APPLICATION FOR CARE AT SAN CARLOS CHIROPRACTIC, INC

Whom may we thank for referring you to this office? ______________________

Today's Date: ______________ HRN: ______________

PATIENT DEMOGRAPHICS

Name: ______________________ Birth Date: _____-_____-_____ Age: _______ ☐ Male ☐ Female

Address: ______________________ City: ______________________ State: _____ Zip: __________

E-mail Address: ______________________ Mobile Phone: ______________ Home Phone: ______________

Marital Status: ☐ Single ☐ Married Do you have Insurance: ☐ Yes ☐ No Work Phone: ______________

Social Security #: ______________________

Employer: ______________________ Occupation: ______________________

Spouse's Name ______________________ Spouse's Employer ______________________

Number of children and ages: ____

Name & Number of Emergency Contact: ______________ ______________ Relationship: ______________

HISTORY of COMPLAINT

Please identify the condition(s) that brought you to this office: Primary: ______________________

Secondary: ______________ Third: ______________ Fourth: ______________

On a scale of **1** to **10** with **10** being the worst pain and **zero** being no pain, rate your above complaints by ***circling the number***:

Primary or chief complaint is:	0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Second complaint is:	0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Third complaint is:	0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Fourth complaint is:	0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

When did the problem(s) begin? ______________ When is the problem at its worst? ☐ AM ☐ PM ☐ mid-day ☐ late PM

How long does it last? ☐ It is constant **OR** ☐ I experience it on and off during the day **OR** ☐ It comes and goes throughout the week

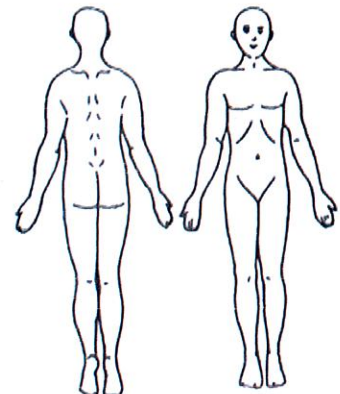
Is your problem the result of ANY type of accident? ☐ Yes, ☐ No How did the injury happen? ______________________

____

Has this condition(s) been treated by anyone in the past? ☐No ☐ Yes **If yes,** when: ______ by whom? ______________

How long were you under care: __________ What were the results? ______________________

Name of any **Previous Chiropractor**: ______________________ ☐ **N/A**



PLEASE MARK the areas on the Diagram with the following **letters** to describe your symptoms:
R = **R**adiating **B** = **B**urning **D** = **D**ull **A** = Aching **N** = **N**umbness **S** = **S**harp/**S**tabbing **T** = **T**ingling

What relieves your symptoms? ______________________

What makes your symptoms feel worse? ______________________

Identify any other injury(s) to your spine, minor or major, that the doctor should know about:

____

____

PAST HISTORY

Have you suffered with any of this or a similar problem in the past? ☐ No ☐ Yes **If yes,** how many times? _________ When was the last episode? ____________________ How did the injury happen? ______________________________

Have you tried other forms of treatment: ☐ No ☐ Yes **If yes,** please state **what** type of treatment: ________________________, and who provided it: ________________________ **How long ago?** _______What were the results. ☐ Favorable ☐ Unfavorable→ please explain. ____

PLEASE identify ALL PAST and any **CURRENT** conditions you feel may be contributing to your present problem:

	HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM
INJURIES →			
SURGERIES →			
CHILDHOOD DISEASES →			
ADULT DISEASES →			

Who is your **Primary Care Physician** (PCP) ? ____

Do you give permission for San Carlos Chiropractic to send reports and treatment plans to your PCP? ☐ Yes ☐ No

SOCIAL HISTORY

1. Smoking: ☐cigars ☐ pipe ☐ cigarettes How often? ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never
2. Alcoholic Beverage: consumption occurs ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never
3. Recreational Drug use: ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never
4. Hobbies -Recreational Activities- Exercise Regime: How does your present problem affect? (See ADL form)

FAMILY HISTORY:

1. Does anyone in your family suffer with the condition(s) you're here for today? ☐ No ☐ Yes
If yes whom: ☐ grandmother ☐ grandfather ☐ mother ☐ father ☐ sister(s) ☐ brother(s) ☐ son(s) ☐ daughter(s)
Have they ever been treated for their condition? ☐ No ☐ Yes ☐ I don't know

2. Any other hereditary conditions the doctor should be aware of? ☐ No ☐ Yes: ______________________________
____

Insurance Assignment of Benefits (N/A if no Health Insurance)

I hereby authorize payment to be made directly to **San Carlos Chiropractic, Inc** for all benefits which may be payable Under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to **San Carlos Chiropractic, Inc.** for any and all services I receive at this office.

________________________________ _____ - _____ - _____
Patient or Authorized Person's Signature **Date Completed**

________________________________ _____ - _____ - _____
Doctor's Signature **Date Form Reviewed**

PATIENT'S SIGNATURE: ________________________________ Date: ____________

GUARDIAN'S NAME: ________________________________

GUARDIAN'S SIGNATURE: ________________________________ Date: ____________

ACTIVITIES OF LIFE

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

ACTIVITIES:	EFFECT:			
Carry Children/Groceries	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sit to Stand	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Climb Stairs	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Pet Care	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Extended Computer Use	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Read/Concentrate	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Getting Dressed	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Shaving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sexual Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sleep	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sitting	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Yard work	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Washing/Bathing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sweeping/Vacuuming	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Dishes	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Laundry	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Garbage	☐ No Effect	☐ Painful (can do)	☐ Painful (limits	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Other: ____________	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform

List Prescription & Non-Prescription drugs you take: ____

____

____

Continued on next page

REVIEW OF SYSTEMS

Please mark **P** for in the **Past, C** for **Currently** have, or **N** for **Never**

___ Headache	___ Pregnant (Now)	___ Dizziness	___ Prostate Problems	___ Ulcers
___ Neck Pain	___ Frequent Colds/Flu	___ Loss of Balance	___ Impotence/Sexual Dysfun.	___ Heartburn
___ Jaw Pain, TMJ	___ Convulsions/Epilepsy	___ Fainting	___ Digestive Problems	___ Heart Problem
___ Shoulder Pain	___ Tremors	___ Double Vision	___ Colon Trouble	___ High Blood Pressure
___ Upper Back Pain	___ Chest Pain	___ Blurred Vision	___ Diarrhea/Constipation	___ Low Blood Pressure
___ Mid Back Pain	___ Pain w/Cough/Sneeze	___ Ringing in Ears	___ Menopausal Problems	___ Asthma
___ Low Back Pain	___ Foot or Knee Problems	___ Hearing Loss	___ Menstrual Problem	___ Difficulty Breathing
___ Hip Pain	___ Sinus/Drainage Problem	___ Depression	___ PMS	___ Lung Problems
___ Back Curvature	___ Swollen/Painful Joints	___ Irritable	___ Bed Wetting	___ Kidney Trouble
___ Scoliosis	___ Skin Problems	___ Mood Changes	___ Learning Disabilty	___ Gall Bladder Trouble
___ Numb/Tingling arms, hands, fingers		___ ADD/ADHD	___ Eating Disorder	___ Liver Trouble
___ Numb/Tingling legs, feet, toes		___ Allergies	___ Trouble Sleeping	___ Hepatitis (A,B,C)

Future Health/Wellbeing Concerns

The majority of the Top 10 health conditions our country struggles with are caused by our Lifestyle! Approximately 75% of our personal health and wellbeing is determined by what we do and don't do. Simply put, for the most part we are in control of our current and future health.

Our doctor(s) at San Carlos Chiropractic are eager to help you with your overall wellbeing!

Do you have any of the following health or wellbeing concerns for you and your family:

___ Weight Management	___ Sleep Disorder	___ Mood Swings	___ Other
___ Heart Disease	___ Proper Exercise	___ Allergies	______________
___ High Blood Pressure	___ Toxins	___ Balance Issues	______________
___ Diabetes	___ ADHD/Hyperactivity	___ Digestive Issues	______________
___ Cancer	___ Depression	___ Joint Pains	
___ Osteoarthritis	___ Proper Nutrition	___ Joint Mobility	
___ Circulatory Disease	___ Stress Management	___ Mobility Issues	

Patient signature: ______________________________ **Today's Date:** __/__/__

Informed Consent HRN_____

Regarding : Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, hold certain risk. While the risk are most often very minimal, in rare cases, complications such as sprain/ strain injuries, irritation of disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at **San Carlos Chiorpractic, Inc** have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do herby consent to treatment by any means, method, and our techniques, the doctor deems necessary to treat my condition at any time through the entire clinical course of my care.

____ Date ____/____/_____

Patient or Authorized Person's Signature

Cancelation Policy

Regarding: Chiropracitc

Please call our office **2 hours prior** to your appointment time to either cancel or reschedule your appointment. All patients will be granted one "grace" visit per month, in which no charge will be applied if you fail to comply. After not complying with the cancelation policy more than once per month a fee of $25 will be applied per visit in which you fail to comply. The $25 will be your responsibility at the next visit and or bill will be mailed. You may reschedule your appointment to a different time on the same day and if you keep that appointment the fee will not apply.

Regarding : Massage Therapy

Please call our office **1 Day prior** to your appointment time to either cancel or reschedule your appointment with our massage therapist. All patients will be granted one "grace" visit per month, in which no charge will be applied if you fail to comply with the policy. After not complying with the stated policy more than once per month you will be charged the full price of the massage ($40-70) per visit in which you fail to comply. The fee will be your responsibility at the next visit and or a bill will be mailed.

____ Date_____/____/______

Patient or Authorized Person's Signature

San Carlos Chiropractic, Inc, 19150 Acorn Rd #103 Ft.Myers, Fl 33967

239-267-3133 * Fax 239-267-8032 *www.DrGlenSchaffer.com

Medical Information Release HRN_______

(Hippa Release Form)

Name:____ Date of Birth_______________

Release of Information

( ) I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to :

( ) Spouse ___________________________________

( ) Children ___________________________________

( ) Parents ___________________________________

( ) Other ___________________________________

( ) Information is not to be released to anyone

This Release of Information will remain in effect until terminated by me in writing.

Messages:

Please call ( ) my cell/home # _______________________ ( ) my work # _______________________

If unable to reach me:

You may leave a detailed message ( )

Please leave a message asking me to return your call ( )

Best time to reach me is day ______________________ between times __________________________

Signed : ______________________________________ Date _______________________________

Employee Intial ______________ Date_______________________________

San Carlos Chiropractic,Inc 19150 Acorn Rd, # 103 Ft.Myers, Fl 33967 (239-267-3133)

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Employee Intial ______________ Date_______________________________

San Carlos Chiropractic,Inc 19150 Acorn Rd, # 103 Ft.Myers, Fl 33967 (239-267-3133)

San Carlos Chiropractic, Inc NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your **P**ersonal **H**ealth **I**nformation. 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 benefits 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 apprize 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 Alicia Zapata, Practice Administrator at 239-267-3133. 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

Patient initials: _________**-retaining *page 1 of 2***

SAN CARLOS CHIROPRACTIC, INC NOTICE REGARDING YOUR RIGHT TO PRIVACY continued...

I have received a copy of **San Carlos Chiropractic, Inc** 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.

______________________________ ______________ ______________
Patient's Name DOB HR#

______________________________ ______________
Patient's Signature Date

______________________________ ______________
Witness Date