CONDE CENTER

Welcome to our office!

Please fill out our Health Record as completely and accurate as possible. We cannot process your insurance claims without the required fields.
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.

About this Patient

First Name _____ **Last Name** _____

Birthdate (mm/dd/yyyy) _____ **Social Security #** _____

Phone # _____ **Email** _____

Gender
◯ Male ◯ Female ◯ Other

Marital Status
◯ Married ◯ Single

Street Address _____

City _____ **State Abbreviation (FL)** _____ **Zip Code** _____

Who may we thank for referring you? _____

Who is your primary care doctor? _____ **Primary Care Doctor Phone Number** _____

Do you have an attorney?
◯ Yes ◯ No

Attorney's Name _____ **Attorney's Phone #** _____

My Insurance

Primary Auto Insurance Company Name

Policy #

Claim #

Relationship to Patient

Policy Holder's Name (if not patient)

Policy Holder's Date of Birth

Gender of Policy Holder

◯ Male ◯ Female

Secondary Insurance Company Name

Policy #

Group #

Relationship to Patient

Policy Holder's Name (if not patient)

Policy Holder's Date of Birth

Gender of Policy Holder

◯ Male ◯ Female

Emergency Contact

First Name

Last Name

Relationship

Phone

Initial Consultation Form

A complete medical history is necessary for a thorough evaluation. Please answer the following to the best of your ability.

Date of Accident

Where did the accident occur?

Were you restrained by a seatbelt?

◯ Yes ◯ No

What was your position in the vehicle?

◯ Driver ◯ Front Passenger
◯ Backseat passenger

Make/Model/Year of your vehicle

What type of vehicle struck your car/truck?

Where did it impact your vehicle?

Where was the tip of the headrest positioned in relation to the top of your head?

Do you recall how far your headrest was from the back of your head?

◯ Yes ◯ No

If yes, explain

Where was your head facing when the collision occurred?

If your car was standing still at the point of impact, where were your feet?

Approximately how far did your car move after being struck? (feet)

Did police arrive to the scene?

Did airbags deploy?

Were you taken to the hospital?

◯ Yes ◯ No

If yes, what was your use of transportation?

If yes, what is the name of the hospital?

What was your form of transportation leaving the hospital?

How long after the accident did you arrive at the hospital?

Were X-Rays or other imaging procedures performed?

◯ Yes ◯ No

If yes, please explain

Did you receive treatment or any prescription/medications at the hospital?

◯ Yes ◯ No

If yes, please explain

Have you ever been involved in a motor vehicle accident before?

◯ Yes ◯ No

If yes, when & where did the accident(s) occur?

If yes, who did you see for care?

Were you aware of the collision as it occured?

◯ Yes ◯ No

Did you lose consciousness at any point during or after the collision?

◯ Yes ◯ No

Were you ejected form the vehicle?

◯ Yes ◯ No

Did any part of your body strike the interior of your vehicle?

◯ Yes

Did you suffer any bruises, cuts or broken bones from the collision?

◯ Yes ◯ No

If yes, please explain

Please explain in detail how your accident happened

Please mark the activities below that have been adversely affected or are difficult to perform since your motor vehicle accident.

Did you suffer any of the following symptoms? (check all that apply)

- ☐ Dizziness
- ☐ Severe Headaches
- ☐ Blurry Vision
- ☐ Ringing in Ear
- ☐ Difficulty with focus
- ☐ Nausea
- ☐ Anxiety
- ☐ Visual Disturbances
- ☐ Vertigo
- ☐ Confusion
- ☐ Muscle Weakness
- ☐ Crying for no reason
- ☐ Depression
- ☐ None of the above
- ☐ Light Headedness
- ☐ Vomiting
- ☐ Memory Loss
- ☐ Sensitivity to Light
- ☐ Difficulty in speech
- ☐ Numbness
- ☐ Other

If other, please explain

_____

Primary Complaint (s):

_____

When did your symptoms begin?

_____

Has this condition

◯ Gotten worse ◯ Stayed Constant ◯ Comes and goes

Does this condition interfere with

- ☐ Work
- ☐ Sleep
- ☐ Daily Routine
- ☐ Other activities

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)

Please rate your major area of pain on a 0-10 (0 being no pain, 10 being worst pain) Pain Rating Scale at the present time

- ◯ 1
- ◯ 2
- ◯ 3
- ◯ 4
- ◯ 5
- ◯ 6
- ◯ 7
- ◯ 8
- ◯ 9
- ◯ 10

What aggravates the problem?

_____

What relives the problem?

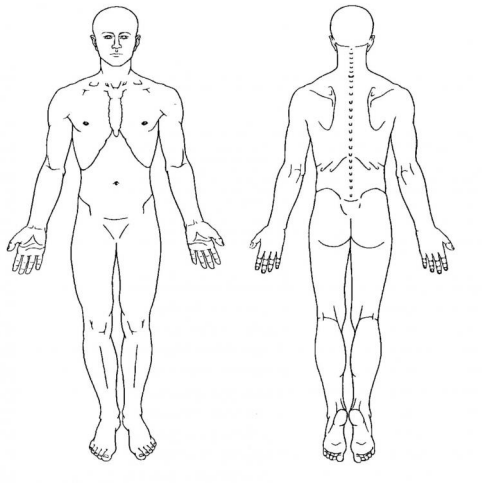
_____

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

_____

Place an X on the image below, where you feel pain, numbness or tingling:

Mark your Pain Point



"//" 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

Health Habits

Please list any PRESCRIPTIONS you are currently taking (including pills, injections, etc)

_____

Over the counter medications

- ☐ Asprin
- ☐ Advil/Motrin/Ibuprofen
- ☐ Aleve
- ☐ Tylenol/Acetaminophen

Please list any vitamin supplements you are currently taking

_____

Do you have any known food or drug allergies?

_____

Please describe all injuries and any surgeries for which you have been treated

_____

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

Is there any chance that you are pregnant?

◯ Yes ◯ No

Health Conditions

PAST MEDICAL HISTORY: Please check each of the conditions that you have had now or in the past.

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

At this time, would you say your health is:

- ☐ Excellent
- ☐ Very Good
- ☐ Fair
- ☐ Poor

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 physical therapy sessions 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!

Acknowledgement of HIPPA Privacy Practices

Federal law requires that we seek your acknowledgement of 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 contract the Privacy Officer.

Signature **Date Signed**

Printed Name **Email**

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**

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**

Informed Consent for Treatment

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, 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 Doctor of Chiropractic who now or in the future work at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the Doctor of Chiropractic named below and/or with other office or clinic personnel 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, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. 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.

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) for which I seek treatment.

Signature

Date Signed

_____

Printed Name

_____

Email

_____