Patient Account Number

_____

12595 SW 137 AVENUE STE 108
MIAMI, FL 33187
(305) 388-7577

Date

_____

PATIENT INFORMATION

First Name _____ Middle Name _____ Last Name _____ Nickname _____

Street Address _____ Apt. _____ City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____ E-mail Address _____ Age _____ Date of Birth _____

Appointment Reminders will be sent via text message 24 Hrs before appointment.

Marital Status
◯ Single ◯ Married ◯ Divorced ◯ Widowed

Sex
◯ Male ◯ Female

Please provide the **LAST 4 DIGITS** of your Social Security Number for insurance verification purposes
XXX-XX-_____

EMERGENCY CONTACT

Full Name _____ Relationship _____ Phone Number _____

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

I authorize Martinez Chiropractic Center and any member of its staff to call, leave voice mail messages and\or e-mail messages and disclose Protected Health Information (PHI) pertaining to me, including but not limited to medical information, such as test results, procedures results, appointment reminders, or any other PHI related to my treatment to the following numbers:

Home: _____ Cell: _____ Work: _____ Fax: _____

Email: _____

I authorize Martinez Chiropractic Center and any member of its staff to disclose my (PHI), including test results to the following individuals, as well as allow them to make changes or ask questions regarding my appointments on my behalf:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Patient Signature: _____ Date: _____

NO ACCIDENT FORM

I am seeking care from Martinez Chiropractic Center the treatment is not due to a work related injury, automobile accident, or slip and fall.

INSURANCE AUTHORIZATION

I hereby authorize payment of benefits due to me from my insurance company and or attorney to be made directly to Martinez Chiropractic Center. I further authorize the release of any medical records required by my insurance carrier. I fully understand that I am financially responsible for any charges covered by this authorization to Martinez Chiropractic Center. In the event that it becomes necessary to institute litigation over the non-payment of our fees, the cost and legal expenses incurred therein are that of the patient.

INSURANCE CERTIFICATION

This is to certify that I have presented any and all information regarding my health insurance plan.

The only health insurance policy in effect is:

Name of Insurance Co: _____ ID: _____ Group: _____

Insured s Name: _____ Relationship with Insured: _____ Insured DOB: _____

My signature certifies that the information I have filled in above is accurate, and that I am not seeking care due to an auto accident, work injury or slip/fall nor do I have an open or pending case.

Patient Name: _____ Patient Signature: _____ Date: _____

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGMENT FORM

I aknowledge that I have received a copy of Martinez Chiropractic Center's Notice of Patient Privacy Practices.

INFORMED CONSENT FORM

I hereby request and consent to the performance of chiropractic treatments and other chiropractic medical procedures, including various forms of physical therapy and diagnostic x-rays by Martinez Chiropractic Center. This consent is extended to other licensed chiropractic Physicians, Chiropractic assistants or licensed Massage Therapists, who now or in the future, are employed by, working with or associated with this office.

I certify that I have had the opportunity to discuss, with the doctor of Chiropractic and/or other office personnel, the nature and purpose of the care that is being provided. I understand that the results are not guaranteed. Further, I have been informed and I understand that, as in the practice of any of the healing arts, in the practice of Chiropractic, there are some risks to treatment including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I also understand that the doctor, who has explained all of these things to me, is not expecting to be able to anticipate and explain all the risks and complications. I will rely on the doctor to exercise appropriate judgment during the course of care, based on the facts known at this time, and in my best interest.

My signature below certifies that I have read, or have had read to me the above consent. I also certify that I have had the opportunity to ask questions and options to care have been explained. By signing this consent form, I agree to the care being provided to me for the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment.

Patient Name: _____ Patient Signature: _____ Date: _____

MASSAGE AND MANUAL THERAPY POLICY

We offer massage and manual therapy in our office as an extra service to our patients. We believe that massage and manual therapy has a value in helping you heal. Our policy is that appointments be pre-scheduled. If you must reschedule or miss an appointment YOU MUST CALL US 24 HOURS IN ADVANCE. If you do not call, there is a $25.00 charge. The only exception to this is if you have a serious emergency. Thank you for your cooperation.

Patient Name: _____ Patient Signature: _____ Date: _____

Patient Health Questionnaire

ChiroCare of Wisconsin, Inc.

Patient Account Number

Patient Name _____ ***Date*** _____

1. When did your symptoms start: _____ ***Describe your symptoms and how they began:***

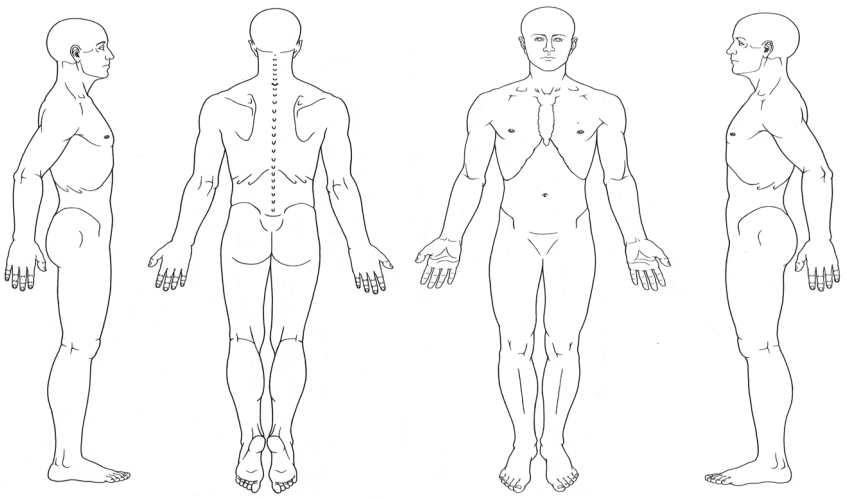
_____

Did your condition start due to a fall, injury or after lifting a heavy object? ☐ Yes ☐ No ☐ Other _____

2. How often do you experience your symptoms?

- ☐ Constantly (76-100% of the day)
- ☐ Frequently (51-75% of the day)
- ☐ Occasionally (26-50% of the day)
- ☐ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?

- ☐ Sharp ☐ Shooting
- ☐ Dull ache ☐ Burning
- ☐ Numb ☐ Tingling

4. How are your symptoms changing?

- ☐ Getting Better
- ☐ Not Changing
- ☐ Getting Worse

5. How bad are your symptoms at their:

	None										Unbearable
a. worst:	⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
b. best:	⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩

6. How do your symptoms affect your ability to perform daily activities?

⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
No complaints		*Mild, forgotten with activity*		*Moderate, interferes with activity*		*Limiting, prevents full activity*		*Intense, preoccupied with seeking relief*		*Severe, no activity possible*

7. What activities make your symptoms worse: _____

8. What activities make your symptoms better: _____

9. Who have you seen for your symptoms?

☐ No One ☐ Other Chiropractor ☐ Medical Doctor ☐ Physical Therapist ☐ Other

a. When and what treatment? _____

b. What tests have you had for your symptoms and when were they performed?

☐ Xrays *date:* ☐ CT Scan *date:* _____

☐ MRI *date:* _____ ☐ Other *date:* _____

10. Have you had similar symptoms in the past? ☐ Yes ☐ No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

☐ This Office ☐ Other Chiropractor ☐ Medical Doctor ☐ Physical Therapist ☐ Other

11. What is your occupation?

_____

☐ Professional/Executive ☐ White Collar/Secretarial ☐ Tradesperson ☐ Laborer ☐ Homemaker ☐ FT Student ☐ Retired ☐ Other

a. If you are not retired, a homemaker, or a student, what is your current work status?

☐ Full-time ☐ Part-time ☐ Self-employed ☐ Unemployed ☐ Off work ☐ Other

12. What do you hope to get from your visit/treatment *(select all that apply):*

☐ Reduce symptoms ☐ Resume/increase activity ☐ Explanation of condition/treatment ☐ Learn how to take care of this on my own ☐ How to prevent this from occurring again ☐

Patient Signature _____ ***Date*** _____

Patient Health Questionnaire - page 2

ChiroCare of Wisconsin, Inc.

Patient Account Number

Patient Name _____ **Date** _____

What type of regular exercise do you perform? ☐ None ☐ Light ☐ Moderate ☐ Strenuous

What is your height and weight? Height ☐☐☐ (Feet / Inches) Weight ☐☐☐ lbs.

For each of the conditions listed below, place a check in the Past column if you have had the condition in the past. If you presently have a condition listed below, place a check in the Present column.

Past	Present	
☐	☐	Headaches
☐	☐	Neck Pain
☐	☐	Upper Back Pain
☐	☐	Mid Back Pain
☐	☐	Low Back Pain
☐	☐	Shoulder Pain
☐	☐	Elbow/Upper Arm Pain
☐	☐	Wrist Pain
☐	☐	Hand Pain
☐	☐	Hip/Upper Leg Pain
☐	☐	Knee/Lower Leg Pain
☐	☐	Ankle/Foot Pain
☐	☐	Jaw Pain
☐	☐	Joint Swelling/Stiffness
☐	☐	Arthritis
☐	☐	Rheumatoid Arthritis
☐	☐	General Fatigue
☐	☐	Inbalance
☐	☐	Visual Disturbances
☐	☐	Dizziness

Past	Present	
☐	☐	High/Low Blood Pressure
☐	☐	Heart Attack
☐	☐	Chest Pains
☐	☐	Stroke
☐	☐	Angina
☐	☐	Kidney Stones
☐	☐	Kidney Disorders
☐	☐	Bladder Infection
☐	☐	Painful Urination
☐	☐	Loss of Bladder Control
☐	☐	Prostate Problems
☐	☐	Abnormal Weight Gain/Loss
☐	☐	Poor/Excessive Appetite
☐	☐	Abdominal Pain
☐	☐	Heartburn
☐	☐	Constipation/Diarrhea/Vomiting
☐	☐	Liver/Gall Bladder Disorder
☐	☐	Cancer
☐	☐	Tumor
☐	☐	Asthma
☐	☐	Chronic Sinusitis

Past	Present	
☐	☐	Diabetes
☐	☐	Excessive Thirst
☐	☐	Frequent Urination
☐	☐	Smoking/Use Tobacco Products
☐	☐	Drug/Alcohol Dependence
☐	☐	Allergies
☐	☐	Depression
☐	☐	Systemic Lupus
☐	☐	Epilepsy
☐	☐	Dermatitis/Eczema/Rash
☐	☐	HIV/AIDS

Females Only

☐	☐	Birth Control Pills
☐	☐	Menstrual Irregularity/Cramps
☐	☐	Pregnancy
☐	☐	Last Menstual Cycle _____

Children ☐ None ☐ # of Children _____

Other Health Problems/Issues

☐ ☐ _____
☐ ☐ _____
☐ ☐ _____

Indicate if an immediate family member has had any of the following:

☐ Rheumatoid Arthritis ☐ Heart Problems ☐ Diabetes ☐ Cancer ☐ Lupus ☐ _____

List all prescription and over-the-counter medications, and nutritional/herbal supplements you are taking:

_____ _____ _____

_____ _____ _____

List all the surgical procedures you have had and times you have been hospitalized:

_____ _____ _____

_____ _____ _____

Patient Signature _____ ***Date*** _____

Doctor's Additional Comments

_____

_____

_____

Doctors Signature _____ ***Date*** _____