

**Edgewater Chiropractic Clinic, P.A.**

201 S. Ridgewood Ave, Suite 11  
Edgewater, FL 32132  
386-423-7575

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip Code** \_\_\_\_\_

**Phone:** \_\_\_\_\_  H  W  C **2<sup>nd</sup> Phone:** \_\_\_\_\_  H  W  C

**Gender:**  M  F **Date of Birth:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Marital Status:** MD S W

**Race:**  Not Specified  White  Am. Indian or Alaska Native  Asian  Black/African American  Hispanic

**Occupation:** \_\_\_\_\_ **Social Security #:** \_\_\_\_\_

**Email:** \_\_\_\_\_

**If you were referred by someone to our office please tell us who so we may thank them.**

\_\_\_\_\_

**Have you seen a Chiropractor in the past?**  Yes  No

**If yes, who** \_\_\_\_\_ **Year?** \_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Do you have health insurance?**  Y  N **Please Present Card at Window**

**Primary Care Physician:** \_\_\_\_\_ **Where?** \_\_\_\_\_

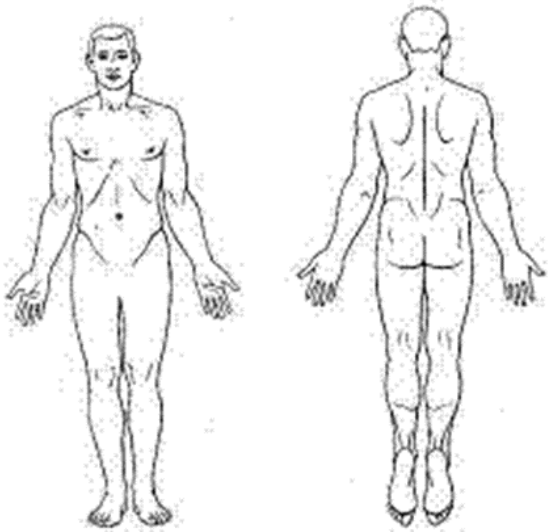
**Last Physical Exam:** \_\_\_\_\_

**For sign-in purposes please select a 4-digit pin number** \_\_\_\_\_

**Are you currently experiencing any of the following symptoms?**

- |   |  |
|---|--|
| <input type="checkbox"/> Nausea or vomiting                       | <input type="checkbox"/> Rapid eye movement    |
| <input type="checkbox"/> Numbness on one side of the face or body | <input type="checkbox"/> Difficulty speaking   |
| <input type="checkbox"/> Fainting or lightheadedness              | <input type="checkbox"/> Headache or neck pain |
| <input type="checkbox"/> Dizziness                                | <input type="checkbox"/> Difficulty swallowing |
| <input type="checkbox"/> Difficulty walking                       | <input type="checkbox"/> Double vision         |

Please circle area(s) where you are feeling symptoms...



What current problem(s) bring you to the clinic today? \_\_\_\_\_

Date this condition began: \_\_\_\_\_

How did this happen:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> FALL               | <input type="checkbox"/> SLIP             | <input type="checkbox"/> YARD WORK       |
| <input type="checkbox"/> LONG DRIVE         | <input type="checkbox"/> LIFTING          | <input type="checkbox"/> CHRONIC ILLNESS |
| <input type="checkbox"/> LONG               | <input type="checkbox"/> REACHING         | <input type="checkbox"/> OTHER           |
| <input type="checkbox"/> POOR NIGHT'S SLEEP | <input type="checkbox"/> HOUSEHOLD CHORES |  |

Has this pain ever happened before? Y N When: \_\_\_\_\_

How Long Did It Last? \_\_\_\_\_

Are you currently being treated for this condition? Yes No

By Whom? \_\_\_\_\_

Have you had any of the following tests? X-rays EMG MRI CT Scan

If yes, Year \_\_\_\_\_ Where \_\_\_\_\_ Why \_\_\_\_\_

Frequency of pain: (please check one)

- |   |   |
|---|---|
| <input type="checkbox"/> Constant (100% of the time)            | <input type="checkbox"/> Occasional (< 50% but > 25% of the time) |
| <input type="checkbox"/> Frequent (< 75% but > 50% of the time) | <input type="checkbox"/> Intermittent (less than 25% of the time) |

What type of pain are you experiencing? (please check all that apply)

- |                                   |   |                                      |
|-----------------------------------|---|--------------------------------------|
| <input type="checkbox"/> Aching   | <input type="checkbox"/> Heavy              | <input type="checkbox"/> Stiffness   |
| <input type="checkbox"/> Annoying | <input type="checkbox"/> Intolerable        | <input type="checkbox"/> Throbbing   |
| <input type="checkbox"/> Burning  | <input type="checkbox"/> Pulling            | <input type="checkbox"/> "Tightness" |
| <input type="checkbox"/> Deep     | <input type="checkbox"/> Sharp "Shock Like" | <input type="checkbox"/> Tingling    |
| <input type="checkbox"/> Dull     | <input type="checkbox"/> Stabbing           |                                      |

Is your pain Radiating? Y N Please Describe \_\_\_\_\_

Since the pain began has it: (please circle)

- |  |  |
|--|--|
| <input type="checkbox"/> Improved        | <input type="checkbox"/> Worsened                        |
| <input type="checkbox"/> Stayed the same | <input type="checkbox"/> Relief which lasted for a while |

Pain level: 1 2 3 4 5 6 7 8 9 10

Symptoms Relieved By: (please check all that apply)

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> None                    | <input type="checkbox"/> Exercise         | <input type="checkbox"/> Prescription Medication |
| <input type="checkbox"/> Chiropractic Adjustment | <input type="checkbox"/> Massage          | <input type="checkbox"/> Rest                    |
| <input type="checkbox"/> Cold Pack               | <input type="checkbox"/> OTC Medication   | <input type="checkbox"/> Stretching              |
| <input type="checkbox"/> Heat Packs              | <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Work                    |

**Activity of Daily Living Most Effected? (Check All That Apply)**

- |  |                                       |  |                                   |
|--|---------------------------------------|--|-----------------------------------|
| <input type="checkbox"/> Employment    | <input type="checkbox"/> Walking      | <input type="checkbox"/> Traveling           | <input type="checkbox"/> Golfing  |
| <input type="checkbox"/> Homemaking    | <input type="checkbox"/> Sitting      | <input type="checkbox"/> Yard Work           | <input type="checkbox"/> Exercise |
| <input type="checkbox"/> Lifting       | <input type="checkbox"/> Sit to Stand | <input type="checkbox"/> Sitting at Computer |                                   |
| <input type="checkbox"/> Personal Care | <input type="checkbox"/> Sleeping     | <input type="checkbox"/> Caring for Family   |                                   |
| <input type="checkbox"/> Standing      | <input type="checkbox"/> Social Life  |  |                                   |

**What tasks do you find difficult due to the pain? (Check All That Apply)**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> bending over          | <input type="checkbox"/> getting to sleep            | <input type="checkbox"/> rising out of chair or bed |
| <input type="checkbox"/> caring for family     | <input type="checkbox"/> grocery shopping            | <input type="checkbox"/> showering or bathing       |
| <input type="checkbox"/> climbing stairs       | <input type="checkbox"/> performing household chores | <input type="checkbox"/> sitting                    |
| <input type="checkbox"/> concentrating         | <input type="checkbox"/> lifting objects             | <input type="checkbox"/> standing                   |
| <input type="checkbox"/> dressing self         | <input type="checkbox"/> looking over shoulder       | <input type="checkbox"/> staying asleep             |
| <input type="checkbox"/> driving car           | <input type="checkbox"/> making love                 | <input type="checkbox"/> using a computer           |
| <input type="checkbox"/> exercising            | <input type="checkbox"/> lying down                  | <input type="checkbox"/> walking                    |
| <input type="checkbox"/> getting in/out of car | <input type="checkbox"/> reaching overhead           | <input type="checkbox"/> participating in yard work |

**How long can you with stand activity before it begins to hurt?**

- 1   5   10   15   20   30   45   60    Seconds  Minutes  Hours

Is Your pain worse (please circle)?                      Morning    Afternoon    Night

Are you currently under significant amount of stress?    Yes    No

Reason \_\_\_\_\_

**Please select if YOU have ever been told you have, had or are currently experiencing any of the following:**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Arthritis              | <input type="checkbox"/> Anxiety                                | <input type="checkbox"/> Cancer                |
| <input type="checkbox"/> Low Back Pain          | <input type="checkbox"/> Depression                             | <input type="checkbox"/> HIV                   |
| <input type="checkbox"/> Mid Back Pain          | <input type="checkbox"/> Dizziness                              | <input type="checkbox"/> Osteopenia            |
| <input type="checkbox"/> Arm/Hand Pain          | <input type="checkbox"/> Epilepsy or Seizures                   | <input type="checkbox"/> Osteomalacia          |
| <input type="checkbox"/> Ankle Pain             | <input type="checkbox"/> Headaches                              | <input type="checkbox"/> Sores That Won't Heal |
| <input type="checkbox"/> Foot Pain              | <input type="checkbox"/> Numbness                               | <input type="checkbox"/> Heart Murmur          |
| <input type="checkbox"/> Hip Pain               | <input type="checkbox"/> Pins/Needles in Arms/Hands             | <input type="checkbox"/> Rheumatoid Arthritis  |
| <input type="checkbox"/> Implant or Plates      | <input type="checkbox"/> Trouble Sleeping                       | <input type="checkbox"/> High Blood Pressure   |
| <input type="checkbox"/> Knee Pain              | <input type="checkbox"/> Stroke                                 | <input type="checkbox"/> Low Blood Pressure    |
| <input type="checkbox"/> Neck Pain              | <input type="checkbox"/> Temp. loss of vision, smell or hearing | <input type="checkbox"/> Apnea                 |
| <input type="checkbox"/> Stiff Neck             | <input type="checkbox"/> Loss of Grip/Strength                  | <input type="checkbox"/> Asthma                |
| <input type="checkbox"/> Osteoporosis           | <input type="checkbox"/> Loss of Hearing                        | <input type="checkbox"/> Emphysema             |
| <input type="checkbox"/> Pins and Screws        | <input type="checkbox"/> Blurred Vision                         | <input type="checkbox"/> Hay Fever             |
| <input type="checkbox"/> Scoliosis              | <input type="checkbox"/> Ringing in Ears                        | <input type="checkbox"/> Persistent Cough      |
| <input type="checkbox"/> Shoulder Pain          | <input type="checkbox"/> Head Feels Heavy                       | <input type="checkbox"/> Pneumonia             |
| <input type="checkbox"/> TMJ                    | <input type="checkbox"/> Fatigue                                | <input type="checkbox"/> Shortness of Breath   |
| <input type="checkbox"/> Cramping               | <input type="checkbox"/> Difficulty Swallowing                  | <input type="checkbox"/> Snoring Issues        |
| <input type="checkbox"/> Chest Pain             | <input type="checkbox"/> Thyroid Dysfunction                    | <input type="checkbox"/> Tuberculosis          |
| <input type="checkbox"/> Muscle Spasm           | <input type="checkbox"/> Abdominal Pain                         | <input type="checkbox"/> Wheezing              |
| <input type="checkbox"/> Any Bleeding/Discharge | <input type="checkbox"/> Light Headed                           | <input type="checkbox"/> Weight Loss/Gain      |

**Had any surgeries? Y N**

Describe \_\_\_\_\_ Year? \_\_\_\_\_

Describe \_\_\_\_\_ Year? \_\_\_\_\_

Describe \_\_\_\_\_ Year? \_\_\_\_\_

Describe \_\_\_\_\_ Year? \_\_\_\_\_

**Have you had a knee replacement? Yes No    Right Left    Year \_\_\_\_\_**

**Have you had a hip replacement? Yes No    Right Left    Year \_\_\_\_\_**

Current medication, including frequency and dosage if known. If there are no current medications check here:

- 1) \_\_\_\_\_ 5) \_\_\_\_\_
- 2) \_\_\_\_\_ 6) \_\_\_\_\_
- 3) \_\_\_\_\_ 7) \_\_\_\_\_
- 4) \_\_\_\_\_ 8) \_\_\_\_\_

List any known allergies you have had to any MEDICATIONS.

If no allergies are known, check here:

- 1) \_\_\_\_\_ 3) \_\_\_\_\_
- 2) \_\_\_\_\_ 4) \_\_\_\_\_

Do you have a pacemaker? Yes No

Are you or could you be pregnant? Yes No

Briefly list additional health conditions: \_\_\_\_\_  
\_\_\_\_\_

Has any doctor diagnosed you with Hypertension presently?  Yes  No

If yes, describe: \_\_\_\_\_

Has any doctor diagnosed you with Diabetes presently?  Yes  No If yes, what kind?  Type I  Type II

*If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%?*  Yes  No  Not Sure

*If yes, other comments regarding Diabetes:* \_\_\_\_\_

Do you have any family history in your mother, father, sibling or grandparents of BACK PAIN, HEADACHES, CANCER, DIABETES, STROKE, ARTHRITIS OR HEART DISEASE?  Y  N

If yes: Who? \_\_\_\_\_

What conditions? \_\_\_\_\_ Age deceased \_\_\_\_\_

If yes: Who? \_\_\_\_\_

What conditions? \_\_\_\_\_ Age deceased \_\_\_\_\_

If yes: Who? \_\_\_\_\_

What conditions? \_\_\_\_\_ Age deceased \_\_\_\_\_

Had any broken bones?  Y  N

Describe \_\_\_\_\_ Year? \_\_\_\_\_

Describe \_\_\_\_\_ Year? \_\_\_\_\_

Due to Insurance guidelines, we must have 3 measurable goals when it comes to your treatment process. Please provide us with your goals.

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_

\_\_\_\_\_  
(Patient or Legal Guardian Signature)

\_\_\_\_\_  
(Date)

# Edgewater Chiropractic Clinic, PA.

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201 S. Ridgewood Ave, Suite 11  
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Phone: (386)423-7575

## Informed Consent for Chiropractic Treatment

### TO THE PATIENT:

I hereby request and consent to the performance of chiropractic adjustments and any other chiropractic procedures, including examination tests, diagnostic x-ray(s) and physical therapy techniques, on me (or on the patient named below for which I am legally responsible) which are recommended by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future render treatment to me while employed by, working for or associated with, or serving as back-up for the doctor of chiropractic named below. I understand that, as with any health care procedure, there are certain complications, which may arise during a chiropractic adjustment. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, Homers' 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. I do not expect the doctor to be able to anticipate all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, are in my best interest. I have had an opportunity to discuss with the doctor named below and/or with office personnel the nature, purpose and risks of chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed.

I have read \_\_\_ or have had read to me \_\_\_ the above explanation of the chiropractic adjustment and related treatment. 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 chiropractic treatment recommended. All of my questions have been answered to my satisfaction. Having been informed of the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions(s) for which I seek treatment.

---

Patients Printed Name

---

Signature of Patient

---

Date

---

Patients Printed Name

---

Printed Name of Patient's Representative

---

Signature of Patient's Representative

---

Relationship/Authority of Patient's Representative

---

Date

## **Edgewater Chiropractic Clinic, PA.**

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### **Health Care Authorization:**

**The patient below authorizes Edgewater Chiropractic Clinic PA and its employees to use and/or disclose protected health information in accordance with the following:**

**Specific Authorizations: I give permission to Edgewater Chiropractic Clinic PA, and its employees to use my phone number, email address, home address and clinical records to contact me with appointments, reminders, missed appointments notification, birthday cards, holiday related cards, information about treatment alternatives, or other health related information.**

**If Edgewater Chiropractic Clinic PA, and its employees contact me by phone, I give them permission to leave a phone message on my answering machine/voice mail.**

**By signing this form, I am giving Edgewater Chiropractic Clinic PA, and its employees my permission to use and disclose my protected health information in accordance with the directives above.**

### **Right to revoke authorization:**

**I have the right to revoke the above authorization by mailing or hand delivering a written notice to the privacy official of Edgewater Chiropractic Clinic PA. The written notice must contain the following information: My name, social security number, date of birth, a clear statement of my intent to revoke this authorization, the date and my signature. The revocation will not be effective until it is received by the privacy official. I have the right to refuse this authorization. If I refuse to sign it, Edgewater Chiropractic Clinic PA, will not refuse to provide treatment.**

**I have the right to inspect or copy the health information to be used/disclosed. I have a right to a copy of the signed authorization.**

**Patient's PRINTED Name:** \_\_\_\_\_

**Patient's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## **Edgewater Chiropractic Clinic, PA.**

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### **INSURANCE AND PAYMENT UNDERSTANDING**

Thank you for choosing Edgewater Chiropractic Clinic, PA. For your chiropractic health care needs. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment process. The following is a statement of our financial policy, which we require that you read and sign prior to any treatment.

Regarding insurance: If you have an insurance plan that we participate in and the services which you are here for are expected to be covered expenses, we will gladly file your insurance claim for you. You will be billed for any amount that your insurance company leaves to your responsibility. We cannot bill your insurance unless you bring in your current insurance card. If your insurance company has not paid your account within 45 days, the balance will be transferred to your responsibility. Please be aware that some considered reasonable and necessary under the Medicare program and/or other medical insurance. If we do not participate with your insurance company, payment is due at the time of service. We accept cash, check, Visa, and MasterCard.

- Non-insured patient: if you do not have insurance, payment is expected at the time of service.
- **A \$50 New Patient exam fee is responsibility of the patient and payment is expected at the time of service.**
- Usual and customary rates: This practice is committed to providing the best treatment for our patient and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
- Adult patients: the adult accompanying a minor and the parents (or guardians) are responsible for full payment of service rendered to the minor.

Edgewater Chiropractic Clinic, PA. is here to provide you with the best possible health care. Our primary concern is your health and wellbeing, not with your insurance company. It is your responsibility to be aware of what your policy details are. Any questions should be directed to our staff.

I have read the above financial policy and I understand and agree to the terms within it.

**Patient's PRINTED Name:** \_\_\_\_\_

**Patient's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## **Edgewater Chiropractic Clinic, PA.**

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EDGEWATER CHIROPRACTIC CLINIC:

### NOTICE REGARDING YOUR RIGHT TO PRIVACY

I have received a copy of the Patient Privacy Notice. I understand my rights as well as the practice's duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Notice of Privacy Practice" at a time in the future and will make the new provisions effective for all information that it maintains past and present. I am aware that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

---

Printed Name

---

DOB

---

Signature

---

Date



# Edgewater Chiropractic Clinic, PA.

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## MEDICAL RECORDS RELEASE FORM

Printed Name: \_\_\_\_\_

DOB: \_\_\_\_\_

You may use or disclose the following health care information:

All my health information including but not limited to, patient notes and charges.

You may disclose this health information to:

Legal Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Legal Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Legal Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

*This authorization may be revoked at any time by providing written notice of revocation. I understand I cannot revoke this authorization retroactively for information already released.*

If patient is under 18 years of age.

\_\_\_\_\_  
Patients Printed Name

\_\_\_\_\_  
Patients Printed Name

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Parent/Guardian Printed Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

## **Edgewater Chiropractic Clinic, PA.**

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This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your Personal Health Information. In addition, we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as dictated by our office policy, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled 'HIPAA' on tables in the reception. Once you have read this notice, please sign the last page, and return only the signature page (page 2) to our front desk receptionist. Keep this page for your records.

### **PERMITTED DISCLOSURES:**

1. Treatment purposes discussion with other health care providers involved in your care.
2. Inadvertent disclosures open treating area mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes to process a claim or aid in investigation.
5. Emergency in the event of a medical emergency we may notify a family member.
6. For public health and safety in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefit purposes.
9. Deceased persons discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders we may call your home and leave messages regarding a missed appointment or apprise you of changes in practice hours or upcoming events.
11. Change of ownership in the event this practice is sold, the new owners would have access to your PHI.

### **YOUR RIGHTS:**

1. To receive an accounting of disclosures.
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice.
3. To request mailings to an address different than residence.
4. To request restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance.
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain one copy of your records at no charge, when timely notice is provided (72 hours). X-rays are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

### **COMPLAINTS:**

If you wish to make a formal complaint about how we handle your health information, please call Dr. Carly Meckle (386) 423-7575. If she is unavailable, you may make an appointment with our receptionist to see her within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to: DHHS, Office of Civil Rights

200 Independence Ave. SW  
Room 509F HHH Building  
Washington DC 20201