



# EAST SIDE CHIROPRACTIC

*"Live Healthy, Be Happy"*

8228 Biscayne Blvd. Miami, FL 33138

T: 305-403-2595 | F: 305-403-1022

First Name \_\_\_\_\_ Middle \_\_\_\_\_ Last Name \_\_\_\_\_ Nickname \_\_\_\_\_

Address \_\_\_\_\_ Apt# \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Cell Number \_\_\_\_\_ Home Number \_\_\_\_\_ Email Address \_\_\_\_\_ Date of Birth \_\_\_\_\_

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

Marital Status

Sex

Single

Married

Divorced

Widowed

Male

Female

### EMERGENCY CONTACT

FULL NAME

RELATIONSHIP

PHONE NUMBER

\_\_\_\_\_

### AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

I authorize East Side Chiropractic Center and any member of its staff to call, leave voice mail messages and/or email messages and disclose Protected Health Information (PHI) pertaining to me, including but not limited to medical information, such as test results, procedure results, appointment reminders, or any other PHI related to my treatment to the following numbers

Home \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_ Fax \_\_\_\_\_

Email \_\_\_\_\_

I authorize East Side Chiropractic Center and any member of its staff to disclose my (PHI), including test results to the following individuals

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone# \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone# \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone# \_\_\_\_\_

Though I am seeking care from East Side Chiropractic Center, the treatment is not due to a work-related injury, automobile accident, or slip and fall. Please Initial \_\_\_\_\_

### INSURANCE AUTHORIZATION

I hereby authorize payment of benefits due to me from my insurance company, if any, to be made directly to East Side Chiropractic Center. I further authorize the release of any medical records requested by my insurance carrier. I fully understand that I am financially responsible for any charges covered by this authorization to East Side Chiropractic Center. In the event, that it becomes necessary to institute litigation over the non-payment of our fees, the cost and legal expenses incurred therein are that of the patient.

### INSURANCE CERTIFICATION

This is to certify that I have presented any, and all information regarding my health insurance plan.

The only health insurance policy in effect is:

Name of Insurance Co. \_\_\_\_\_ ID# \_\_\_\_\_ Group# \_\_\_\_\_

Name of Insured \_\_\_\_\_ Relationship to Insured \_\_\_\_\_

My signature certifies that the information I have completed is accurate, and that I am not seeking care due to an Auto accident, work injury or slip and fall, nor do I have any open or pending cases.

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

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### RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

I Acknowledge that I have received HAVE RECEIVED A COPY OF East Side Chiropractic Center's Notice of Patient Privacy Practices

### INFORMED CONSENT FORM

I hereby request and consent to the performance of chiropractic treatment and other chiropractic medical procedures, including various forms of physical therapy and diagnostic x-rays by East Side Chiropractic Center. This consent is extended to other licensed chiropractic physicians, chiropractic assistants or licensed massage therapist, who now or in the future are employed by, or are associated with this office.

I certify that I have had the opportunity to discuss with the doctor of Chiropractic and/or other office personnel, the nature and purpose of the care that is being provided. I understand that the results are not guaranteed. Furthermore, I have been informed and I understand that, as in the practice of any of the healing arts, in the practice of Chiropractic care there are some risks to treatment including but not limited to fractures, disk injuries, strokes, dislocations and sprains. I also understand that the doctor, who has explained all of these things to me, is not expecting to be able to anticipate and explain all the risks and complications. I will rely on the doctor to exercise appropriate judgment during the course of care, based on the facts known at this time and in my best interest.

My signature below certifies that I have read or have had read to me that above consent. I also certify that I have had the opportunity to ask questions and options of care have been explained to me. By signing this consent form, I agree to the care being provided to me for the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment.

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

### Massage and Manual Therapy Policy

We offer massage and manual therapy in our office as an extra service to our patients. We believe that massage and manual therapy has a value of helping you heal. Our policy is that appointments be pre-scheduled. If you must reschedule or miss an appointment YOU MUST CALL US 24 HOURS IN ADVANCE. If you do not call, there is a \$25 charge. The only exception to this is if you have a serious emergency. Thank you for your cooperation.

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

# Patient Health Questionnaire

ChiroCare of Wisconsin, Inc.



ChiroCare Use Only rev 4/19/99

Patient Name Michelle Murphy

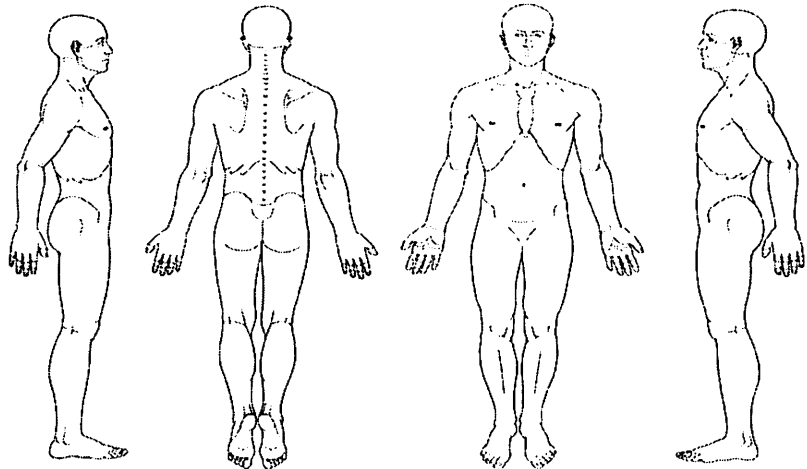
Date 08/14/2019

1. When did your symptoms start: \_\_\_\_\_

Describe your symptoms and how they began:

2. How often do you experience your symptoms? Indicate where you have pain or other symptoms

- Constantly (76-100% of the day)
- Frequently (51-75% of the day)
- Occasionally (26-50% of the day)
- Intermittently (0-25% of the day)



3. What describes the nature of your symptoms?

- Sharp  Shooting
- Dull ache  Burning
- Numb  Tingling

4. How are your symptoms changing?

- Getting Better
- Not Changing
- Getting Worse

5. How bad are your symptoms at their:

- None Unbearable
- a. worst: ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
- b. best: ⑩ ⑨ ⑧ ⑦ ⑥ ⑤ ④ ③ ② ①

6. How do your symptoms affect your ability to perform daily activities?

- ① No complaints      ② Mild, forgotten with activity      ③ Moderate, interferes with activity      ④ Limiting, prevents full activity      ⑤ Intense, preoccupied with seeking relief      ⑥ Severe, no activity possible

7. What activities make your symptoms worse: \_\_\_\_\_

8. What activities make your symptoms better: \_\_\_\_\_

9. Who have you seen for your symptoms?

- No One  Medical Doctor  Other
- Other Chiropractor  Physical Therapist

a. When and what treatment? \_\_\_\_\_

b. What tests have you had for your symptoms and when were they performed?

- Xrays date: \_\_\_\_\_  CT Scan date: \_\_\_\_\_
- MRI date: \_\_\_\_\_  Other date: \_\_\_\_\_

10. Have you had similar symptoms in the past?

- Yes  No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

- This Office  Medical Doctor  Other
- Other Chiropractor  Physical Therapist

11. What is your occupation?

- Professional/Executive  Laborer  Retired
- White Collar/Secretarial  Homemaker  Other
- Tradesperson  FT Student

a. If you are not retired, a homemaker, or a student, what is your current work status?

- Full-time  Self-employed  Off work
- Part-time  Unemployed  Other

12. What do you hope to get from your visit/treatment (select all that apply):

- Reduce symptoms  Explanation of condition/treatment  How to prevent this from occurring again
- Resume/increase activity  Learn how to take care of this on my own

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

Date 08/14/2019

# Patient Health Questionnaire - page 2

ChiroCare of Wisconsin, Inc.

ChiroCare Use Only rev 1/20/99

Patient Name Michelle Murphy Date 08/14/2019

What type of regular exercise do you perform?  None  Light  Moderate  Strenuous

What is your height and weight? Height    Feet   Inches Weight    lbs.

For each of the conditions listed below, place a check in the Past column if you have had the condition in the past. If you presently have a condition listed below, place a check in the Present column.

| Past                     | Present                  |                          | Past                     | Present                  |                             | Past                     | Present                  |                              |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|-----------------------------|--------------------------|--------------------------|------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Headaches                | <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure         | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Neck Pain                | <input type="checkbox"/> | <input type="checkbox"/> | Heart Attack                | <input type="checkbox"/> | <input type="checkbox"/> | Excessive Thirst             |
| <input type="checkbox"/> | <input type="checkbox"/> | Upper Back Pain          | <input type="checkbox"/> | <input type="checkbox"/> | Chest Pains                 | <input type="checkbox"/> | <input type="checkbox"/> | Frequent Urination           |
| <input type="checkbox"/> | <input type="checkbox"/> | Mid Back Pain            | <input type="checkbox"/> | <input type="checkbox"/> | Stroke                      | <input type="checkbox"/> | <input type="checkbox"/> | Smoking/Use Tobacco Products |
| <input type="checkbox"/> | <input type="checkbox"/> | Low Back Pain            | <input type="checkbox"/> | <input type="checkbox"/> | Angina                      | <input type="checkbox"/> | <input type="checkbox"/> | Drug/Alcohol Dependence      |
| <input type="checkbox"/> | <input type="checkbox"/> | Shoulder Pain            | <input type="checkbox"/> | <input type="checkbox"/> | Kidney Stones               | <input type="checkbox"/> | <input type="checkbox"/> | Allergies                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Elbow/Upper Arm Pain     | <input type="checkbox"/> | <input type="checkbox"/> | Kidney Disorders            | <input type="checkbox"/> | <input type="checkbox"/> | Depression                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Wrist Pain               | <input type="checkbox"/> | <input type="checkbox"/> | Bladder Infection           | <input type="checkbox"/> | <input type="checkbox"/> | Systemic Lupus               |
| <input type="checkbox"/> | <input type="checkbox"/> | Hand Pain                | <input type="checkbox"/> | <input type="checkbox"/> | Painful Urination           | <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Hip/Upper Leg Pain       | <input type="checkbox"/> | <input type="checkbox"/> | Loss of Bladder Control     | <input type="checkbox"/> | <input type="checkbox"/> | Dermatitis/Eczema/Rash       |
| <input type="checkbox"/> | <input type="checkbox"/> | Knee/Lower Leg Pain      | <input type="checkbox"/> | <input type="checkbox"/> | Prostate Problems           | <input type="checkbox"/> | <input type="checkbox"/> | HIV/AIDS                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Ankle/Foot Pain          | <input type="checkbox"/> | <input type="checkbox"/> | Abnormal Weight Gain/Loss   |                          |                          |                              |
| <input type="checkbox"/> | <input type="checkbox"/> | Jaw Pain                 | <input type="checkbox"/> | <input type="checkbox"/> | Loss of Appetite            |                          |                          |                              |
| <input type="checkbox"/> | <input type="checkbox"/> | Joint Swelling/Stiffness | <input type="checkbox"/> | <input type="checkbox"/> | Abdominal Pain              |                          |                          |                              |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis                | <input type="checkbox"/> | <input type="checkbox"/> | Ulcer                       |                          |                          |                              |
| <input type="checkbox"/> | <input type="checkbox"/> | Rheumatoid Arthritis     | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis                   |                          |                          |                              |
| <input type="checkbox"/> | <input type="checkbox"/> | General Fatigue          | <input type="checkbox"/> | <input type="checkbox"/> | Liver/Gall Bladder Disorder |                          |                          |                              |
| <input type="checkbox"/> | <input type="checkbox"/> | Muscular Incoordination  | <input type="checkbox"/> | <input type="checkbox"/> | Cancer                      |                          |                          |                              |
| <input type="checkbox"/> | <input type="checkbox"/> | Visual Disturbances      | <input type="checkbox"/> | <input type="checkbox"/> | Tumor                       |                          |                          |                              |
| <input type="checkbox"/> | <input type="checkbox"/> | Dizziness                | <input type="checkbox"/> | <input type="checkbox"/> | Asthma                      |                          |                          |                              |
|                          |                          |                          | <input type="checkbox"/> | <input type="checkbox"/> | Chronic Sinusitis           |                          |                          |                              |

### Females Only

|                          |                          |                      |
|--------------------------|--------------------------|----------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Birth Control Pills  |
| <input type="checkbox"/> | <input type="checkbox"/> | Hormonal Replacement |
| <input type="checkbox"/> | <input type="checkbox"/> | Pregnancy            |

### Other Health Problems/Issues

|                          |                          |
|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |

Indicate if an immediate family member has had any of the following:

Rheumatoid Arthritis  Heart Problems  Diabetes  Cancer  Lupus

List all prescription and over-the-counter medications, and nutritional/herbal supplements you are taking:

List all the surgical procedures you have had and times you have been hospitalized:

Patient Signature \_\_\_\_\_ Date 08/14/2019

Doctor's Additional Comments

Doctors Signature \_\_\_\_\_ Date 08/14/2019