

# Blue Q Health & Wellness

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

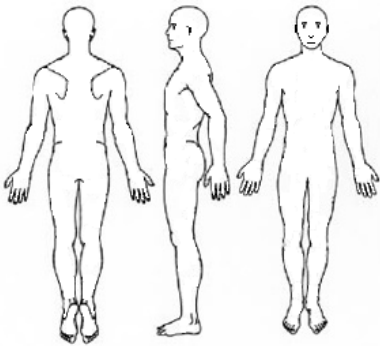
Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Insurance: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Main Complaint/Reason for Visit: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Area(s) of complaint (circle on diagram); Please describe in the blank space to the right of the diagram:



Stiffness Soreness Numbness Tingling Weakness Swelling Dull Achy Sharp Stabbing Burning

If you are experiencing pain, please circle a number: (No Pain) **0-1-2-3-4-5-6-7-8-9-10** (Severe)

When did your symptom(s) begin? \_\_\_\_\_

How often do symptoms occur? (Circle One) Occasional Intermittent Frequent Constant Is the  
complaint getting: (Circle One) Better Worse Same/Not Changing N/A

Affected Activities of Daily Living: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What makes the problem(s) better? \_\_\_\_\_

What makes the problem(s) worse? \_\_\_\_\_

## Medical History:

Have you treated elsewhere for this condition? N or Y (Date of last visit: \_\_\_\_\_)

Name/Location/ Phone: \_\_\_\_\_

Do you have a Family Physician: N or Y (Do we have your permission to contact them: Y or N )

Name/Location: \_\_\_\_\_

# Blue Q Health & Wellness

Have you been hospitalized last 5 yrs? N or Y (explain) \_\_\_\_\_

Have you had Surgery last 5 yrs? N or Y (explain) \_\_\_\_\_

Have you had a serious Accident/Injury last 5 yrs? N or Y (explain) \_\_\_\_\_

Do you have any Allergies? N or Y (list) \_\_\_\_\_

Are you currently taking any Medication? N or Y (list) \_\_\_\_\_

**WOMEN ONLY:**  
 Are you currently pregnant? Y or N (Yes, due date: \_\_\_\_\_)  
 Date of Last Physical Exam: \_\_\_\_\_ Where? \_\_\_\_\_

**REVIEW OF SYMPTOMS: Which of the following conditions do you now have or have you previously had? (circle)**

- |                       |          |                   |               |                |
|-----------------------|----------|-------------------|---------------|----------------|
| Arthritis             | Asthma   | Sinus Issues      | Blood Clotts  | Allergies      |
| Tuberculosis          | Diabetes | Vertigo           | ADD/ADHD      | Epilepsy       |
| Migraine/HA's         | Thyroid  | High BP           | Low BP        | Heart Trouble  |
| Pacemaker             | HIV/AIDS | Cancer            | Polio         | Scoliosis      |
| Mental/Emotional      |          | Prostate Trouble  | Hormonal      | Dislocation    |
| Disc Herniation/Bulge |          | Rheumatic Fever   | Bone Fracture | Osteoporosis   |
| Kidney Disease        |          | Digestive Trouble | Acid Reflux   | Sleep Disorder |
|                       |          |                   |               | <b>NONE</b>    |

**Family History:**

	Cancer	Diabetes	Blood Pressure	Heart Attack	Stroke	Osteoporosis	Arthritis	Scoliosis	Other
Father									
Mother									
Sibling (s)									
Child/Children									
Grandparent(s)									

## Receipt of Notice of Privacy Practices Written Acknowledgement Form

I understand that my health information will remain private and will not be shared with anyone without my written or verbal approval. I have received a copy of Blue Q Health and Wellness PLLC Notice of Privacy Practices. I understand that Blue Q Health and Wellness PLLC has the right to change its Notice of Privacy Practices from time to time and that I may contact Blue Q Health and Wellness PLLC at any time to obtain a current copy of the Notice of Privacy Practices. I authorize the sharing of my health information with the following party or parties listed below:

\_\_\_\_\_  
*(List any names of lawyers, doctors, or family members who may contact us for your health information)*

\_\_\_\_\_  
 Patient Name (or Guardian)

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Representative of Blue Q Health and Wellness

\_\_\_\_\_  
 Date

# Blue Q Health & Wellness

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## CHIROPRACTIC

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Reason for Visit:

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### **Medical History:**

**Have you been to a Chiropractor?** N or Y (Date of last visit: \_\_\_\_\_)

Name/Location/ Phone: \_\_\_\_\_

Type of Chiropractic Care and outcome: \_\_\_\_\_

Questions/Comments/Concerns:

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Goals of Treatment:

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I hereby request and consent to the performance of a chiropractic evaluation and treatment (for myself or for a minor) by Dr. Erika Meister (chiropractor) at Blue Q Health and Wellness. I will have the opportunity to discuss with the doctor and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts known to her, is in my best interest. I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor Signature \_\_\_\_\_ Date \_\_\_\_\_

# Blue Q Health & Wellness

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(Please complete if verifying insurance benefits)

## ASSIGNMENT OF BENEFITS

I, \_\_\_\_\_, assign all of the rights and benefits of any applicable health insurance policies, personal injury protection, medical payments, or other coverage provided by any insurance policy issued pursuant to Florida Statutes §627.730 - §627.7405, to Erika Meister DC at Blue Q Health and Wellness PLLC or other provider, for services and supplies provided to me.

I agree to pay any co-payment or deductible not covered by the applicable health insurance policy, personal injury protection, medical payments, or other insurance coverage.

This assignment includes, but is not limited to:

- all rights to collect benefits directly from any insurance carrier obligated to provide
- benefits for services and supplies I have received;
- all rights to take legal or other action against any insurance carrier obligated to provide
- benefits if for any reason the insurance carrier fails to pay any benefits due; and
- all rights to recover attorney fees, legal assistant fees, costs, and any interest on fees
- and costs, for any legal or other action taken by Blue Q Health and Wellness PLLC as my assignee.

This is an assignment of rights only, and is not a delegation of any of my duties under the subject insurance policy. I agree that Blue Q Health and Wellness PLLC or health provider may retain any attorney it chooses to bring legal action against any insurance carrier obligated to provide benefits for services and supplies I have received, and that the attorney chosen may be different than any attorney I may have handling any claim I may have for personal injuries. I have been given a copy of this assignment to retain for my records; I have read this assignment and I am satisfied that I fully understand the purpose and implications of executing this assignment and do so freely and voluntarily.

\_\_\_\_\_  
Patient Name (or Guardian)

\_\_\_\_\_  
Date

The undersigned, as authorized representative of Blue Q Health and Wellness PLLC accepts the assignment of benefits as set forth above.

\_\_\_\_\_  
Representative of Blue Q Health and Wellness

\_\_\_\_\_  
Date

We hope that you enjoy your treatment and tell others!

\*If there is anything else that we can do here at blue Q Health and Wellness to make your treatment even better, please let our front desk know : )

# Blue Q Health & Wellness

## Functional Rating Index

For use with **NECK and/or BACK** problems only

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities.

For each item below, please circle the number **which most likely describes your condition right now.**

### 1. Pain Intensity

<u>0</u> No pain	<u>1</u> Mild Pain	<u>2</u> Moderate Pain	<u>3</u> Severe Pain	<u>4</u> Worst Possible Pain
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### 2. Sleeping

<u>0</u> No pain	<u>1</u> Mild Pain	<u>2</u> Moderate Pain	<u>3</u> Severe Pain	<u>4</u> Worst Possible Pain
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### 3. Personal Care (washing, dressing, etc.)

<u>0</u> No pain	<u>1</u> Mild Pain	<u>2</u> Moderate Pain	<u>3</u> Severe Pain	<u>4</u> Worst Possible Pain
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### 4. Travel

<u>0</u> No pain	<u>1</u> Mild Pain	<u>2</u> Moderate Pain	<u>3</u> Severe Pain	<u>4</u> Worst Possible Pain
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### 5. Work

<u>0</u> No pain	<u>1</u> Mild Pain	<u>2</u> Moderate Pain	<u>3</u> Severe Pain	<u>4</u> Worst Possible Pain
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### 6. Recreation

<u>0</u> No pain	<u>1</u> Mild Pain	<u>2</u> Moderate Pain	<u>3</u> Severe Pain	<u>4</u> Worst Possible Pain
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### 7. Frequency of Pain

<u>0</u> No pain	<u>1</u> Mild Pain	<u>2</u> Moderate Pain	<u>3</u> Severe Pain	<u>4</u> Worst Possible Pain
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### 8. Lifting

<u>0</u> No pain	<u>1</u> Mild Pain	<u>2</u> Moderate Pain	<u>3</u> Severe Pain	<u>4</u> Worst Possible Pain
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### 9. Walking

<u>0</u> No pain	<u>1</u> Mild Pain	<u>2</u> Moderate Pain	<u>3</u> Severe Pain	<u>4</u> Worst Possible Pain
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### 10. Standing

<u>0</u> No pain	<u>1</u> Mild Pain	<u>2</u> Moderate Pain	<u>3</u> Severe Pain	<u>4</u> Worst Possible Pain
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Signature \_\_\_\_\_

Date \_\_\_\_\_

Name \_\_\_\_\_

Total Score \_\_\_\_\_

# Blue Q Health and Wellness Policies

## Cancellations and Missed Appointment Policy

Appointments canceled same day or missed (no call/no show) will incur either a **\$30 charge, the full service amount, or count toward the service package.** All appointments must be canceled or rescheduled by the close of the day prior (7:00pm the day before) in order to avoid the charge or package deduction.

I acknowledge and understand the policy and have been given a copy for my records (if requested).

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Signature

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Date