Blue Q Health & Wellness

Name:_____ _____Today's Date:_____

Address:_____ City/State/Zip:_____

Insurance:_____ Date of birth: _____

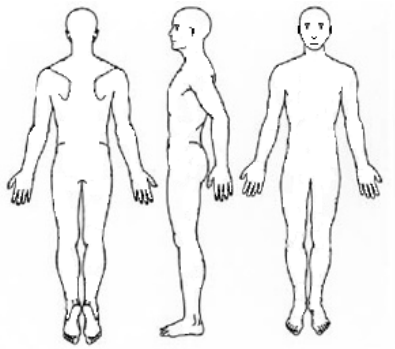
Phone:_____ Email:_____

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: _____

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

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

CHIROPRACTIC

Name:_____ DOB: _____ Today's Date:_____

Reason for Visit:

_____
_____
_____
_____
_____

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:

_____
_____

Goals of Treatment:

_____
_____
_____
_____

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_____

(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 <u>enjoy</u> your treatment and <u>tell others</u>!

*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 :)

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

0	1	2	3	4
No pain	Mild Pain	Moderate Pain	Severe Pain	Worst Possible Pain

2. Sleeping

0	1	2	3	4
No pain	Mild Pain	Moderate Pain	Severe Pain	Worst Possible Pain

3. Personal Care (washing, dressing, etc.)

0	1	2	3	4
No pain	Mild Pain	Moderate Pain	Severe Pain	Worst Possible Pain

4. Travel

0	1	2	3	4
No pain	Mild Pain	Moderate Pain	Severe Pain	Worst Possible Pain

5. Work

0	1	2	3	4
No pain	Mild Pain	Moderate Pain	Severe Pain	Worst Possible Pain

6. Recreation

0	1	2	3	4
No pain	Mild Pain	Moderate Pain	Severe Pain	Worst Possible Pain

7. Frequency of Pain

0	1	2	3	4
No pain	Mild Pain	Moderate Pain	Severe Pain	Worst Possible Pain

8. Lifting

0	1	2	3	4
No pain	Mild Pain	Moderate Pain	Severe Pain	Worst Possible Pain

9. Walking

0	1	2	3	4
No pain	Mild Pain	Moderate Pain	Severe Pain	Worst Possible Pain

10. Standing

0	1	2	3	4
No pain	Mild Pain	Moderate Pain	Severe Pain	Worst Possible Pain

Signature _____ Date_____

Name_____ Total Score_____

Card on File Policy

In an effort to expedite the checkout process and to help with weekend and after hour appointments, we will require a credit or debit card on file (square card processing system). Other forms of payment will still be accepted at checkout. The card on file can/will be used for the following: balances due, payment for services completed, and appointment cancellations same day ($30 fee), no call/no shows missed appointments (full fee), packages, insurance copayments, etc. An electronic notification will be sent by email or text when payment is processed. If notification preferences change, please notify us by phone or at the front desk.

I authorize Blue Q Health and Wellness to charge the portion of my bill that is my financial responsibility to the following credit or debit card:

(Circle one of the following)

Amex **Visa** **MasterCard** **Discover**

Last 4 digits of your Card Number: _____

Cardholder Name: _____

Zip Code: _____

Email/Phone number you would like receipt sent to: _____

I (we), the undersigned, authorize and request Blue Q Health and Wellness, LLC to charge my card on file, indicated above, for balances due for services rendered. This authorization relates to all payments not covered by my insurance company or any fees associated with missed and same day cancellations. This authorization will remain in effect until I (we) cancel this authorization. To cancel, I (we) must give a 30 day notification to Blue Q Health and Wellness and the account must be in good standing.

Patient Name (Print): _____

Patient Signature: _____ Date:_____