At Last Chiropractic
5611 Skytop Drive
Lithia, FL 33547
(813) 461-6500

Introduction

Contact

First Name _____ Last Name _____

Address _____

City _____ Prov _____ Postal _____

Home Phone _____ Cell Phone _____

Other Phone _____ Email _____

Gender Male Female Birthdate _____

Height _____ Shoe Size _____ Weight _____

Marital Status Single Married Divorced Widowed

Spouse _____ Num. of Children _____ Names/Ages _____

Emergency Contact _____ Phone _____ Relationship _____

How did you hear about us? None Patient Physician Attorney Advertisement

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Family Physician _____ Date of Last Visit _____

Physician Phone _____

Work Status Full Time Part Time Disability Student Retired Unemployed

Employer _____ Occupation _____ Employer Phone _____

Employer Address _____

Have you missed work due to this injury? Yes No

Missed work start date? _____ Return or anticipated return date _____

Condition

The Symptoms that have prompted you to seek care today include: _____

Have you seen other doctors for this condition? Yes No

Prior Interventions Acupuncture Chiropractic Heat Homeopathic Ice Massage Medication OTC Meds Physiotherapy Surgery Other

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What is the condition related to? Auto Accident Home Injury Sports Injury Work Injury Other

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When did your problem first start? _____

Have you had this condition before? Yes No

Does the pain radiate or travel to other parts of the body? Yes No

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Does anyone from your family suffer from the same condition? Yes No

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What makes the condition worse? Bending Coughing Defecation Lifting Sitting Sneezing Stairs Standing Walking Other

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What makes the condition better? Bed Rest Heat Ice Massage Medication Other

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Does this condition affect employment? Yes No

Does this condition affect recreation? Yes No

Does this condition affect household? Yes No

Does this condition affect personal? Yes No

Does this condition affect sleep? Yes No

What else should we know about your current condition? _____

Rate the severity of your pain from 0 to 10

Pain Duration Constant Intermittent

Current Medications Blood Pressure Insulin Muscle Relaxants Nerve Pills Pain Other

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Supplements Yes No

Sleep Position Back Left Side Right Side Stomach

Hours of sleep per night? (1-24)_____

Have you had x-rays in the last six months? Yes No

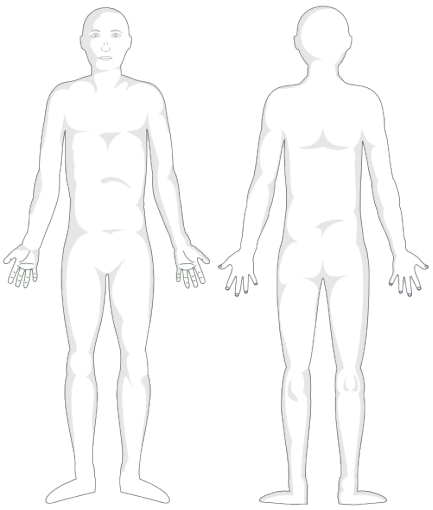
I realize that x-ray examinations may be hazardous to an unborn child. I certify to the best of my knowledge I am not pregnant.

Yes No

Last Cycle: _____

Pain

Please Select the Area(s) that you are experiencing pain?



Systems

Select options below indicating age at diagnosis and other relevant details.

Musculoskeletal Osteoporosis

Back Problems

Knee Injuries

Arthritis

Hip Disorders

Foot/Ankle Pain

Scoliosis

TMJ Issues

Shoulder Problems

Elbow/Wrist Pain

Neck Pain

Poor Posture

Neurological Anxiety

Headaches

Dizziness

Depression

Numbness

Pins and Needles

Cardiovascular High Blood Pressure

Poor Circulation

High Cholesterol

Low Blood Pressure

Chest Pain

Respiratory	Asthma
	Shortness of Breath
	Emphysema
	Apnea
	Pneumonia
	Allergies
Digestive	Anorexia or Bulimia
	Constipation
	Food Sensitivities
	Ulcer
	Diarrhea
	Heartburn
Sensory	Blurred Vision
	Nose Bleeds

	Chronic Ear Infections
	Ringing in Ears
	Sore Throat
	Loss of Smell
	Hearing Loss
Integumentary	Skin Cancer
	Rash
	Acne
	Psoriasis
	Bruise Easily
	Hair Loss
	Eczema
	Slow Healing
Endocrine	Thyroid Issues
	Swollen Glands

	Low Blood Sugar
	Immune Disorder
	Low Energy
	Frequent Infection
Genitourinary	Kidney Stones
	Prostate Issues
	Bedwetting
	Infertility
	PMS Symptoms
General	Fainting
	Loss of Appetite
	Sudden Weight Gain
	Fatigue
	Loss of Sleep

Weakness

Sudden Weight Loss

History

Personal Illness History Aids Alcoholism Allergies Arteriosclerosis Cancer Chicken Pox Diabetes Epilepsy Glaucoma Goiter Gout Heart Disease Hepatitis HIV Positive Malaria Measles Multiple Sclerosis Mumps Polio Rheumatic Fever Scarlet Fever STD Stroke Tuberculosis Typhoid Ulcer Other

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Surgery/Trauma History Cancer Back Surgery Bypass Surgery Hernia Other

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Fractures Yes No

Auto Accident Yes No

Spinal Injury Yes No

Hospitalization Yes No

Alcohol Use None Daily Weekly

Coffee Use None Daily Weekly

Tobacco Use None Daily Weekly

Exercise None Daily Weekly

Pain Reliever None Daily Weekly

Soft Drinks None Daily Weekly

Water Intake None Daily Weekly

Family History

Mother Age

Age At Death

Illness

Health Good Bad

Father Age

Age At Death

Illness

Health Good Bad

Sibling Age

Age At Death

Illness

Health Good Bad

Sibling Age

Age At Death

Illness

Health Good Bad

Finalize

What is the most significant thing you can do to improve your health? _____

How committed are you at achieving your maximum health potential

How do you want us to handle your problem? Temporary Relief Maximum Correction

Please Read the following carefully before signing.

Notice of Privacy Practices Acknowledgement

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your Personal Health Information. In addition, we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as dictated by our office policy, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances.

Permitted Disclosures:

? Treatment purposes ? discussion with other health care providers involved in your care

? Inadvertent disclosures ? open treating area means open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room

? For payment purposes ? to obtain payment from your insurance company or any other collateral source

? For worker?s compensation purposes ? to process a claim or aid in investigation

? Emergency ? in the event of a medical emergency, we may notify a family member

? For public health and safety ? in order to prevent or lessen a serious or eminent threat to the health or safety

of a person or general public

? To governmental agencies or law enforcement ? to identify or locate a suspect, fugitive, material witness, or missing person

? For military, national security, prisoner, and government benefits purposes

? Deceased persons ? discussion with coroners and medical examiners in the event of a patient?s death

? Telephone calls or emails and appointment reminders ? we may call your home/cell and leave voice/text messages regarding an appointment, a missed appointment, or notify you of changes in practice hours or upcoming events

? Announcing names in queue at the front desk & reception area ? we announce the first and last names of patients in queue that are waiting to be treated (eg. ?Jane Smith, please proceed to room 2?). Please notify the office manager if you would like this to be changed

? Change of ownership ? in the event this practice is sold, the new owners would have access to your Personal Health Information

Your rights:

? To receive an accounting of disclosures

? To receive a paper copy of the comprehensive Detail Privacy Notice

? To request mailings to an address different than residence

? To request restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.

Terms of Acceptance

In order to provide the most effective healing environment, the most effective application of chiropractic procedures, and the strongest possible doctor-patient relationship, it is essential for both parties to be working toward the same objective. It is important that each person understand both the objective and the method that will be used to attain this goal. This will prevent any confusion or disappointment.

? Chiropractic is a very specific science, authorized by law to address spinal health concerns and needs. It is not the practice of medicine.

? Chiropractic seeks to maximize the inherent healing power of the human body by restoring normal nerve functions through the adjustments of vertebral subluxation(s). Subluxations are deviations from normal spinal

structures and configurations, and considered to be a partial dislocation. A subluxation that interferes with normal nerve processes is called a neuro-structural shift.

? The chiropractic adjustment process, as defined in the law of this jurisdiction, involves the application of a specific directional thrust to a region or regions of the spine with the specific intent of re-positioning misaligned spinal segments. This is a safe, effective procedure applied over one million times a day with doctors of chiropractic in the United States alone.

? Chiropractic does not seek to replace or compete with your medical, dental, or other type(s) of health professionals. They retain responsibility for care and management of medical conditions. We do not offer advice regarding treatment prescribed by others.

Informed Consent For Chiropractic Care

Chiropractic Care, like all forms of health care while offering considerable benefits may also provide some level of risk. This level of risk is often very minimal. Yet in rare cases, injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include: sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral injury that could lead to a stroke.

Prior to receiving chiropractic care in this office, a health history and physical examination will be completed. These procedures are performed to assess your specific conditions, your overall health, and in particular, your spinal health. These procedures will assist us in determining if chiropractic care is needed, and if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

By signing below:

? I understand and accept that there are risks associated with chiropractic care and give consent to the examination that the doctor deems necessary and the chiropractic care, including spinal adjustments, as reported following my assessment.

? I authorize and request payment of insurance benefits directly to Dr. Carissa Hughes and/or Dr. Anthony Taylor. I agree that this authorization will cover all services rendered until I revoke the authorization. I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to

the patient. It is customary to pay for services when rendered unless other arrangements have been made in advance. I understand that I am financially responsible for charges not covered by this assignment.

Print Name____ Signature__ Date ____

If this health profile is for a minor/child, please fill out and sign below.

Name of Practice Member Who is a Minor/Child:____

I authorize Dr. Carissa Hughes and/or Dr. Anthony Taylor, and any and all At Last Chiropractic staff to perform diagnostic procedures, radiographic evaluations, render chiropractic care, and perform chiropractic adjustments to my minor/child as legally allowed. As of this date, I have the legal right to select and authorize health care services for my minor/child. If my authority care is revoked or altered, I will immediately notify At Last Chiropractic.

Guardian Signature___ Guardian Relationship to Child_ Date___

We love to have pictures in our office! If you would allow us to have your picture in the office, please sign below.

For valuable consideration, I hereby irrevocably consent to and authorize the use and reproduction by At Last Chiropractic, or anyone authorized by At Last Chiropractic, of any and all photographs/videos which were taken of myself and my child, for the purposes of promotional TV, website, social media, and/or print ad whatsoever, without further compensation to me. All negatives and positives, together with the prints shall constitute the property of At Last Chiropractic, solely and completely. Any information voluntarily provided by a patient shall also be used in conjunction with the above listed information for purposes previously mentioned. Confidentiality, in regards to any reported conditions, is also waived to the extent of information pertinent to the promotion material only. I authorize At Last Chiropractic to share this information via their website and their social media platforms including but not limited to Facebook and Instagram, and for use in the office. All other unrelated patient information shall remain private and protected (according to Health Information and Privacy Act laws).

Signature____ Date ____

X-Ray Authorization

As your health care provider, At Last Chiropractic is legally responsible for your chiropractic records. We must maintain a record of your x-rays in our files. At your request, we will provide you with a copy of your x-rays. The fee for the copy is $15 and must be paid in advance. Digital x-rays on a CD will be available within 72 hours of prepayment on any regular practice hours day.

Please Note: X-rays are utilized in this office to help locate and analyze vertebral subluxations. These x-rays are

not used to investigate for medical pathology. The doctors of At Last Chiropractic do not diagnose or treat medical conditions. However, the doctors will refer questionable x-ray films to be interpreted by a radiologist hired by At Last Chiropractic. The radiologist will submit a report of their interpretation to At Last Chiropractic, and if any abnormalities are found, we will bring it to your attention so that you can seek proper medical advice.

By signing below, I am agreeing to the Notice of Privacy Practices Acknowledgement, Terms of Acceptance, X-Ray Authorization, and all the terms and conditions above.

Print Name____ Signature__ Date ____

Female Patients Only:

To the best of my knowledge, I BELIEVE I AM NOT PREGNANT at the time x-rays are taken at, At Last Chiropr

**After agreeing, please Sign and Submit

Signature