rely on the doctor to exercise appropriate judgement during care, based on the facts known at this time, and in my best interest.

My signature below certifies that I have read or have had read to me the above consent. I also certify that I have had the opportunity to ask questions and options to care have been explained. By signing this consent form, I agree to the care being provided to me for the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment.

_____ _____

Patient Name Witness's Signature

_____ _____

Patient Signature Date

_____

Parent or Guardian

_____ _____

Date DOB

_____ _____

Dr. Blackburn MR#

Apex Health & Wellness
5110 S. Florida Ave. #103
Lakeland, FL 33813
Robert Blackburn, D.C
863-816-5864

Name: _____

The primary treatment used by Doctor of Chiropractic is the spinal adjustment. I will use that procedure to treat you.

- The nature of the chiropractic adjustment

I will use my hands upon your body in such a way as to move your joints. That may cause an audible "pop or click," much as you have experienced when you "crack" your knuckles. You may feel or sense movement.

- The material risks inherent in chiropractic adjustment.

As with any health care procedure, there are certain complications which may arise during a chiropractic adjustment. Those complications include: fractures, disc injuries, dislocations, and muscle strain, Homer's syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment.

- The probability of those risks occurring

Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during exam and X-ray. Stroke has been the subject of tremendous disagreement with the profession with one prominent authority (1) saying that there is as most of a one-in-a million chance of such an outcome. Since even risk should be avoided if possible, we employ tests in our exam which are designed to identify if you may be susceptible to that kind of injury. The other complications are also generally described as "rare".

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE

Please check the appropriate block and sign below:

I have read ❑ or have had read to me ❑ the above explanation of the chiropractic adjustment. I have discussed it with Dr. Robert Blackburn and have had my questions answered to my satisfaction. 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 treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

_____ _____

Date Patient Name (Print)

_____ _____

Witness Signature Patient Signature