Health History

Patient Name: _____ DOB:_____ Date:_____

Chief Complaint:_____

History of Present illness:

Location:

_____**Quality**:_____

(Where is the pain/problem?) (Example: normal vs abnormal color, activity, etc..)

Severity: _____ **Duration:** _____

(How severe is the pain/problem on a scale of 1-5 with 5 being the most severe?)

(How long have you had this pain/ problem? When did it start?)

Timing: _____ **Context:** _____

(Does the pain/problem occur at a specific time?) (Where were you at the onset of this pain/problem?)

Associated Signs/Symptoms _____ **Modifying Factors**_____

_____ _____

(What other associated problems have you been having?)

(What makes the pain/problem worse or better? Have you had previous episodes?)

Past Medical History

(Have you ever had the following: (circle "yes" or "no"/ leave blank if you are uncertain.)

Measles…… NO YES Anemia……..NO YES Back Trouble…….NO YES
Hepatitis…….NO YES Mumps……. NO YES Bladder Infection…….NO YES
High Blood Pressure……NO YES Ulcer……NO YES Chicken Pox…… NO YES
Epilepsy…….NO YES Low Blood Pressure…….NO YES Kidney Disease……NO YES
Whooping Cough… NO YES Migraine Headaches. NO YES Hemorrhoids…….NO YES
Thyroid Disease……NO YES Scarlet Fever……. NO YES Tuberculosis……..NO YES
Date of Last Chest X-Ray_____ Bleeding Tendency…….NO YES Diphtheria…… NO YES
Diabetes……..NO YES Asthma……..NO YES Any Other Disease…….NO YES
Small pox……. NO YES Cancer……..NO YES Hives of Eczema……..NO YES
(Please List): Pneumonia……. NO YES Polio……NO YES
AIDS & HIV……NO YES Rheumatic Fever… NO YES Glaucoma……NO YES
Infectious Mono……NO YES _____ Arthritis……. NO YES
Hernia……NO YES Bronchitis……..NO YES Venereal Disease… NO YES
Blood or Plasma Mitral Valve Prolepses….NO YES
_____ Transfusion……..NO YES Stroke……NO YES

Previous Hospitalizations/Surgeries/Serious Illnesses	When?	Hospital, City, State
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medication: (include nonprescription)

_____

_____

Have you ever taken Fen-Phen/Redux? NO YES
Are you taking any medications (prescription or over the counter) for acid indigestion? O yes O no
if yes what type: _____

Allergies:

_____

_____

Patient Social History:

Marital Status Single: _____ Married: _____ Separated: _____ Divorced: _____ Widowed: _____
Use of Alcohol Never: _____ Rarely: _____ Moderate: _____ Daily: _____
Use of Tobacco Never: _____ Rarely: _____ Moderate: _____ Daily: _____
Use of Drugs Never: _____ Type/Frequency: _____
Excessive Exposure At home or at work to: Fumes: _____ Dust: _____ Solvents: _____
Airborne Particles: _____ Noise: _____

CLINICIAN SIGNATURE: _____ DATE REVIEWED:_____

PATIENT NAME: _____DATE:_____

Name:_____ DOB _____ Date:_____

Family Medical History:

	Age	Disease	If Deceased, Cause Of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Spouse:	_____	_____	_____
Children:	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Indicate which of the below you have experienced in the last 1-2 months
1=Never; 2=Rarely; 3=Occasionally; 4=Frequently; 5=Constantly

Eyes/Ears/Nose/Throat/Respiratory

Asthma	1 2 3 4 5
Stuffy Nose	1 2 3 4 5
Hay Fever	1 2 3 4 5
Sore throat	1 2 3 4 5
Chronic Cough	1 2 3 4 5
Chest Congestion	1 2 3 4 5
Frequent Sneezing	1 2 3 4 5
Itchy/Watery Eyes	1 2 3 4 5
Drainage	1 2 3 4 5
Earache / Ear Infection	1 2 3 4 5
Itching	1 2 3 4 5
Hoarseness	1 2 3 4 5
Shortness of Breath	1 2 3 4 5
Wheezing	1 2 3 4 5

Muscular/Skeletal

Muscle Aches	1 2 3 4 5
Fibromyalgia	1 2 3 4 5
Arthritis	1 2 3 4 5
Joint Pain	1 2 3 4 5
Low Back Pain	1 2 3 4 5
Neck Pain	1 2 3 4 5
Wrist/Hand Pain	1 2 3 4 5
Elbow Pain	1 2 3 4 5
Shoulder Pain	1 2 3 4 5
Hip Pain	1 2 3 4 5
Knee Pain	1 2 3 4 5
Ankle/Foot Pain	1 2 3 4 5
Pain b/t shoulder blades	1 2 3 4 5

Neurological

Headaches	1 2 3 4 5
Migraines	1 2 3 4 5
Dizziness	1 2 3 4 5
Numbness	1 2 3 4 5
Tingling	1 2 3 4 5
Pins/needles in hands or feet	1 2 3 4 5

General

Fatigue	1 2 3 4 5
Malaise	1 2 3 4 5
Weakness, tiredness	1 2 3 4 5
Lightheadedness	1 2 3 4 5
Irritability	1 2 3 4 5
Constipation	1 2 3 4 5
Diarrhea	1 2 3 4 5
Feeling foggy	1 2 3 4 5
Forgetfulness	1 2 3 4 5

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

_____ _____

Signature of the Patient, Parent or Guardian Date

Doctor's Review _____ _____

Signature of Doctor Date

NEUROLOGICAL AND VASCULAR PATIENT QUESTIONNAIRE

NAME:_____ DATE:_____

For any YES answer, please notify the Doctor.

1. Do you suffer from neck pain with pain in your shoulder, arms or hands? NO YES
Comment:_____

2. Do you have weakness, numbness or burning in your shoulder, arms or hands? NO YES
Comment:_____

3. Do your hands or arms fall asleep regularly? NO YES
Comment:_____

4. Do you have reduced feeling (sensation) or swelling in your hands or arms? NO YES
Comment:_____

5. Do you suffer from a loss of handgrip strength? NO YES
Comment:_____

6. Do you suffer from back pain with pain in your buttocks, legs or feet? NO YES
Comment:_____

7. Do you have weakness, numbness or burning in your buttocks, legs or feet? NO YES
Comment: _____

8. Do your legs or feet fall asleep regularly? NO YES
Comment:_____

9. Do you have reduced feeling (sensation) or swellings in your legs, feet? NO YES
Comment:_____

10. Do you suffer from cold hands or feet? NO YES
Comment:_____

11. Do you suffer from headaches, dizziness or memory loss? NO YES
Comment:_____

12. Do you have difficulty maintaining your balance? NO YES
Comment:_____

13. Do you suffer from vertigo or blurred vision? NO YES
Comment:_____

14. Do you suffer from a reduced hearing capacity? NO YES
Comment:_____

15. Do you suffer from ringing in your ears? NO YES
Comment:_____

16. Do you have bladder or bowel control problems on a regular basis? NO YES
Comment:_____

Patient Name_____ Date: _____ Email: _____

SS #/SIN_____ DOB_____ □ Male □ Female
Home phone_____ Cell Phone _____
Check appropriate Box: □ Minor □ Single □ Married □ Divorced □ Widowed □ Separated
Race □ White □ Black □ Asian □ Other_____ Ethnicity □ Hispanic □ Non-Hispanic
Patient's Address _____City _____ State_____
Zip_____ Employer Name: _____
Spouse or Patient's Guardian name_____
Spouse's Employer_____
Whom may we thank for referring you? _____
Person to contact in case of an emergency_____
Phone_____

In case of a medical emergency, if the patient is of school age 15+, is ok to treat in my absence.

_____ _____
Parent or Guardian Date

Responsible Party
Name of The Person responsible for this account _____Relationship to Patient _____
Address _____
Home Phone _____ E-Mail _____
Cell Phone _____ Driver's License # _____
Date of Birth: _____ Is the person currently a patient at our office? □ Yes □ No

Do you have any Medical insurance? □ Yes □ No
if yes, complete the following: Name of the insured_____
Relationship to patient_____ Birthdate_____
SS#/SIN_____ Name of Employer_____ Work Phone _____
Address of Employer_____ State _____
Zip_____ Insurance Company_____
Group #_____ Union or local # _____
Ins. Co. Address _____ City _____ State _____
Zip_____

ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS
AS WELL AS AN APPOINTMENT AND/OR DESIGNATION AS MY PERSONAL REPRESENTATIVE AND AN ERISA/PPACA REPRESENTATIVE AND BENEFICIARY

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay BAY AREA HEALTHCARE, INC/BAY AREA WELLNESS CENTER, INC as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided. I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that have been or will be rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under. I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same. I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment, appointment, and designation will remain in effect unless revoked by me in writing. It is my intent that the effective date of this document shall relate back to include all services, supplies, test, treatments, or medications that have been previously provided by Healthcare Provider. A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

Signed this _____ day of _____, 20 ____. X_____ (SEAL)
(patient signature)

X_____(SEAL) X_____
(signature of Guardian if applicable) (please print patient name)

Medical Information Release Form (HIPAA Release Form)

Full 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_____
[ ] Child(ren)_____
[ ] Other_____
[ ] 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 home:_____
[ ] my work:_____
[ ] my cell number:_____

Are we authorized to text you to remind you of appointments?
[ ] YES
[ ] NO

If unable to reach me:
[ ] you may leave a detailed message
[ ] please leave a message asking me to return your call
[ ] _____

The best time to reach me is (day)_____ between (time)_____

Signed: _____ Date: ____/____/_____
Witness:_____ Date: ___/____/_____

HIPAA PRIVACY POLICY PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health insurance portability and accountability act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (i.e. my insurance company)
- The day to day healthcare operation of your practice

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you and anytime to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and healthcare operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at anytime. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this _____ day of _____, 20____.

Print Patient Name: _____Relationship to Patient:_____

Signature:_____

Bay Area Wellness Center, Inc / Bay Area Healthcare, Inc 3600 1st Avenue North Saint Petersburg, Florida 33713

Release of Patient Records Authorization

I hereby authorize _____

To release a copy of my patient records, including any XRAY reports, containing protected health information to:

Bay Area Wellness Center, Inc / Bay Area Healthcare, Inc
3600 1 st Ave N. St. Petersburg, FL 33713

Phone: (727) 327 – 4522 Fax: (727) 327 – 8069

This authorization is given pursuant to Florida Statute 456.057 and HIPAA regulations. I understand that Florida Statute 456.057(10) makes it clear that any third party to whom records are disclosed is prohibited from further disclosing any information in the medical records without the expressed written consent of the patient or the patient's legal records without the expressed written consent of the patient or the patient's legal representative.

_____
Patient's Signature or Patient's Legal Representative's Signature

_____
Patient's Printed Name

_____
Patient's Date of Birth

_____
Date Signed

Specific description of information to be disclosed:
_____
_____
_____

BAY AREA HEALTHCARE, INC
BAY AREA WELLNESS CENTER, INC

I hereby request and consent to the performance of chiropractic manipulation and manual therapy techniques and other chiropractic procedures, including various modes of physical therapeutic modalities and procedures and diagnostic X-rays, where warranted, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below.

I have had an opportunity to discuss with the doctor of chiropractic named below the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment and diagnostic services including but not limited to:

Manipulation: increased pain or discomfort, fractures, disc injuries, strokes, dislocations and sprains.

Therapeutic Modalities and procedures: additional pain and discomfort. Endurance exercise may cause increased risk of acute Myocardial Infarction (heart attack) in patients with known or possible cardiac conditions.

Radiographs: ionizing radiation can be harmful to a fetus for those who are pregnant or might be pregnant.

I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest. The doctor named below has additionally explained the risks associated with my refusal of treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) f)or which I seek treatment.

Patient/Guardian Signature_____ Date _____

Doctor Signature _____ Date_____