CONDE CENTER

Welcome to our office!

Please fill out our Health Record as completely and accurate as possible. If you have any questions, please don't hesitate to ask one of our qualified Chiropractic Assistants.
It is our pleasure to be of service to you. Our commitment to you is to promote the highest quality of health and well-being with Chiropractic care.

About this Patient

First Name _____ **Last Name** _____

Street Address _____

Birthday _____ **Social Security #** _____

City _____ **State/Province** _____ **Zip Code** _____

Phone _____ **Email** _____

Gender
◯ Male ◯ Female ◯ Other

Marital Status
◯ Married ◯ Single

Who may we thank for referring you? _____ **Who is your primary care doctor?** _____

Employer Information

Employer _____

Work Address _____

Work City | **Work State** | **Work Zip**

Work Phone | **Type of Work**

My Health Insurance

Insurance Company

Policy # | **Group #**

Secondary Insurance Company Name

Policy # | **Group #**

About The Insured Person

First Name | **Last Name**

Date of Birth | **Relation**

Emergency Contact

First Name | **Last Name**

Relationship | **Phone**

Initial Consultation Form

Primary Complaint (s):

Where did this injury take place?

- [ ] Home
- [ ] Work
- [ ] Auto Accident
- [ ] Other

If other, please explain

When did this condition begin?

_____

Has this condition

◯ Gotten worse ◯ Stayed Constant ◯ Comes and goes

Does this condition interfere with

☐ Work ☐ Sleep
☐ Daily Routine ☐ Other activities

How long has this problem been present?

☐ Days ☐ Weeks
☐ Months ☐ Years

Has this condition occurred before?

◯ Yes ◯ No

Explain

_____

Have you seen other doctors for this condition?

◯ No ◯ Yes

Doctor's Name (s)

_____

Type of Treatment

_____

Diagnostics: Please list any previous diagnostic test given for the current complaints. (Imaging, Bloodwork)

_____

Overall frequency of complaint (choose one)

◯ Constant - 100% of the time ◯ Frequent - 75%
◯ Intermittent - 50% ◯ Occasional - 25%

Overall intensity of complaint (choose one)

◯ Minimal (An annoyance but has no effect on activity) ◯ Slight (Tolerable with some impairment to activity)
◯ Moderate (Tolerable with marked impairment of activity) ◯ Severe (Intolerable and cannot perform any activities)

Is this problem affecting any other area of your body? If yes, please explain:

_____

Does it interfere with your normal daily activities (Family, recreation, sports)?

_____

Does your symptoms increase while performing your normal work duties?

◯ Yes ◯ No

If yes, please select the amount below that you feel your symptoms increase at work:

◯ 0% ◯ 10% ◯ 20%
◯ 30% ◯ 40% ◯ 50%
◯ 60% ◯ 70% ◯ 80%
◯ 90% ◯ 100%

What aggravates the problem?

_____

What relives the problem?

_____

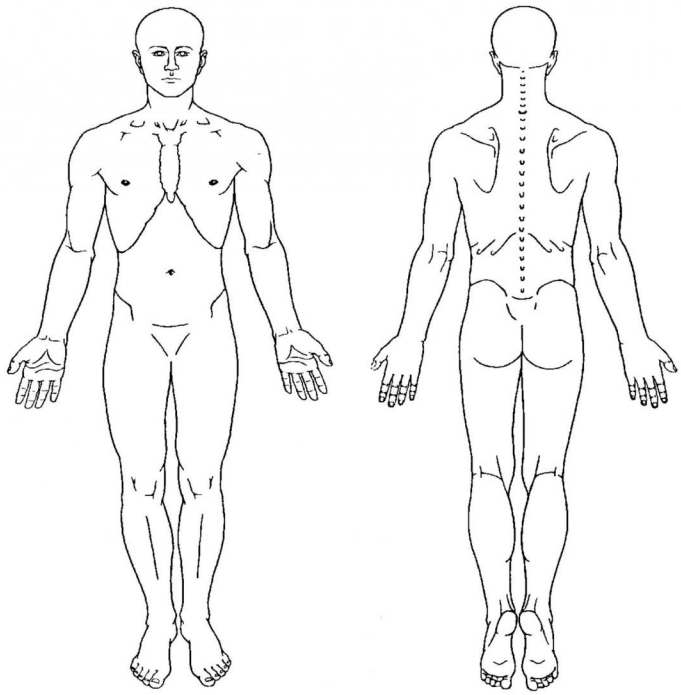
If this problem went without being taken care of, how do you think it would affect you?

_____

On the diagram, please mark the following symptoms, if they apply:

"//" for stabbing pain
"N" on/in areas where you have numbness
"B" for burning pain
"T" in areas where you have tingling
"A" for aching pain
"Sw" in areas where you have swelling
"W" for weakness
"C" in areas where you have cramps
"St" in areas where you feel stiffness
"IM" for tremor/involuntary movements

Mark your Pain Point



Health Habits

Medications? If you are currently taking any, please list them.

Please list any vitamin supplements you are currently taking

Do you have any known food or drug allergies?

Do you smoke?
◯ Yes ◯ No

Do you drink alcohol?
◯ Yes ◯ No

Do you drink coffee?
◯ Yes ◯ No

Do you exercise regularly?
◯ Daily ◯ Moderately ◯ No

Do you wear:
☐ Heel lifts ☐ Sole Lifts
☐ Inner Soles ☐ Arch Supports

Health Conditions

Please check each of the diseases or conditions that you have had now or in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan and the possibility of being accepted for care.

Health Conditions:

- ☐ Severe or Frequent Headaches
- ☐ Loss of Sleep
- ☐ Frequent Neck Pain
- ☐ Digestive Problems
- ☐ Thyroid Problems
- ☐ Heart Surgery/Pacemaker
- ☐ Difficulty Breathing
- ☐ Arthritis
- ☐ HIV/AIDS
- ☐ Shingles
- ☐ Autoimmune Disorder
- ☐ Depression
- ☐ Metal Implants
- ☐ Osteoporosis
- ☐ Seizures
- ☐ Vision Problems
- ☐ Weight Gain/Loss
- ☐ Weakness
- ☐ Sinus Problems
- ☐ Hepatitis
- ☐ Numbness or Pain in Arms/Legs/Hands
- ☐ Ulcers/Colitis
- ☐ Kidney Problems
- ☐ High/Low Blood Pressure
- ☐ Rheumatic Fever
- ☐ Alcohol/Drug Abuse
- ☐ Diabetes
- ☐ Chemotherapy
- ☐ Cardiac Pacemaker
- ☐ Fibromyalgia
- ☐ MRSA
- ☐ Parkinsons
- ☐ Smoking
- ☐ Fever/Sweats/Chills
- ☐ Sleep Apnea
- ☐ Numbness/Tingling
- ☐ Cancer
- ☐ Pain Between the Shoulders
- ☐ Lower Back Problems
- ☐ Heart Attack/Stroke
- ☐ Congenital Heart Detect
- ☐ Psychiatric Problems
- ☐ Asthma
- ☐ Venereal Disease
- ☐ Tuberculosis
- ☐ Anemia
- ☐ Dizzy Spells
- ☐ Emphysema/Bronchitis
- ☐ Multiple Sclerosis
- ☐ Rheumatoid Arthritis
- ☐ Thyoid Disease
- ☐ Nausea or Vomiting
- ☐ Fatigue

FOR WOMEN ONLY:

Is there any chance that you are pregnant?

◯ Yes ◯ No

Date of last menstrual period

_____

Experience with Chiropractic

Have you been adjusted by a chiropractor before?

◯ Yes ◯ No

Approximate date of last visit?

_____

Reason for those visits?

_____

Goals for my Care

People see Chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of their pain, and others for correction of whatever is malfunctioning in their bodies. Your Doctor will weigh your needs and desires when recommending your treatment program.

Please check the type of care desired so that we may be guided by your wishes whenever possible.

Relief Care: Symptomatic relief of pain or discomfort

☐ Yes

Corrective Care: Correcting and relieving the cause of the problem as well as the symptoms

☐ Yes

Comprehensive Care: Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic care.

☐ Yes

Missed Appointments

We strive to provide you with the utmost professionalism and excellence of service. Our commitment to your well-being and health is something we take seriously.

We care about you and realize it would be a disservice to you if we did not emphasize the importance of your own commitment to the care you need and to the actions we recommend to you.

- Your faithfulness to the recommended number of adjustments is key to ensuring optimum results.
- With the exception of emergencies, it is vital that you keep all your appointments. Reminder cards are provided to help you save the date. If you need to re-schedule an appointment, please call our office and arrange for a make-up appointment. We would prefer the make up appointment to be within the same week.
- In the instance of a no show without notice by phone 24 hours prior to your appointment time we reserve the right to charge you a $50.00 fee.

Thank you for your understanding. We greatly appreciate you as our patient and strongly desire excellent results and success for you!

Assignment of Benefits, Release of Information, and Reimbursement Policy Conde Center, 401 W Atlantic Ave, #014, Delray Beach, FL 33444

Authorization for Release of Information
I authorize the release of any medical information necessary to process my insurance claims.
Authorization of Assignment
I authorize payment of medical benefits to the Conde Center For Chiropractic Neurology for services rendered to me.
Reimbursement Policy
We often do not know exactly what your insurance company will pay us for covered or non-covered services until we receive payment. Either way, we usually accept their payment after any deductible, co-payment, and co-insurance is handled. Please understand that your insurance is an agreement between you and your insurance company and all services rendered to you are ultimately your responsibility.

Signature

Date Signed

_____

Printed Name

_____

Email

_____

Acknowledgement of HIPPA Privacy Practices:

Federal law requires that we seek your acknowledgement if the Notice of Privacy Practices. Please complete below.
I acknowledge that I have received this Notice of Privacy Practices and that I understand that if I have any questions regarding this notice I may contact the Privacy Officer.

Signature **Date Signed**

Printed Name **Email**

In addition, I authorize the Conde Center For Chiropractic Neurology to discuss my chiropractic/neurology treatment needs with:

Name: **Relationship to Patient**

Patient Consent For Use and/or Disclosure of Protected Health Information to carry out treatment, payment and healthcare operations

1. The Practice's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and had encouraged me to read the Privacy Notice carefully prior to signing this Consent.
2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
3. I understand that, and consent to the following appointment reminders that will be used by the Practice: a) a postcard mailed to me at the address provided by me; and b) telephoning the number provided by me and leaving a message on my answering machine or with the individual answering the phone.
4. The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.
5. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment, and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.
6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.
7. I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.
8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

Signature **Date Signed**

Printed Name **Email**