Patient Name:________________________________ Age:______ Sex:_____ Today's Date:______________________

Address: ____ City:_________________ State:____ Zip:____________

Are Text Reminders ok?________ Cell Phone: ___________________________ Date of Birth:_________________

Emergency Contact:___________________ Contact Number:________________ Relationship:___________________

I will be paying today by: __Cash __Check __Credit Card

Email:____Occupation:___________________________________

Previous Chiropractic Treatment? Y / N Name of Previous Chiropractor:_____________________________________

Last Chiropractic Treatment? ___________________ Primary Care Physician: __________________________________

***Referred by** (friend, coworker, physician, family member)?* ____

What type of care are you interested in? ☐ Pain relief only ☐ Healing condition ☐ Optimizing your health

What is your **long term goal** from treatment (ex. play round of golf):____

Is today's visit due to a work related injury? Yes / No Is today's visit due to an auto accident? Yes / No

(If yes to either question above, check with the receptionist, additional information is needed.)

Date of Injury______________________________

Patient Signature_____________________________________

(Primary Insurance Carrier)____ Phone:_________________________

Claims Address: ________________________________ City:____________________ State: ________ Zip:___________

ID Number:____ Group Number:__________________________________

Insured:________________________ Dob:______________________ Relation: ______________________________

- For Office Use Only-

	☐ In Network	☐ Out Network
Effective Date:	___/___/_____	___/___/_____
Deductible:	$___________	$___________
Remaining:	$___________	$___________
Co-Insurance:	$___________	$___________
Co-Pay:	$___________	$___________
$ Max Allowable/yr	$___________	$___________
Max Visits/yr	___visits	___remaining

Modalities Per Visit:

w/ CMT: ____ 29200:__________

97140________ Performed by LMT Under Chiro Supervision?

97810___________ Acupuncture

E0730________ TENS

L3020____________ Orthotics

E0855________ C/S traction

L0627____________ L/S Brace

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North Tampa Spine & Joint Center

Chief Complaint____

When did symptoms begin?___________________________ Have you had this problem before?__________________

Was the Onset: ☐ Gradual ☐ Sudden Since its Onset, has it gotten: ☐ Worse ☐ Better

Describe what caused the pain:____

Have you detected any possible relationship of your current complaint with any of the following?

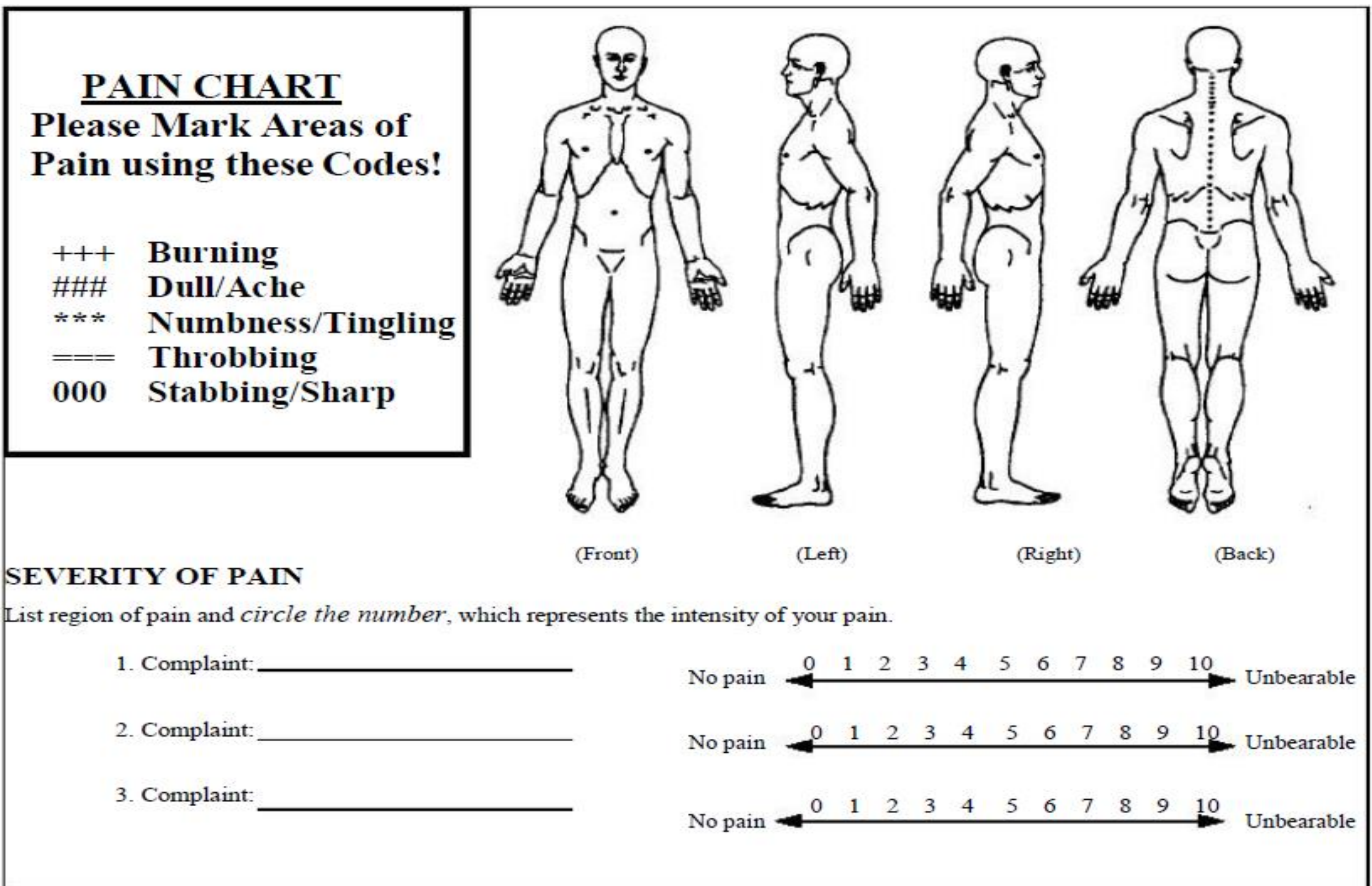
☐Muscle Weakness ☐Bowel/Bladder problems ☐Digestion ☐Cardiac/Respiratory ☐Other:_______________

Have you tried any self-treatment or taken any medication (over the counter or prescription)? ☐Yes ☐No

If Yes, Explain:____ Results:_____________________________________

List Medications:____

Currently Pregnant? ☐Yes ☐No Are you currently taking anti-coagulant or blood thinning meds? ☐Yes ☐No



Patient Signature_______________________ Date_______________

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PAST HEALTH HISTORY: would you say your health is (check one): □Excellent □Very Good □Good □Fair □Poor

1. Have you ever experienced your present problem before for which you are consulting us: ☐Yes ☐No

   If yes, When:________. Was treatment provided? ☐Yes ☐No If yes, by whom:____________________

2. Have you ever had a stroke or issues with blood clotting? ☐Yes ☐No If yes, when:____________________

3. Have you recently experienced dizziness, unexplained fatigue, weight loss, or blood loss? ☐Yes ☐No

4. Have you ever had any major illnesses, injuries, broken bones, hospitalizations, accidents, or surgeries? ☐Yes ☐No

Date	Injury/Fracture/Illness/Surgery	Treatment	Results

SOCIAL HISTORY

Recreational Activities (Hobbies):____

□Yes □No Do you exercise?__________ times per week.

□Yes □No Do you smoke?___________packs per day.

□Yes □No Do you consume alcohol? How many drinks per week?________________________________

□Yes □No Do you use tobacco? What/How much per day?____________________________________

□Yes □No Do you get adequate sleep? If no, Explain:______________________________________

□Yes □No Is your life stressful? If yes, Explain:____

□Yes □No Do you use recreational drugs? If yes, Explain:__________________________________

Do you or have you ever had any problems with the following areas? (please mark **Y** or **N** in each of the following:)

Please explain any (yes) answers in space below:

1. _____Eyes
2. _____Ears, Nose, Mouth, Throat
3. _____Heart
4. _____Lungs/Breathing
5. _____Digestion/Bowels
6. _____Urinary
7. _____Muscles Pain or weakness
8. _____Nerves
9. _____Joints/Bones
10. _____Skin
11. _____Internal Organs
12. _____Blood
13. _____Allergies

____
____
____
____
____
____

Family Health History (indicate which family member)

□ Heart Disease________________________________ □ Cancer________________________________

□ Diabetes____________________________________ □ Arthritis_______________________________

□ Other ______________________________________

Patient Signature______________________ Date______________

ACKNOWLEDGMENT 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.

*DO NOT SIGN UNTIL YOU HAVE REVIEWED THE LAMINATED COPIES GIVEN WITH PACKET!

____________________ Patient Signature(please print) Date__________________

____________________(if a minor) Parent, Guardian or Patients Legal Representative

____________________Signature Date__________________

Informed Consent

I have read or had read to the Informed Consent to treat, alternative treatments, and treatment results of a chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING I have made my decision voluntarily and freely.
*DO NOT SIGN UNTIL YOU HAVE REVIEWED THE LAMINATED COPIES GIVEN WITH PACKET!

____________________ Signature of Patient Date__________________

____________________Signature of Parent or Guardian Date__________________

AUTHORIZATION AND ASSIGNMENT & OFFICE POLICIES

I acknowledge that I have read and agree to the Authorization and Assignment. I understand it is my duty to pay all debts in full to North Tampa Spine & Joint Center.
*DO NOT SIGN UNTIL YOU HAVE REVIEWED THE LAMINATED COPIES GIVEN WITH PACKET!

____________________ Signature of Patient Date__________________

____________________Signature of Parent or Guardian Date__________________