Harbor Chiropractic of Palmetto
517 8th Ave W, Ste 100, Palmetto, FL 34221 · 941-304-3013

PIP New Patient Intake Form

Name _____ Preferred Name (if applicable) _____

Address _____City _____

State _____ Zip Code _____ **Preferred Number:** □ Home □ Cell □ Work

Home Phone (_____) _____-_____ **Cell Phone (_____) _____-_____**

Work Phone (_____) _____-_____ **Email _____ (for appointment reminders)**

Date of Birth: _____ **Sex:** □ Male □ Female **Social Security Number: _____-_____-_____**

Marital Status: M S W D **Preferred Language:** □ English □ Other _____ **Race/Ethnicity:** _____

How were you referred to our office? _____

Employer Data_____

Employer _____ Occupation _____

Emergency Contact Data _____

Name _____ Phone Number _____

Primary Insured's Name: _____ Primary Insured's Date of Birth: ____/_____/_____

Primary Care Physician/Family Medical Doctor_____□ I was referred by this physician___

Name _____ Phone Number _____

Insurance Information: Please check any and all insurance coverage that may be applicable in this case:

□ Major Medical □ Medicare □ Auto Accident □ Medical Savings Account & Flex Plans □ Other

Name of Primary Insurance Company: _____

Name of Secondary Insurance Company (if any):_____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

Please list who we may speak with regarding you chiropractic care and account (please note, we cannot speak with or release any information to anyone not listed): _____

_____

Patient's Signature: _____ Date: _____

Guardian's Signature Authorizing Care: _____ Date: _____

Harbor Chiropractic Office and Financial Policy_____

Our recommendations are based on a desire to see you get well and stay well. Chiropractic care is covered under many insurance plans. Most of our patients that have health or accident insurance will fall under one of the plans discussed in this policy. Regardless of your coverage, we'll suggest the chiropractic care we think you need. We ask that you read and understand our policy as it applies to your particular situation.

SCHEDULING
While we do schedule appointments in order to reduce waiting time for you and others, patients are welcome to stop in anytime. Please be aware, however, that walk-in patients will be seen after all regularly scheduled patients have been seen. Although we do not charge for missed or cancelled appointments, we do request 24 hours' notice when possible. In consideration of our other patients, we will be unable to schedule further appointments if three (3) consecutive appointments are missed without notification.

PATIENTS WITHOUT INSURANCE
We request that 100% of the first visit be paid at the time of the visit. For future visits, we will discuss payment options to make you chiropractic care more affordable.

GROUP OR INDIVIDUAL INSURANCE
Your insurance is an agreement between you and your insurance company, not between your insurance company and our office. We cannot be certain if your insurance covers Chiropractic, although most policies do provide coverage. The amount they pay varies from one policy to another. When possible, we will call to verify benefits on your insurance; however, **the benefits quoted to us by your insurance company are not a guarantee of payment.** As a courtesy to you, our office will complete any necessary insurance forms at no additional charge, and file them with your insurance company to help you collect. It is to be understood and agreed that any services rendered are charged to you directly and **you are personally responsible for payment of any non-covered services, deductibles or co-pays.** You may also pay the full amount due each day thereby qualifying for our Time of Service Reduction in fees. You may then submit the bill to your insurance carrier for reimbursement.

PERSONAL INJURY OR AUTOMOBILE ACCIDENTS
Please present your auto insurance card, your health insurance card, and tell us if you have retained an attorney. There are a few options available to the PI patient:

1. Pay cash for your care and we will submit reports whenever necessary.
2. We will bill (accept assignment) from the Med Pay/PIP portion of your auto insurance.
3. We will accept a Letter of Protection or Doctor's Lien from an attorney and await payment at the time of settlement as long as you remain an active patient.

Although you are ultimately responsible for your bill, we will wait for settlement of your claim for up to six months after your care is completed. Once the claim is settled or if you suspend or terminate care, any fees for services are due immediately.

MEDICARE
We do accept assignment from Medicare. The check is usually sent directly to our office in payment of the services that Medicare will cover which for Chiropractors is ONLY manual manipulation of the spine. Medicare pays 80% of the allowable fee once the deductible has been met. You are required to pay the deductible and the remaining 20%. All other services we provide are NON-COVERED. These services include, but are not limited to, x-rays, examinations, therapies, orthotics, supports, and/or nutritional supplements. Medicare patients are fully responsible for charges of non-covered services. Secondary insurance may or may not pay for these non-covered services. Our office completes and files the forms for Medicare at no charge.

SECONDARY INSURANCE
Please inform us of any secondary insurance you may have. We will assist you if you need help in filing but are unable to speak directly.

MANAGED CARE PLANS
We are preferred providers for most insurance companies. Some plans require you to pay a co-pay at the time of service. Other plans may have a deductible amount to be met first. After that deductible has been satisfied, you and your insurance company will share a percentage of the cost that varies from plan to plan. A referral from your primary care physician may also be necessary. Out of network benefits are usually available if a referral is not obtained.

FLEX PLANS/MEDICAL SAVINGS ACCOUNTS
Please inform us if you have a medical savings account, sometimes known as a 'flex plan'. We will be happy to provide you with a statement of your charges for reimbursement.

INSURANCE FORMS/PAYMENT
If you receive any correspondence from your insurance carrier pertaining to the care you have received at this office or a request of more information regarding your care, please bring it in as soon as possible. It is very important that we keep your file as up to date as possible. Occasionally, either by mistake, or due to provisions in your policy, the check issued by the insurance company for payment of services rendered in our office, may come to you instead of the office. If you should receive any unexpected check in the mail, please contact up to see if it does represent payment of your bill here.

I have read and understand the payment/office policy of Harbor Chiropractic. **I understand that my insurance is an arrangement between me and my insurance company, and NOT between Harbor Chiropractic and my insurance company.** I request that Harbor Chiropractic prepare the customary forms at no charge so that I may obtain insurance benefits. I also understand that if my insurance does not respond within 60 days, or if I suspend or terminate my schedule of care as prescribed by the doctors of Harbor Chiropractic that fees will be due and payable immediately.

Patient's Signature: _____ Date: _____
Guardian's Signature Authorizing Care: _____ Date: _____

Informed Consent

Please read and understand the entire document prior to signing. Should you have any questions, please ask.

The use of hands or a mechanical instrument will be placed upon your body in such a way as to move your joints. This procedure is referred to as "Spinal Manipulation" or "Spinal Adjustment." As the joints in your spine are moved, you may experience a "pop" as part of the process.

As with any healthcare procedure, there are certain complications that can occur as a result of a spinal manipulation. These compilations include, but are not limited to: muscle strain, cervical myelopathy, disc and vertebral injury, fractures, strains and dislocations, Bernard-Horner's Syndrome (aka oculosympathethetic palsy), costovertebral strains and separation. Rare complications include but are not limited to stroke. The most common complication or complaint following spinal manipulation is an ache or stiffness at the site of adjustment. We are aware of these complications, and in order to minimize their occurrence we will take precautions. These precautions include but are not limited to my taking your detailed clinical history and examining you for any defect which would cause a complication. This examination may include the use of x-rays. The use of x-ray equipment may pose a risk if you are pregnant. If you are pregnant, you should inform our office while taking your clinical history.

Other treatment options for your condition may include self-administered, over the counter analgesics and rest; medical car and prescription drugs such as anti-inflammatory, muscle relaxants, and pain killers; hospitalization; surgery. Please be aware that there are risks and benefits to the "other treatment options" and you may wish to discuss them with your primary medical physician.

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Harbor Chiropractic and have had my questions answered to my satisfaction. Having been informed the risks, I hereby give my consent to the treatment.

Patient's Signature: _____Date: _____
Guardian's Signature Authorizing Care: _____ Date: _____

 Doctor's Initials _____

Patient Health Information Consent

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is obligated to agree to those restrictions only to the extent they coincide with state and federal law.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. Our office may contact you periodically regarding appointments, treatments, products, services, or charitable work performed by our office. You may choose to opt-out of any marketing or fundraising communications at any time.
6. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
7. Patients have the right to file a formal complaint with our privacy official and the Secretary of HHS about any possible violations of these policies and procedures without retaliation by this office.
8. Our office reserves the right to make changes to this notice and to make the new notice provisions effective for all protected health information that it maintains. You will be provided with a new notice at your next visit following any change.
9. This notice is effective on the date stated below.
10. If the patient refuses to sign this consent for the purpose of treatment, payment, and health care operations, the chiropractic physician has the right to refuse to give care.

Patient's Signature: _____ Date: _____
Guardian's Signature Authorizing Care: _____ Date: _____

Acknowledgments

To set clear expectations, improve communication and help you get the best results in the shortest amount of time, please read each statement, and initial your agreement.

Initials ____ I instruct the chiropractor to deliver the care that, in her professional judgement, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.

Initials ____ I grant permission to be called, emailed, and/or contacted via text to confirm or reschedule an appointment and to be sent occasional cards, letters, texts, emails or health information to me as an extension of my care in this office.

Initials ____ To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity, or cause of my health concern.

Authorization for the Release of Medical Records

Patient Name: _____ Date of Birth:_____

I hereby request and authorize:

Harbor Chiropractic
517 8TH Ave West, Suite 100
Palmetto, FL 34221
T-941-304-3013 / F-941-304-3014

_____To Disclose information to: _____To Receive Information from:

Provider/Medical Facility/Hospital: _____
Address: _____
Phone Number: _____ Fax Number: _____

Information to be disclosed include copies of:

_____Entire Record	_____X-ray Reports
_____Progress Notes	_____X-ray Films
_____Physical Exam forms	_____Other, specify:
_____Daily chart notes	_____

This authorization will be effective after the date signed, unless cancelled in writing. I understand that the cancellation will have no effect on information released prior to receiving the cancellation. A copy of this authorization is as valid as the original.

_____ Date: _____
Patient's Signature

_____ Date: _____
Guardian/Parent/Legal Representative Signature

If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law.

Notice to recipient of information: This information has been disclosed to you from confidential records, which are protected by law. Unless you have further authorization, laws may prohibit you from making any further disclosures of this information without the specific written consent of the patient or legal representative.

Doctor's Lien

To: Attorney/Insurance Carrier
_____
_____
_____

HJC Squared, LLC
d/b/a Harbor Chiropractic of Palmetto
517 8th Ave. W., Ste 100, Palmetto, FL 34221

Re: Medical Reports and Doctor's Lien

I do hereby authorize the above provider to furnish you with a report of his examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was involved.

I hereby authorize and direct you to pay directly to said doctor such sums as may be due and owing him for medical services rendered me both by reason of this accident and by reason of any other bills that are due his office and to withhold such sums from settlement, judgment, or verdict as may be necessary to adequately protect said doctor. And I hereby further give a lien on my case to said doctor against any and all proceeds of any settlement, judgment, or verdict which may be paid to you or myself as the result of the injuries for which I have been treated or injuries in connection herewith.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for service rendered to me and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover said fee.

Patient's Name: _____
Patient's Signature: _____ Date: _____
Guardian's Signature Authorizing Care: _____ Date: _____

The undersigned does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect said doctor above named.

This lien does not constitute a request or agreement between the parties for the attorney or law firm to act as a collection agency for the above-named doctor/doctor's office.

Signature: _____ Date: _____

Harbor Chiropractic of Palmetto
517 8th Ave W, Ste 100, Palmetto, FL 34221 · 941-304-3013
HJC Squared, LLC d/b/a Harbor Chiropractic of Palmetto

IRREVOCABLE ASSIGNMENT OF INSURANCE BENEFITS, RELEASE, & DEMAND

Insurer and Patient Please Read the Following in its Entirety Carefully!

I, the undersigned patient/insured knowingly, voluntarily, and intentionally irrevocably assign the rights and benefits of my automobile Insurance, also known as Personal Injury Protection (hereinafter PIP), Uninsured Motorist and Medical Payments policy of insurance to the above health care provider. I understand it is the intention of the provider to accept this assignment of benefits in lieu of demanding payment at the time services are rendered. I understand this document will allow the provider to file suit against an insurer for payment of the insurance benefits or an explanation of benefits and to seek §627.428 damages from the insurer. If the provider's bills are applied to a deductible, I agree this will serve as a benefit to me. This assignment of benefits includes transportation, medications, supplies, overdue interest and any potential claim for common law or statutory bad faith/unfair claims handling. If the insurer disputes the validity of this assignment of benefits, then the insurer is instructed to notify the provider in writing within five days of receipt of this document. Failure to inform the provider shall result in a waiver by the insurer to contest the validity of this document. Failure to inform the provider shall result in a waiver by the insurer to contest the validity of this document. The undersigned directs the insurer to pay the health care provider the maximum amount directly without any reductions & without including the patient's name on the check. To the extent the PIP insurer contends there is a material misrepresentation on the application for insurance resulting in the policy of insurance is declared voided, rescinded, or canceled, I as he named insured under said policy of insurance, hereby assign the right to receive the premiums paid for my PIP insurance to this provider and to file suit for recovery of the premiums. The insurer is directed to issue such a refund check payable to this provider only. Should the medical bills not exceed the premium refunded, then the provider is directed to mail the patient/named insured a check which represents the difference between the medical bills and the premiums paid.

Disputes: The insurer is directed by the provider and the undersigned to not issue any checks or drafts in partial settlement of a claim that contain or are accompanied by language releasing the insurer or its insured/patient from liability unless there has been a prior written settlement agreed to by the health provider (specifically the office manager) and the insurer as to the amount payable under the insurance policy. The insured and provider hereby contests and objects to any reductions or partial payments. Any partial or reduced payment, regardless of the accompanying language, issued by the insurer and deposited by the provider shall be done so under protest, at the risk of the insurer, and the deposit shall not be deemed a waiver, accord, satisfaction, discharge, settlement or agreement by the provider to accept a reduced amount as payment in full. The insurer is hereby placed on notice that this provider reserves the right to seek the full amount of the bills submitted. If the PIP insurer states it can pay claims at 200% of the Medicare Fee Schedule or any other fee schedule contained within F.S. 627.736 then the insurer is instructed & directed to provide this provider with a copy of the policy of insurance within 10 days. Any effort by the insurer to pay a disputed debt as full satisfaction must be mailed to the address above, after speaking with the office/billing manager and mailed to the attention of the **Office/Billing Manager.** See Fla. Stat. §673.3111.

EUOs and IMEs: If the insurer schedules a defense examination or examination under oath (hereinafter "EUO") the insurer is hereby INSTRUCTED to send a copy of said notification to this provider. The provider or the provider's attorney is expressly authorized to appear at any EUO or IME set by the insurer. The health care provider is not the agent of the insurer or the patient for any purpose.

This assignment applies to both past and future medical expenses and is valid even if undated. A photocopy of this assignment is to be considered as valid as the original. I agree to pay any applicable deductible, co-payments, for services rendered after the policy of insurance exhausts and for any other services unrelated to the automobile accident. The health care provider is given the power of attorney to: endorse my name on any check for services rendered by the above provider; and to request and obtain a copy of any statements or examinations under oath given by patient.

Release of information: I hereby authorize this provider to: furnish an insurer, an insurer's intermediary, the patient's other medical providers, and the patient's attorney via mail, fax, or email, with any and all information that may be contained in the medical records; and for my insurance carrier to **send insurance coverage information (declaration sheet & policy of insurance) in writing and telephonically to the above-named provider**; request from any insurer all explanation of benefits (EOBs) for all providers and non-redacted PIP payout sheets; obtain any written and verbal statements the patient or anyone else provided to the insurer; obtain copies of the entire claim file and all medical records, including but not limited to, documents, reports, scans, notes, bills, opinions, X-rays, IMEs, and MRIs, from any other medical provider or any insurer. The provider is permitted to produce my medical records to its attorney in connection with any pending lawsuits. The insurer is directed to keep the patient's medical records from this provider private and confidential. The insurer is not authorized to provide these medical records to anyone without the patient's and the provider's prior express written permission. **PLEASE NOTE: The insurer is not authorized to release protected health information (PHI) to third party vendors that schedule independent medical examinations or independent medical examination physicians**.

Demand: Demand is hereby made for the insurer to pay all bills within 30 days without reductions and to mail the latest non-redacted PIP payout sheet and the insurance coverage declaration sheet, and the insurance policy to the above provider within 15 days, as well as notify the provider pursuant to F.S. 627.736(6)(f) when benefits have been exhausted. The insurer is directed to pay the bills in the order they are received. However, if a bill from this provider and a claim from anyone else is received by the insurer on the same day the insurer is directed to not apply this provider's bill to the deductible. If a bill from this provider and claim from anyone else is received by the insurer on the same day then the insurer is directed to pay this provider first before the policy is exhausted. In the event the provider's medical bills are disputed or reduced by the insurer for any reason, or amount, the insurer is to: set aside the entire amount disputed or reduced; escrow the full amount at issue; and not pay the disputed amount to anyone or any entity, including myself, until the dispute is resolved by a Court. Do not exhaust the policy. The insurer is instructed to inform, in writing, the provider of any dispute.

Certification: I certify that: I have read and agree to the above; I have not been solicited or promised anything in exchange for receiving health care; I have not received any promises or guarantees from anyone as to the results that may be obtained by any treatment or service; I agree the provider's prices for medical services, treatment and supplies are reasonable and customary.

Caution: Please read before signing. If you do not completely understand this document please ask us to explain it to you. If you sign below we will assume you understand and agree to the above.

Patient's Name________ Patient's Signature _____
(Please Print) (If patient is a minor, signature of parent/guardian)

Date _____

 Doctor's Initials _____

PIP Insurance Information

Your Insurance Company _____
Insurance Company Address_____
Have you been contacted by an insurance adjustor regarding this claim? □Yes □No
If yes, name of adjustor: _____Phone Number: _____
Claim Number: _____
Do you have an attorney that has advised you in this case? □Yes □No
If yes: Attorney's name_____
Address_____
Phone Number: _____

Patient's Signature: _____ Date: _____
Guardian's Signature Authorizing Care: _____Date: _____

MOTOR VEHICLE COLLISION / PERSONAL INJURY QUESTIONNAIRE

Date of Accident: _____ Time of Accident: _____ Location: _____

CONDITIONS AT THE TIME OF THE ACCIDENT:

Time of day:	**Road Conditions:**	**Visibility:**	**Visibility compromised by:**
□Full daylight	□Dry	□Excellent	□Brightness □Fog
□Dawn	□Damp	□Good	□Darkness □Traffic
□Dusk	□Wet	□Fair	□Rain
□Night		□Poor	

Please describe what happened in the accident: _____
_____
_____

THE FOLLOWING QUESTIONS PERTAIN TO YOU AND THE VEHICLE YOU WERE IN:

Year: _____ Make: _____ Model: _____

Your position in the vehicle:
□Driver
□Passenger -------- Location------ □Left □Middle □Right
□Other _____ □Front Passenger □Rear Passenger □Third Seat (rear)

Speed of your vehicle:
□Stopped □Moving Moderately
□Parked □Moving Fast
□Slowing □Moving at approx. ____MPH
□Moving Slowly

Why Vehicle was slowed or stopped:
□Traffic Signal □Parking
□Pedestrian □Traffic
□Stop Sign □Busy Intersection

Collision Type:
□Driver Side Impact □Head On Collision □Passenger Side Impact □Rear Impact
□Front Impact □Pedestrian Incident

Patient's Name: _____ Date: _____

THE FOLLOWING QUESTIONS CONCERN THE OTHER VEHICLE INVOLVED IN THE ACCIDENT:

Year: _____ Make: _____ Model: _____

THE FOLLOWING QUESTIONS CONCERN THE MOMENT OF IMPACT OF THE ACCIDENT:

Were you...
- □Totally unaware that the accident was impending
- □Aware that the accident was impending
- □Aware that the accident was impending and braced for it

Restraints: (check all that apply)
- □Seat belt
- □Shoulder harness
- □No restraints

If you were the driver of the vehicle, was your foot on the brake pedal? □Yes □No □Knocked off by impact

Was the air bag deployed?
- □Car not equipped with air bag
- □Air bag deployed
- □Air bag not deployed

What position was YOUR headrest in?
- □High position
- □Middle position
- □Low position

Position of YOUR head at time of impact?
- □Facing straight ahead
- □Tilted forward
- □Rotated to the left
- □Rotated to the right

Was your head thrown...?
- □Backward and then forward
- □Forward then backward
- □To the left □To the left then the right
- □To the right □To the right, then the left

Position of Your body at time of impact?
- □Straight
- □Tilted forward
- □Rotated to the left
- □Rotated to the right

Was your body thrown...?
- □Backward and then forward
- □Forward then backward
- □To the left □To the left then the right
- □To the right □To the right, then the left
- □Across the vehicle
- □Outside the vehicle □Under the vehicle

Damage to vehicle YOU were in:
- □Incurred minimal damage
- □Incurred moderate damage
- □Incurred severe damage
- □Was totaled
- □Not known

Citations:
- □None issued
- □Yourself
- □Driver of vehicle patient was a passenger of
- □Driver of other vehicle
- □Not sure

BECAUSE OF THE FORCE OF THE COLLISION, WHICH OBJECTS IN THE VEHICLE DID YOUR BODY STRIKE?

Body Part(s) Struck: Head / Right Arm / Left Arm / Torso / Right Leg / Left Leg / other: _____

□Steering wheel	□Right door	□Dashboard	□Left window
□Windshield	□Right window	□Armrest	□Console
□Headrest	□Gear shift	□Rear view mirror	□Front seat
□Left door	□Backseat	□Other: _____	

THE FOLLOWING QUESTIONS CONCERN THE TIME PERIOD IMMEDIATELY FOLLOWING THE ACCIDENT:

Did you lose consciousness?
- □Yes
- □No

Immediately following the accident, did you feel...?

□Dizzy	□Weak	□Nauseated	
□Dazed	□Nervous	□Disoriented	

Were you able to walk unaided?
□Yes
□No

Where did you go...?
□Drove home □Drove to work
□Was driven home □Was driven to work
□Drove to hospital □Drove to school
□Was driven to hospital □Was driven to school
□Taken to hospital via ambulance
Which hospital? □ Blake □ Manatee □ Lakewood □ Other_____

Next day discomfort...?
□increased □decreased □same

Did your major complaints exist before the accident?
□Yes □ No

In what areas did you IMMEDIATELY feel pain?

□Head	Shoulder	□Left	□Right	Hip	□Left	□Right
□Neck	Arm	□Left	□Right	Thigh	□Left	□Right
□Upper back	Elbow	□Left	□Right	Knee	□Left	□Right
□Mid back	Wrist	□Left	□Right	Calf	□Left	□Right
□Ribs	Hand	□Left	□Right	Ankle	□Left	□Right
□Chest	Fingers	□Left	□Right	Foot	□Left	□Right
□Abdomen	Buttock	□Left	□Right	Toes	□Left	□Right
□Low Back						
□Pelvis						

Did you experience lacerations (cuts)? If so, where? _____

At the hospital, what areas were x-rayed? □N/A
□Head □Neck □Upper back □Mid back □Low Back □Pelvis □Other: _____

Any advanced imaging (CT Scan, MRI)? □N/A
□Head □Neck □Upper back □Mid back □Low Back □ Pelvis □Other: _____

Check symptoms you have noticed since the accident:

□Headaches	□Neck Pain	□Upper back	□Shoulder Pain	□Mid back
□Rib Pain	□Chest Pain	□Low Back	□Depression	□Dizziness
□Fatigue	□Irritability	□Fever	□Nervousness	□Paralysis
□Tension	□Fainting	□Sciatica	□Sinus Pain	□Sore Muscles
□Menstrual Problems	□Pinched Nerve	□Loss of Sleep	□Loss of Balance	□Light Bothers Eyes
□Jaw Pain/Clicking	□Buzzing in Ears	□Arm/Leg Pain	□Numbness/Tingling	□Loss of Memory
□Cold Hands/Feet	□Loss of Smell	□Digestive Problems	□Stomach Upset	□Joint Pain/Stiffness
□Vision Problems	□Urinary Problems	□Sleeping Problems	□Pins/Needles Feeling	
□Difficulty Swallowing		□Head Feels Too Heavy	□Other: _____	

Is there an open insurance claim in process now? □Yes □No
Have you lost time from work? □Yes □No □Haven't returned to work at this time.
□Returned to work on: _____ □Dates of disability: From: _____ to _____

Patient's Signature:_____ Date:_____
Guardian's Signature Authorizing Care:_____ Date:_____

Patient's Name: _____ Date: _____

HISTORY OF PRESENT ILLNESS:

Please answer each section for each individual symptom. (i.e.: Low back pain and neck pain would be completed separately) If only one symptom, only complete region #1. If more than 2 regions of complaint, please request an additional sheet.

#1: Location on body: _____ R / L Pain Intensity: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

When did your symptoms begin? _____ How did they begin? _____

Are your symptoms a result of: □ Motor Vehicle Accident □Work Related Accident □ Other_____
Current Open Insurance Claim: □ Yes □ No

How often do you experience your symptoms?
□ Constantly: (76-100% of the day) □ Frequently (51-75% of the day) □ Intermittently (26-50% of the day) □ Occasionally (0-25% of the day)

Is the pain: □ Not applicable
□ Unaffected by time of day? □ Worse in the morning? □ Worse in the afternoon? □ Worse at night

What describes the nature of your symptoms?
□ Ache □ Burning □ Dull □ Sharp □ Stabbing □ Throbbing
□ Weakness □ Numbness/Tingling □ Stiffness □ Other _____ □ Radiates into _____

Does anything aggravate your pain? □ No If yes, check below
□ Activity (circle: Heavy / Light / Moderate) □ Bending □ Lifting □ Standing □ Stress
□ Temperature Changes □ Twisting □ Other _____

Does anything improve your pain? □ No If yes, check below
□ Cold □ Heat □ Activity □ Lying Down □ OTC Medication □ Postural Changes
□ Prescribed Medications □ Rest □ Stretching □ Support Brace □ Other _____

#2: Location on body: _____ R / L Pain Intensity: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

When did your symptoms begin? _____ How did they begin? _____

Are your symptoms a result of: □ Motor Vehicle Accident □Work Related Accident □ Other_____
Current Open Insurance Claim: □ Yes □ No

How often do you experience your symptoms?
□ Constantly: (76-100% of the day) □ Frequently (51-75% of the day) □ Intermittently (26-50% of the day) □ Occasionally (0-25% of the day)

Is the pain: □ Not applicable
□ Unaffected by time of day? □ Worse in the morning? □ Worse in the afternoon? □ Worse at night

What describes the nature of your symptoms?
□ Ache □ Burning □ Dull □ Sharp □ Stabbing □ Throbbing
□ Weakness □ Numbness/Tingling □ Stiffness □ Other _____ □ Radiates into _____

Does anything aggravate your pain? □ No If yes, check below
□ Activity (circle: Heavy / Light / Moderate) □ Bending □ Lifting □ Standing □ Stress
□ Temperature Changes □ Twisting □ Other _____

Does anything improve your pain? □ No If yes, check below
□ Cold □ Heat □ Activity □ Lying Down □ OTC Medication □ Postural Changes
□ Prescribed Medications □ Rest □ Stretching □ Support Brace □ Other _____

If there are MORE regions of complaint, please request additional sheet from one of our chiropractic assistants.

Patient's Name: _____ Date: _____

Social History: (Check all that apply to you)
Tobacco Use: □ Current tobacco use □ Not a current tobacco user □ Never a tobacco user
Alcohol Use: □ None □ Light/Moderate □ Heavy □ Former Alcoholic
Activity Level: □ None □ Light □ Moderate □ Vigorous

Hospitalizations: □ **None If yes, list:** _____
_____

Surgeries: □ **None If yes, list:** _____
_____

Prior Accidents/Injuries: □ **None If yes, list:** _____
_____

Past Medical History/Current Conditions (Check all that apply to you) □ **None**

□ Arthritis	□ Cancer	□ Diabetes	□ Heart Disease
□ High Blood Pressure	□ Psychiatric Illness	□ Skin Disorder	□ Stroke
□ Fibromyalgia	□ Asthma	□ Osteoporosis/penia	□ Other _____

Current Medications/Supplements: □ **If yes, List:** _____

Allergies: □ **None If yes, List:** _____

Family History: □ **None**
(check if applicable and indicate **F**ather, **M**other, **S**ister, **B**rother)
Arthritis: _____ Cancer: _____ Diabetes: _____ Heart Disease: _____ Hypertension: _____ Stroke: _____
Other: _____
Check if applicable to you: ____ As an adopted child, little is known of my birth parents or family.

Previous Chiropractic Care: □ Yes □ No Date of last adjustment: _____
Preferred Method of Adjusting (if applicable): □ Manual □ Instrument

Previous Tests: □ MRI □ X-Rays □ CT
Region, Date, and Results: _____

WOMEN ONLY: Are you pregnant or possibility of being pregnant? □ Yes □ No □ Uncertain (LMP: ____)
If yes, due date: _____

Patient's Name: _____ Date: _____

Review of Systems – ☐ **None**(Check box if you have/have had trouble with any of the following. Leave blank if not applicable)

General	**Past**	**Present**	**HEENT**	**Past**	**Present**	**Skin/Hair**	**Past**	**Present**
Lethargy/Weakness			Headaches/Migraines			Rashes/Skin Trouble		
Recurring Fever			Eye/Vision Problem			Flushing		
Weight Loss/Gain			Nose Bleeds			Excess Acne		
Dizziness			Sore Throat			Eczema		
Fever			Hoarseness			Psoriasis		
Chills			Swollen glands			Skin Cancer		
Cardiovascular:	**Past**	**Present**	Sinus Trouble			Skin Color Change		
Chest Pain/Pressure			Ear/Hearing Problem			Change in hair/nail		
Heart Attack			Dental Problems			Easy Bruising		
Shortness of Breath			TMJ Problems			**Gastrointestinal**	**Past**	**Present**
Palpitations			**Respiratory:**	**Past**	**Present**	Loss of Appetite		
Swelling hands/feet			Chronic Cough			Nausea/Vomiting		
Hypertension (HBP)			Asthma/Wheezing			Diarrhea		
High Cholesterol			Short of Breath			Constipation		
Heart Murmur			Exercise Intolerance			Abdominal Pain		
Blood Clots			Sleep Apnea			Ulcers		
Pacemaker			Emphysema			Bloating/Cramping		
Mitral Valve Prolapse						Heartburn		
Neurologic	**Past**	**Present**	**Musculoskeletal**	**Past**	**Present**	Hemorrhoids		
Frequent Headache			Arthritis			Hepatitis		
Migraines			Joint Pain/Swell			Cirrhosis		
Dizziness			Neck Pain			Gastric Reflux		
Fainting			Back Pain			Bowel/Bladder Issues		
Memory Loss			Trauma			**Blood/Lymph**	**Past**	**Present**
Poor Balance			Osteoporosis			Anemia		
Numbness/tingling			Scoliosis			Bleeding		
Pins/Needles			Cramping			Bruising		
Muscle Weakness						Blood Clots		
Seizures			**Endocrine**	**Past**	**Present**	Past Transfusions		
Stroke			Diabetes			Leukemia		
Tremors			Thyroid Problems			Lymphoma		
Head Injury			Sweating			HIV/AIDS		
Psychiatric	**Past**	**Present**	Hot/Cold Intolerance			Sickle Cell		
Insomnia			Weight Loss			**Urinary**	**Past**	**Present**
Diff Concentrating			Weight Gain			Excess/Pain Urination		
Memory Loss/Confusion			Excess Urination			Incontinence		
Depression			Excess thirst			Urgency		
Anxiety			Appetite Change			Kidney Stones		
Agitation/Irritability						**Allergies**	**Past**	**Present**
Female	**Past**	**Present**	**Male**	**Past**	**Present**	Seasonal		
Menstrual Irregularity			Testicular Pain/Lumps			Food		
Hot Flashes			Prostate Disease			Medication		
Breast Pain/Lumps								
Menopause								

Patient's Name: _____ Date: _____

Rate your current difficulties by placing the appropriate number in the box (below; a **1 / 2 / 3**). NO check marks! If an activity does not cause pain or if pain does not affect an activity, leave box **blank**.

[1] This activity causes some pain, but it is of minor annoyance.
[2] This activity causes a significant amount of pain.
[3] I cannot perform this activity due to pain and disability.

Self-Care and Personal Hygiene: ___bathing ___brushing teeth ___putting on shoes ___doing laundry ___grooming hair ___making bed ___putting on pants ___doing dishes ___washing face ___putting on shirt ___cooking ___taking out trash ___going to bathroom or sitting on toilet

Physical Activities: ___standing ___walking ___reaching ___bending right ___twisting right ___sitting ___squatting ___bending ___bending left ___twisting left ___reclining ___bending back ___kneeling ___looking left ___looking right

Functional Activities: ___carrying small objects ___lifting weight off table ___push/pull standing ___carrying large objects ___climbing stairs/incline ___exercising upper body ___exercising lower body ___carrying purse/case ___lifting objects off floor ___push/pull seated

Social & Recreational Activities: ___jogging ___biking ___swimming ___dancing ___golfing ___bowling ___hunting ___fishing ___gardening ___basketball ___soccer ___hockey ___competitive sports

Difficulties with Travel: ___driving in car ___riding as passenger ___entering and exiting vehicle ___driving for long periods of time ___riding as passenger for long period of time

Other Activities: ___concentrating ___studying ___listening ___reading ___writing ___using computer ___sleeping ___sexual relation

How does your condition interfere with the things you do every day? Please think about the 4 following areas and make notes on how these daily activities have been affected since the condition began.

HOME: _____
_____

WORK: _____
_____

RECREATION:_____
_____

PERSONAL LIFE: _____
_____

Patient's Name: _____ Date: _____

Oswestry Disability Index for LOWER BACK PAIN (if applicable)

This questionnaire has been designed to give information as to how your lower back pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only the ONE box which applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just mark the box which most closely describes your problem

Section 1 – Pain Intensity

- ❑ I have no pain at the moment.
- ❑ The pain is very mild at the moment.
- ❑ The pain is moderate at the moment.
- ❑ The pain is fairly severe at the moment.
- ❑ The pain is very severe at the moment.
- ❑ The pain is the worst imaginable at the moment.

Section 2 – Personal Care (washing, dressing, etc)

- ❑ I can look after myself normally without causing extra pain.
- ❑ I can look after myself normally, but it causes extra pain.
- ❑ It is painful to look after myself and I am slow and careful.
- ❑ I need some help but manage most of my personal care.
- ❑ I need help every day in most aspects of self-care.
- ❑ I do not get dressed, wash with difficulty, and stay in bed.

Section 3 - Lifting

- ❑ I can lift heavy weights without extra pain.
- ❑ I can lift heavy weights, but it gives extra pain.
- ❑ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (i.e. on a table).
- ❑ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ❑ I can lift only very light weights.
- ❑ I cannot lift or carry anything at all.

Section 4 – Walking

- ❑ Pain does not prevent me walking any distance.
- ❑ Pain prevents me walking more than 1mile.
- ❑ Pain prevents me walking more than 1/2 of a mile.
- ❑ Pain prevents me walking more than 100 yards.
- ❑ I can only walk using a stick or crutches.
- ❑ I am in bed most of the time.

Section 5 – Sitting

- ❑ I can sit in any chair as long as I like.
- ❑ I can sit in my favorite chair as long as I like.
- ❑ Pain prevents me from sitting for more than 1 hr.
- ❑ Pain prevents me from sitting for more than 30 min.
- ❑ Pain prevents me from sitting for more than 10 min.
- ❑ Pain prevents me from sitting at all.

Section 6 – Standing

- ❑ I can stand as long as I want without extra pain.
- ❑ I can stand as long as I want but it gives me extra pain.
- ❑ Pain prevents me from standing more than 1 hour.
- ❑ Pain prevents me from standing for more than 30 min.
- ❑ Pain prevents me from standing for more than 10 min.
- ❑ Pain prevents me from standing at all.

Section 7 – Sleeping

- ❑ My sleep is never disturbed by pain.
- ❑ My sleep is occasionally disturbed by pain.
- ❑ Because of pain, I have less than 6 hours sleep.
- ❑ Because of pain, I have less than 4 hours sleep.
- ❑ Because of pain, I have less than 2 hours sleep.
- ❑ Pain prevents me from sleeping at all.

Section 8 – Sex life (if applicable)

- ❑ My sex life is normal and causes no extra pain.
- ❑ My sex life is normal but causes some extra pain.
- ❑ My sex life is nearly normal but is very painful.
- ❑ My sex life is severely restricted by pain.
- ❑ My sex life is nearly absent because of pain.
- ❑ Pain prevents any sex life at all.

Section 9 – Social Life

- ❑ My social life is normal and cause me no extra pain.
- ❑ My social life is normal but increases the degree of pain.
- ❑ Pain has no significant effect on my social life apart from limiting my more energetic interests.
- ❑ Pain has restricted my social life and I do not go out as often.
- ❑ Pain has restricted social life to my home.
- ❑ I have no social life because of pain.

Section 10 – Traveling

- ❑ I can travel anywhere without pain.
- ❑ I can travel anywhere but it gives extra pain.
- ❑ Pain is bad but I manage journeys of over 2 hours.
- ❑ Pain restricts me to short necessary journeys under 30 min.
- ❑ Pain prevents me from traveling except to receive treatment.

 Doctor's Initials _____

Harbor Chiropractic of Palmetto
517 8th Ave W, Ste 100, Palmetto, FL 34221 · 941-304-3013

Patient's Name: _____ Date: _____

NECK Disability Index for NECK PAIN (if applicable)

This questionnaire has been designed to give information as to how your neck pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only the ONE box which applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just mark the box which most closely describes your problem

Section 1 – Pain Intensity

- ❑ I have no pain at the moment.
- ❑ The pain is mild at the moment.
- ❑ The pain comes and goes and is moderate.
- ❑ The pain is moderate and does not vary much.
- ❑ The pain is very severe but comes and goes.
- ❑ The pain is severe and does not vary much.

Section 2 – Personal Care (Washing, Dressing, etc.)

- ❑ I can look after myself normally without causing extra pain.
- ❑ I can look after myself normally, but it causes extra pain.
- ❑ It is painful to look after myself and I am slow and careful.
- ❑ I need some help but manage most of my personal care.
- ❑ I need help every day in most aspects of self-care.
- ❑ I do not get dressed, wash with difficulty and stay in bed.

Section 3 – Lifting

- ❑ I can lift heavy weights without extra pain.
- ❑ I can lift heavy weights, but it gives extra pain.
- ❑ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
- ❑ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ❑ I can lift very light weights.
- ❑ I cannot lift or carry anything at all.

Section 4 – Reading

- ❑ I can read as much as I want to with no neck pain.
- ❑ I can read as much as I want to with slight neck pain.
- ❑ I can read as much as I want with moderate neck pain.
- ❑ I cannot read as much as I want because of moderate neck pain.
- ❑ I can hardly read at all because of severe neck pain.
- ❑ I cannot read at all.

Section 5 – Headaches

- ❑ I have no headaches at all.
- ❑ I have slight headaches that come infrequently.
- ❑ I have moderate headaches which come infrequently.
- ❑ I have moderate headaches which come frequently.
- ❑ I have severe headaches which come frequently.
- ❑ I have headaches almost all the time.

Section 6 – Concentration

- ❑ I can concentrate fully when I want to with no difficulty.
- ❑ I can concentrate fully when I want to with slight difficulty.
- ❑ I have a fair degree of difficulty in concentrating when I want to.
- ❑ I have a lot of difficulty in concentrating when I want to.
- ❑ I have a great deal of difficulty in concentrating when I want to.
- ❑ I cannot concentrate at all.

Section 7 – Work

- ❑ I can do as much work as I want to.
- ❑ I can do my usual work, but no more.
- ❑ I can do most of my usual work, but no more.
- ❑ I cannot do my usual work.
- ❑ I can hardly do any work at all.
- ❑ I cannot do any work at all.

Section 8 – Driving

- ❑ I can drive my car without any neck pain.
- ❑ I can drive my car as long as I want with slight neck pain.
- ❑ I can drive my car as long as I want with moderate pain
- ❑ I cannot drive my car as long as I want because of moderate pain in my neck.
- ❑ I can hardly drive at all because of severe neck pain.
- ❑ I cannot drive my car at all.

Section 9 – Sleeping

- ❑ I have no trouble sleeping.
- ❑ My sleep is slightly disturbed (< 1 hour sleepless).
- ❑ My sleep is mildly disturbed (1-2 hours sleepless).
- ❑ My sleep is moderately disturbed (2-3 hours sleepless).
- ❑ My sleep is greatly disturbed (3-5 hours sleepless).
- ❑ My sleep is completely disturbed (5-7 hours sleepless).

Section 10 – Recreation

- ❑ I am able to engage in all my recreation activities with no neck pain at all.
- ❑ I am able to engage in all my recreation activities, with some pain in my neck.
- ❑ I am able to engage in most, but not all, of my usual recreation activities because of pain in my neck.
- ❑ I am able to engage in a few of my usual recreation activities because of pain in my neck.
- ❑ I can hardly do any recreation activities because of pain in my neck.
- ❑ I cannot do any recreation activities at all.