

# Miami Beach Family & Sports Chiropractic Center

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

File # \_\_\_\_\_

◆ Confidential Patient Information ◆

PLEASE PRINT:

Name \_\_\_\_\_ Social Security Number \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Age \_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex M F Status: Single Married Divorced Domestic Partnership Widowed Number of Children \_\_\_\_

Home Phone( ) \_\_\_\_\_ Business Phone( ) \_\_\_\_\_ Cell Phone( ) \_\_\_\_\_

Skype \_\_\_\_\_ Twitter \_\_\_\_\_ Email \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Busines Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Name of Spouse or Parent \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Who To Contact In Case of Emergency ? \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

What Hobbies/Sports Are You Active In ? \_\_\_\_\_

Purpose of Today's Visit: \_\_\_\_\_

Briefly State Your Main Complaint \_\_\_\_\_

Briefly Describe How Your Symptoms Began / Or How Your Injuries Were Caused \_\_\_\_\_

Briefly Describe How Your Symptoms Affect Your Daily Job, Household and Recreational Activities \_\_\_\_\_

**Are Your Complaints Caused From An "On The Job" Injury Or From A Personal Injury Such As A Car Accident Or Slip And Fall? If Yes, Please Tell The Receptionist Immediately**

Please Complete the information below so your doctor will have a better understanding of your whole health profile...

**CHECK YOUR PRESENT SYMPTOMS ONLY!!!**

- |   |   |  |  |
|---|---|--|--|
| <input type="checkbox"/> Headache               | <input type="checkbox"/> Pins & Needles in Legs | <input type="checkbox"/> Loss of Smell           | <input type="checkbox"/> Shortness of Breath     |
| <input type="checkbox"/> Neck Pain              | <input type="checkbox"/> Numbness in Fingers    | <input type="checkbox"/> Loss of Taste           | <input type="checkbox"/> Stomach Upset/Nausea    |
| <input type="checkbox"/> Back Pain              | <input type="checkbox"/> Numbness in Toes       | <input type="checkbox"/> Diarrhea                | <input type="checkbox"/> Loss of Bladder Control |
| <input type="checkbox"/> Neck/Back Stiffness    | <input type="checkbox"/> Fatigued/Tired Often   | <input type="checkbox"/> Constipation            | <input type="checkbox"/> Swelling Anywhere       |
| <input type="checkbox"/> Sleeping Difficulty    | <input type="checkbox"/> Depression             | <input type="checkbox"/> Feet Seem Cold          | <input type="checkbox"/> Frequent Nose Bleeds    |
| <input type="checkbox"/> Nervousness            | <input type="checkbox"/> Light Bothers Eyes     | <input type="checkbox"/> Hands Seem Cold         | <input type="checkbox"/> Pressure in Head/Neck   |
| <input type="checkbox"/> Tension                | <input type="checkbox"/> Loss of Memory         | <input type="checkbox"/> Cold Sweats             | <input type="checkbox"/> Spots in Front of Eyes  |
| <input type="checkbox"/> Irritability           | <input type="checkbox"/> Ringing in Ears        | <input type="checkbox"/> Fever                   | <input type="checkbox"/> Heart Palpitations      |
| <input type="checkbox"/> Chest Pain             | <input type="checkbox"/> Face Flushed           | <input type="checkbox"/> Excessive Coughing      | <input type="checkbox"/> Muscle Cramps           |
| <input type="checkbox"/> Dizziness              | <input type="checkbox"/> Buzzing in Ears        | <input type="checkbox"/> Difficulty Swallowing   | <input type="checkbox"/> Hot/Cold Flashes        |
| <input type="checkbox"/> Head Seems To Heavy    | <input type="checkbox"/> Loss of Balance        | <input type="checkbox"/> Burning Upon Urination  | <input type="checkbox"/> Female Problems         |
| <input type="checkbox"/> Pins & Needles in Arms | <input type="checkbox"/> Fainting               | <input type="checkbox"/> Blood in Stool or Urine | <input type="checkbox"/> I Am Pregnant           |

Symptoms other than above: \_\_\_\_\_

◆Have You Recently Lost A Significant Amount Of Weight Without Trying ? Yes No

◆Have you been treated for this or any other health condition by a DC, DO or MD physician in the past year? Yes No

◆ If Yes, Name of Doctor \_\_\_\_\_ Doctor's Phone Number ( ) \_\_\_\_\_

# Authorizations & Releases

NAME: \_\_\_\_\_ FILE #: \_\_\_\_\_

**Office Policy Regarding Payment For Services & Insurance Reimbursement:**

I understand and agree that health insurance policies are an arrangement between an insurance company and myself. Furthermore, I understand that the Miami Beach Family & Sports Chiropractic Center will prepare any necessary reports and forms to assist me in collecting from my insurance company, and that any amount authorized to be paid to Miami Beach Family & Sports Chiropractic Center, Inc., will be credited towards my account upon receipt. However, I clearly understand and agree that ALL SERVICES RENDERED ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT, including payment of any applicable insurance deductible and/or insurance co-payments. I also understand that if I suspend or terminate my care and treatment prior to the doctor releasing or discharging me from care, any fees for professional services rendered to me will be immediately due and payable.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Witness: \_\_\_\_\_

**Authorization To Release Medical Information:**

I authorize the release of any medical information necessary to process my insurance claim(s). I also certify that all insurance information given to this healthcare provider is correct and complete.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Witness: \_\_\_\_\_

**Consent For Physician To Proceed With Examination & Treatment:**

Although extremely rare, there are risks of being treated with physical therapy, massage therapy, rehabilitation and chiropractic, including sprains, strains, fractures, herniation, burns, bruises, strokes and even death (1 in 5.85 million manipulations). I understand that if I am accepted as a patient by the physicians of the Miami Beach Family & Sports Chiropractic Center, I am authorizing them to proceed with any examination & treatment that may be necessary. Any risks regarding examination & treatment have been discussed and explained to my satisfaction and I understand the doctor feels the benefits outweigh the risks. I voluntarily consent to the rendering of care, including examinations, treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carryout the instructions of such physician(s).

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Witness: \_\_\_\_\_

Parent or Guardian's

Signature Authorizing & Consenting To The Care Of A Minor: \_\_\_\_\_

**Authorization To Release Healthcare/Medical Records:**

I, \_\_\_\_\_ hereby authorize any person to whom this authorization is presented, either in person, by mail, by fax or otherwise; to furnish the Miami Beach Family & Sports Chiropractic Center/Dr. Corey Narson/Dr. Todd Narson; ANY AND ALL MEDICAL RECORDS, MEDICAL REPORTS, X-RAYS OR OTHER DIAGNOSTIC TEST REPORTS & FILM concerning my present or past health condition/injury or general health status.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Witness: \_\_\_\_\_

**Limited Power Of Attorney To Endorse Checks:**

I agree that this office and any of its duly authorized agents and employees be given power of attorney to endorse/sign my name on any and all checks, drafts, money orders, unpaid insurance claims or affidavits, **which are payable to me for professional services rendered to me by Miami Beach Family & Sports Chiropractic Center/Dr. Corey Narson/Dr. Todd Narson**. The undersigned by these presents does thus give and grant this limited power of attorney to the above named office or doctor the full power and authority to do and perform the intents and purposes as the undersigned might or could do if personally present insofar as the endorsing and cashing of said checks are concerned. The undersigned does hereby ratify and confirm any and all actions taken by said attorney in accordance with this special power of attorney and which the said attorney shall do or cause to be done by virtue of these presents.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Witness: \_\_\_\_\_

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Witness: \_\_\_\_\_

# Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as “informed consent” and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an “arterial dissection” that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit. I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent or Guardian: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**REVIEW OF SYSTEMS**

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

Date: \_\_\_\_\_

**General**

- Unexplained weight loss       Fever       Trouble sleeping       Weakness  
 Unexplained weight gain       Chills       Recent cold or flu       Fatigue       NONE

**Skin**

- Rashes    Itching       Color changes       Lumps       Dryness       Hair & nail changes       NONE

**Head**

- Headache       Head injury/trauma       Bumps or areas of tenderness       NONE

**Eyes**

- Visual problems       Blurry vision       Double vision       Wear glasses/contacts       Flashing lights  
 Specks or spots in vision       Pain       Glaucoma       Itching       Redness       NONE

**Ears**

- Decreased hearing       Earache / Ear pain       Ringling in ears (tinnitus)       fluid discharge from ear(s)       NONE

**Nose**

- Stuffiness       Itching       Nosebleeds       fluid discharge       Hay fever       Sinus pain       NONE

**Throat**

- Toothache       Pain with swallowing       Sore tongue       Bleeding gums       Non-healing sores  
 Hoarseness       Lump in throat       Dry mouth       NONE

**Neck**

- Lumps       Pain       Swollen glands       Stiffness       NONE

**Breasts**

- Do you do Self Exams?  Yes  No       Lumps       Discharge      Are you breast feeding?  Yes  No       NONE

**Respiratory**

- Coughing (dry or wet, productive)       Coughing up blood       Shortness of breath       Labored breathing  
 Sputum/Color \_\_\_\_\_       Painful breathing       Wheezing       NONE

**Cardiovascular**

- Chest pain or discomfort       Difficulty breathing when lying down       Chest or shoulder/arm pain with physical activity  
 Tightness in chest       Shortness of breath with activity       Sudden awakening from sleep w/shortness of breath  
 Palpitations       NONE

**Gastrointestinal**

- Difficulty swallowing       Change in bowel habits       Yellow eyes or skin       Nausea       Diarrhea  
 Heartburn       Rectal bleeding       Gas or Bloating       Abdominal pain after or during meal  
 Change in appetite       Constipation       Abdominal pain prior to meal       NONE

**Urinary**

- Urinate frequently       Blood in urine       Yellow eyes or skin       Feel like urinating but can't or little  
 Change in urinary strength       Incontinence       Burning with urination       NONE

**Genital****Male**

- Do you do regular self testicular exams?  Yes  No  
 Sores       Pain with sex       STDs, if yes which \_\_\_\_\_       Erectile dysfunction  
 Hernia       Masses or pain       Penile discharge       NONE

**Female**

- Pain with sex       STDs, if yes which \_\_\_\_\_       Vaginal discharge       Vaginal dryness       Hot flashes       NONE

**Vascular**

- Calf pain when walking       Leg cramping       Varicose or spider veins       NONE

**Musculoskeletal**

- Muscle or joint pain       Back pain       Neck pain       Stiffness       Redness of the joints       Trauma       Swelling of the joints       NONE

**Neurological**

- Dizziness       Weakness       Tremors       Fainting       Numbness       Headaches       Seizures       Tingling       NONE

**Hematologic**

- Bruising easily       Bleeding easily       NONE

**Endocrine**

- Heat or cold intolerance       Frequent urination       Change in appetite       Sweating       Increase Thirst       NONE

**Psychiatric**

- Nervousness       Memory Loss       Stress       Depression       Anxiety       NONE