Markley Chiropractic & Acupuncture, L.L.C.
1802 W Baker St Plant City, FL 33563

New Patient Information

PLEASE PRINT CLEARLY: Today's Date: ____/____/20____

Patient Name: ______________________________________ Nickname/Preferred Name: __________________

E-mail: _________________________________ Gender: M F Age: ___ DOB: ___/___/___

Address: ____ City: _________________________________

State: _____ Zip: ___________ Social Security#: ______-_____-______ Driver's Lic. #: ___________________

Contact Information & Permissions

Home Phone: (____) ______________ Cell Phone: (____) ______________ Work Phone: (___) ______________

E-mail: _________________________ May we e-mail you? ◯ Y ◯ N May we contact you at work? ◯ Y ◯ N

May we leave voicemail on Home / Cell phone: ◯ Y ◯ N **Permissions can be changed at any time upon request**

Personal Information

Work Status: ◯ FT ◯ PT ◯ R ◯ Student Marital Status: ◯ S ◯ M ◯ D ◯ W #Children: _____

Employer: _____________________________ Occupation: ____

Employer Address: ____ City: ______________________________

State: _____ Zip: __________

Females: Last Menstrual Period: ____/____/____ Pregnant: ◯ Y ◯ N Nursing: ◯ Y ◯ N

Spouse, Parent or Guardian Name: __________________________________ Age: ____ DOB: ____/____/____

Spouse/Parent/Guardian Employer: _______________________________ Occupation: ______________________

Emergency Contact

Emergency Contact Person 1: ______________________________ Relationship to Patient: ___________________

Home Phone: (___) _______________ Cell Phone: (___) ________________ Work Phone: (___) _______________

Emergency Contact Person 2: ______________________________ Relationship to Patient: ___________________

Home Phone: (___) _______________ Cell Phone: (___) ________________ Work Phone: (___)

Insurance Information

Do you have health insurance: ◯ Y ◯ N Carrier Name: ___________________ Group Name: _______________

Policy #: __________________________________ Group #: ________________________

◯ Ins Card Copied ◯ DL Copied

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Notice of Financial Responsibility
If there is insurance coverage that will be submit for processing for treatment and services received at this practice, patient understands that insurance benefits are not guaranteed and coverage for payment is determined when claims are received and processed. Any verification of benefits provided is only an estimate of coverage. Patients are encouraged to contact insurance payers directly to learn more about your individual policy benefits and limitations.
Please sign below to acknowledge patient responsibility for the patient portion of insurance charges and/or payment in full for non-covered items or services. If there is no insurance coverage, patient is responsible for the balance due for services at the time of service for each visit.

____ _____________________
Patient/Guardian/Authorized Party Signature *Date*

Who may we thank for referring you? ____________________________ ◯Internet ◯ Yellow Pages

◯ Doctor: Name of Dr.______________________________ ◯ Friend / Family member

◯ Other____

Health Information:

Health Concerns: (please list in priority order & use back of questionnaire or additional paper if needed)

1.____

2.____

3. ____

Treatment: What type of treatment are you looking for?
◯ **Symptom Relief** ◯ **Correctional Care** ◯**Total Wellness Care** ◯ **All 3 previous choices**

Symptoms/Complaints: (relating to your primary complaint(s)

When did Symptoms begin? _____________ What initiated symptoms? ___________________________

____
Have you previously been treated for this condition by another provider? ◯ Y ◯ N

If yes, by whom? ________________________ Treatment received: _____________________________

Have you had any reactions to previous treatment: ◯ Y ◯ N

Describe: ____
If this is a recurrence, when did you initially notice this problem? _________________________________

Has worsened over time: ◯ Y ◯ N ◯ Same ◯ Better ◯ Worse

How long does it last? ◯ All day ◯ Hours ◯ Minutes

Is this condition interfering with your: ◯ Work ◯ Sleep ◯ Daily Routine ◯ Recreation

◯ Other: ____

Describe the symptoms (check all that apply): ◯ Pain ◯ Sharp ◯ Dull ◯ Numbness ◯ Tingling

◯ Aching ◯ Burning ◯ Stabbing ◯ Stiffness ◯ Other: ______________________________

What makes the problem worse? ◯ Standing ◯ Sitting ◯ Lying ◯ Bending ◯ Lifting ◯ Twisting

◯ Other: ____

Have you found things that relieve symptoms? ◯ Y ◯ N If yes, describe: _______________________

Do you have other conditions or symptoms that may be related to current symptoms? ◯ Y ◯ N

If yes, what? ____

Have you ever been in an auto accident or other physical trauma: ◯ Past year ◯ 1-5 years ◯ 5+ years

◯ Never Describe: ____

Scars/Surgical Procedures (Please list all):

____

____

Miscellaneous & Habits:

Are you: ◯ Left handed ◯ Right handed ◯ Ambidextrous

Exercise: ◯ Light ◯ Moderate ◯ Heavy

Exercise Type: ____ Frequency: _____________________

Approximately how many hours do you sleep per night? ______

Uninterrupted Sleep: ◯ Y ◯ N Do you feel rested upon waking? ◯ Y ◯ N Vivid Dreams? ◯ Y ◯ N

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How many meals per day do you eat? ________ How much water per day do you drink: _________________

How many bowel movements do you have each day? ____________

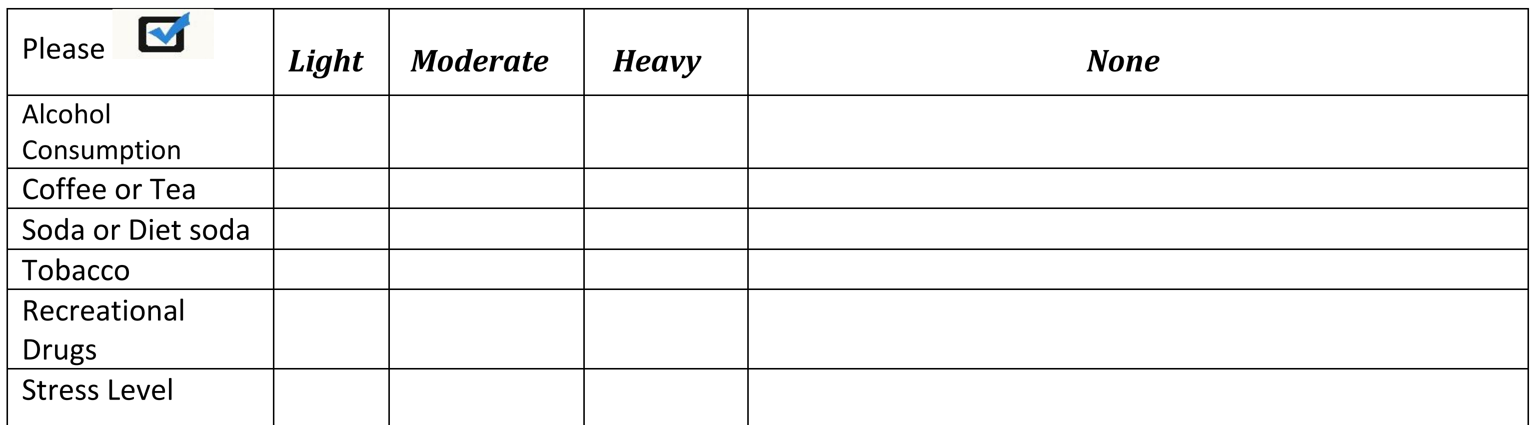
Work Activity

◯ Heavy Labor ◯ Light Labor ◯ Mostly Sitting ◯ Mostly Standing ◯ Walking/Moving ◯ Driving

Personal & Family History:
Identify conditions that you or any of your family members have now or have previously had.

(G=Grandparents, M=Mother, F=Father, S=Siblings, X=Self)

_____Allergies
_____Alcoholism
_____Anemia
_____Cancer
_____Deep Vein Thrombosis
_____Detached Retina
_____Diabetes
_____Eczema
_____Emphysema
_____Epilepsy
_____Goiter
_____Gout
_____Heart Disease
_____HIV/AIDS
_____Miscarriage(s)
_____Mumps
_____Pleurisy
_____Pneumonia
_____Polio
_____Rheumatic Fever
_____Stroke
_____Tumor(s)
_____ Ulcer(s)
_____ Female Organ Dysfunction
_____ Over weight
_____Headaches/migraines
_____ Addiction
_____ other: _______________



Please	*Light*	*Moderate*	*Heavy*	*None*
Alcohol Consumption				
Coffee or Tea				
Soda or Diet soda				
Tobacco				
Recreational Drugs				
Stress Level				

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Current Medications (Include - all Prescriptions and over the counter including Vitamins)			
Prescribing Dr.	**Name of Medication**	**Dose**	**Frequency**

Allergies/Sensitivities: (please check and list all that apply)		
	Description	**Reaction**
◯ **Medications**		
◯ **Food**		
◯ **Seasonal**		
◯ **Other**		

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Informed Consent to Chiropractic Care

Chiropractic Adjustment: The doctor will use his/her hands or a mechanical device in order to adjust your spinal joints. This procedure is called a spinal adjustment and is intended to reduce spinal subluxation (slight dislocation of the spinal joints). You may feel a 'click' or a 'pop' as well as a movement of the joint. Various ancillary procedures such as, support pillows, cold laser, traction or hot/cold packs may also be used.
Risks: As with any health care procedure, complications are possible following a chiropractic adjustment. Fracture of bone, muscular strain, ligament strain, dislocation of joints, injury to intervertebral discs, nerves or spinal cord are all rare occurrences and generally result from some underlying weakness of the bone or surrounding tissues. Usually, there is an underlying, pre-existing vascular condition like atherosclerosis that contributes in a stroke resulting after a neck adjustment. A minority of patients may notice stiffness or soreness after the first few days of treatment. We will not accept individuals for treatment unless we feel confident that we can safely help them.

Probability of Risks: The risks and complications of chiropractic care, acupuncture and massage have all been described as 'rare'. The risk of cerebrovascular injury or stroke has been estimated at one in one million to one in twenty million, and can be even further reduced by our screening procedures. The probability of adverse reaction due to ancillary procedures is also considered to be 'rare'.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

I have had the following risks of my case explained to me. If you/and/or the individual listed below understand the above information, please sign below. This signature authorizes treatment, acknowledges Notice of Privacy Practices and also authorization to submit to insurances (if applicable). Patient or guardian understands that he/she is responsible for payment of all services.

Patient Authorization: I have read or have had read to me, the explanation of care offered at this facility. I have had the opportunity to have any questions answered. I have fully evaluated the risks and benefits of undergoing treatment and hereby give my full consent to the items mentioned above.

____ ____________________
Patient/Guardian/Authorized Party printed name *Date*

____ ____________________
Patient/Guardian/Authorized Party signature *Date*