Advanced Chiropractic Nutrition Center, P.A.
440 Third St., Suite A Neptune Beach, Florida 32266
(904) 249-5999, (904) 249-1768 (fax)

Confidential Patient Health Record

Personal Information:
Last:_____________________First:____________________Middle: ___________________
Sex: Male/Female Date of Birth: ____________ Age: _________________
Marital Status: [] Single [] Married [] Widowed [] Divorced [] Separated
Spouse Name:____________________Children's Names/Ages: _________________________
____
Address: ____ Apt#: ____
City:____________________________State:_________Zip: _____
Home Phone_______________Work Phone________________Cell Phone _______________
Email Address: _______________________________________
Employer:_________________Occupation:______________________Hrs/wk _____________
Job Duties % of time: Sitting:___Standing___Walking___Light Labor___Heavy Labor___

How did you hear about our office? Friend____Internet_____ Location ______Insurance Co. ___
Referral___ (Pls, let us know the name of the person that referred you) _____________________
Other?____

REQUEST FOR SPECIAL CONFIDENTIAL COMMUNICATIONS PROCEDURES:
I hereby request that Advanced Chiropractic Nutrition Center P.A. place all telephone calls and text messages to the following phone number: ____
Phone carrier (i.e Sprint, AT&T): ____
Can we send information to the address listed above? Yes or No
If no, pls list the address? ____

I understand that there may be a potential security risk of my personal health information if there is a security breach.

Due to possible security risks, I am opting out of reminds via text message and would rather be reminded via telephone. ______

Patient Signature: _____________________________________ Date: ______________

Parent/ Legal Guardian Signature: __________________________________

Emergency Contact:
Last:______________First:_____________ Middle: _____________Contact number: ______________
Address:____

Relationship to patient: [] Spouse [] Relative [] Friend [] other

Current Health Condition:
1. What is the chief complaint (what brought you in)? _________________________________
2. When did the discomfort start? _______________ Onset sudden or gradual? ____________
3. Is the condition [] Auto Related [] Job Related [] Home injury [] Slip or Fall [] Lifting [] Slept wrong [] Unknown cause [] Other:____
4. Since the problem began have the symptoms been getting worse or have they been relatively unchanged? ____
5. What aggravates the discomfort? ____

6. What relieves the discomfort? ____
7. Does it radiate into the arms, hands, buttocks or feet? If yes, explain: ________________________
8. How would you describe your discomfort? (circle all that apply) aching, burning, deep, dull, numb, sharp, stabbing, throbbing, tight, tingling. Other? ______________________________________
9. What is the severity? 1-10 with 10 being the worst? ____________________________________
10. When is the discomfort worse? ___Morning ___ Afternoon ___ Evening
11. Is the discomfort ____constant _____intermittent ____ varies
12. Have you had any prior interventions or treatments? ___________________________________
13. List any medications you are taking for this condition?_________________________________
14. Are they helping? Y or N
15. Do you suffer with any other condition that you would like us to look at? Y or N Explain: ____
16. Have you had any testing, i.e. MRI, X-ray or CT scan? Y or N If yes, where? ______________
17. Do you have any herniated discs or bulging discs? Y or N
18. What limitations do you have due to pain? ____

Family Physician: DR______________________________Last Seen: _______________________________
Treated for :____

Past Health History:
1. Have you seen other doctors for this condition? Y or N if yes, who? ____________________________
2. Type of Treatment: ____
3. Were you satisfied with the results of your treatment? Y or N? If no, explain ____
3. Previous Chiropractic Care: [] I have not previously seen a chiropractor
Doctor's Name: ___________ Location: ____________________ Date of your last visit? __________

Accidents or Injuries: [] No prior accident/ Injuries

1. What type of accident did you have? [] Auto [] Slip/Fall [] Work [] Motorcycle [] Other _______
2. When was the injury? __________
3. What injuries did you sustain? ________________
4. Have you ever had a litigated claim following an accident? Y or N
5. Did you receive a settlement? Y or N
6. Have you been rated with a permanent impairment rating following an accident? Y or N

Hospitalizations and dates:

____

____

Current Medications (List all): ____

Supplements (List all): ____

Allergies: Do you have any drug or food allergies? [] N [] Y
If yes, explain ____

Surgeries: [] None [] Appendectomy [] Back [] C-section [] Dental [] D&C [] Gallbladder [] Heart [] Hernia repair [] Neck [] Hysterectomy [] Joint replacement or repair (L or R) - knee, shoulder, hip or other ______________________________[] Laminectomy [] Mastectomy [] Rotator Cuff [] Skin Cancer [] Stomach [] Spinal Fusion [] Vasectomy [] Other Cancer
[]Other____

Females only: Ob/Gyn _______________________
Females: Any possibility of Pregnancy? Y or N (initials) _________
I [] currently have menses. [] currently do not have menses.
My menses are [] regular [] irregular
Date of last menses? _____________

Family History: List and family history of disease or illness:
____
____

Social History:
[] Cigarette/Cigar [] None [] Previous [] Current #packs/ day _____ #Yrs. ____________
Coffee: #Cups/day _______ Regular or Decaf
Tea: #cups/day ________
Alcohol: [] do not drink [] social consumption only [] drink the following [] beer [] liquor [] wine
Quantity of ____ oz. per [] day [] week [] month
Hobbies: _____________________________________ Stresses: _______________________

Review of Systems

These symptoms may seem un-related to the reason for your appointment, however, these questions must be answered carefully as the problems can affect your overall course of care.

Constitutional: [] None [] chills [] daytime drowsiness [] fatigue [] fever [] night sweats [] weight loss [] weight gain

Eye/ Vision: [] None [] blindness [] cataracts [] blurred vision [] change in vision [] double vision [] eye pain [] glaucoma [] itching [] tearing [] wear glasses/contacts [] other ___________________________

Ears, Nose & Throat: [] None [] bleeding [] denture [] difficulty swallowing [] discharge [] dizziness [] ear discharge [] ear pain [] fainting [] frequent sore throats [] headaches (major/minor/migraine) [] hearing loss [] history of head injury [] hoarseness [] loss of sense of smell [] nasal congestion [] nose bleeds [] sinus infection [] Tinnitus (ringing in ears) [] TMJ []
Other:____

Respiration: [] None [] Asthma [] Coughing up blood [] Cough [] Shortness of Breath [] Wheezing [] other ____

Cardiovascular: [] None [] Angina (chest pain or discomfort) [] heart murmur [] heart problems [] high blood pressure [] low blood pressure [] orthopnea (difficulty breathing lying down) [] Palpitations [] waking with shortness of breath [] Shortness of breath with exercise [] swelling of legs [] ulcers [] varicose veins. [] Other: ____

Gastrointestinal: [] None [] Abdominal Pain [] Belching [] Black-tarry stools [] Constipation [] Diarrhea [] Difficulty swallowing [] Heartburn [] Hemorrhoids [] Indigestion [] Jaundice [] Nausea [] Rectal bleeding [] Abnormal stool size or color [] Vomiting blood [] Other ______________________________

Female: [] None [] Birth control [] Breast lumps/pain [] Burning Urination [] Cramps
[] Frequent Urination [] Pregnancy [] Urine retention
[] Vaginal Bleeding [] Vaginal Discharge [] Other ____

Male: [] None [] Burning urination [] Erectile dysfunction [] Frequent urination [] Hesitancy/dribbling [] prostate problems [] urine retention
[] Other ____

Endocrine: [] None [] Cold intolerant [] Diabetes [] Excessive appetite [] Excessive hunger [] Excessive thirst [] Abnormal urination [] Goiter [] Hair loss [] Heat Intolerance [] Unusual hair growth [] Voice Changes[]Other:____

Skin: [] None [] Changes in nail color [] Changes in skin color [] Hair growth [] Hair loss [] Hives [] History of skin disorders [] Itching [] Parenthesis [] Rash [] Skin/lesions [] Varicosities [] Other
____

Nervous System: [] none [] Dizziness [] Strokes [] Facial weakness [] Headache [] Limb weakness [] Loss of memory [] Numbness [] Seizures [] Slurred Speech [] Tremor [] Unsteadiness of gait/ loss of balance [] Other:____

Psychological: [] None [] Anxiety [] Insomnia[] Behavioral change [] Bi-polar disorder [] Convulsions [] Depression [] Other____

Hematologic: [] None [] Anemia [] Bleeding [] Blood clotting [] Blood Transfusion [] Bruising [] Fatigue [] Lymph node swelling [] Other ____

RECEIPT OF NOTICE OF PRIVACY PRACTICES:

My signature below indicates that I have received and/or reviewed a copy of my Notice of Privacy Practices. I have also been given the option of signing a separate Patient Consent Form. I understand that this form will be placed in my patient chart and maintained for six years.
Patient Signature: ____________________________________ ______ Date: ___________________

Parent/ Legal Guardian Signature: ____

ACCOUNTING OF DISCLOSURES:

By signing below, I authorize any holder of medical or other information about me to release to the above insurance company any information needed for this or a related insurance claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to either myself or the party who accepts assignment. I authorize Advanced Chiropractic Nutrition Center to provide any and all information to the above-named insurance companies to obtain payment for the evaluation and treatment provided.
Patient Signature: ____________________________________ ______ Date: ____________________

Parent/ Legal Guardian Signature: ____

Payment Options:

[ ] Self Pay

[ ] You have insurance, but do not want your insurance billed. You would prefer to pay out of pocket**.**

[ ] You would like to use your insurance (please fill out below).

Filing insurance is a courtesy that our office provides. You are responsible for any insurance denials, copays and deductibles.

Payment is made at the end of each of visit but this amount is subject to change if the insurance company explanation of benefits is different.

Insurance Information- Primary
Insurance Carrier: ___________________________ Pol Holder Name: __________________________
Member ID #: _____________________________ Group #: __________________________
Policy Holders Social Security # _____ -____-______ Date of birth: _____/______/_____

Insurance Information- Secondary
Insurance Carrier: _____________________ Pol Holder Name: ____________________________
Member ID #: ______________________________ Group #: _____________________
Policy Holders Social Security # _____ -____-______ Date of birth: _____/______/____

PATIENT PAYMENT RESPONSIBILITIES:

I understand that if I am uninsured or have an insurance that is not accepted at the practice, that I will be responsible for payment in full at the time of service. I understand that insurance copays, deductibles, co-insurance and charges not filed with insurance are due at the time of services. Failure to make payment when requested is a basis for legal action, and the undersigned agrees to pay all cost for collections, including a reasonable fee, and hereby waives his/her rights of exemption under the laws of State of Florida and any other state. I understand that I will be responsible for ANY charges that are not paid by my insurance company. I understand that it is my responsibility to know the limits of my coverage and to pay any fees that my insurance company denies. (As a service to you, our staff will bill your insurance carrier, but if you do not pay your balance in a timely fashion, we will ask that you pay in full at your visits and file on your own claims.) I understand that procedures may fall under major medical; therefore, I will be responsible for paying the deductible amount at the time of service. The patient also agrees to pay all cost of collections, legal cost, attorney fees and 1 ½% interest monthly in the event the Patient's account balance becomes delinquent.

Patient Signature: ____ Date: _______________Parent/

Legal Guardian Signature: _____________________________________