Caloosahatchee Chiropractic
1951 Collier Ave Suite B Fort Myers, Florida 33901
(P)239.672.4071 (F)239.677.3115 CaloosahatcheeChiropractic.com

CASE HISTORY

Name _____ Age _____ Date _____

Address _____ City _____ State____ Zip_____

Date of Birth _____ Sex: M F Marital Status: S M D W

Phone (Home) _____ Phone (Cell) _____

Occupation _____ Phone (Work) _____

Employer _____ Email Address _____

Present condition due to an injury? _ Yes _ No _ On the Job _ Auto Accident _ Other _____

HEALTH REPORT:

Reason for seeking care: _____

List any other doctors seen for this: _____

List any diagnosis and type of treatment: _____

Have you had similar accidents or injuries before? _ Yes _ No If yes, explain: _____

Have you ever received chiropractic treatment before? _ Yes _ No

Have you been treated for any health condition by a physician in the last year? _ Yes _ No

If yes, explain: _____

Are you currently taking medication? _ Yes _ No List medications: _____

_____

List conditions you are taking medications for: _____

List the approximate dates of any surgery or treated conditions:_____

_____

Family History: Health conditions, age of death and cause of death.

Father: _____ Mother:_____

Brother/s & Sister/s: _____

Do you smoke Y/N ___ If yes, how much per day? _____

Alcohol Y/N _Daily _Weekly _Social Occasions

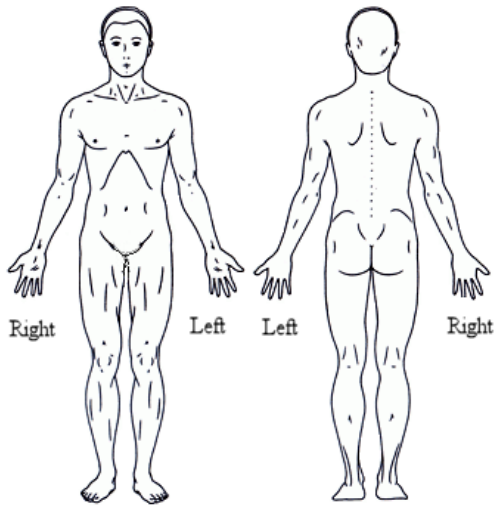
Caffeinated drinks per day _____

Do you take Vitamins/Supplements Y/N If yes, list:_____

PRESENT COMPLAINT

Please circle degree of pain, 0 none, 10 severe pain.

0 1 2 3 4 5 6 7 8 9 10



Using the symbols below, mark on the pictures where you feel pain.

Numbness	= = =
Dull Ache	OOO
Burning	XXX
Sharp/Stabbing	/ / /
Pins, Needles	+ + +
Other ____	^ ^ ^

What activities aggravate your condition/pain?

_____

What activities lessen your condition/pain?

_____

Is this condition worse during certain times of the day? Y/N If yes, when?_____

Is this condition interfering with: Work?_____ Sleep?_____ Routine?_____ Other?_____

Is this condition progressively getting worse? Y/N If yes, how so?_____

Please mark each item below for each sign or symptom you presently have or previously had:

GENERAL SYMPTOMS
_ Convulsions
_ Dizziness
_ Fainting
_ Headache
_ Nervousness
_ Numbness
_ Wheezing

MUSCLES & JOINTS
_ Low Back Problems
_ Pain between Shoulders
_ Neck Problems
_ Arm Problems
_ Leg Problems
_ Swollen Joints
_ Painful Joints
_ Stiff Joints
_ Sore Muscles
_ Weak Muscles
_ Walking Problems
_ Sprains/Strains
_ Broken Bones

RESPIRATORY

_ Asthma

_ Chronic Cough

_ Difficulty Breathing

_ Spitting Blood

_ Spitting Phlegm

CARDIO-VASCULAR

_ High Blood Pressure

_ Heart Attack

_ Pain over Heart

_ Poor Circulation

_ Heart Trouble

_ Rapid Heart

_ Slow Heart

_ Strokes

_ Swelling Ankles

_ Varicose Veins

EAR/NOSE/THROAT

_ Earache

_ Ear Noises

_ Enlarged Thyroid

_ Frequent Colds

_ Hay Fever

_ Nasal Blockage

_ Nose Bleeds

_ Pain Behind Eyes

_ Poor Vision

_ Sinusitis

_ Sore Throats

_ Tonsillitis

GASTRO-INTESTINAL

_ Belching/Gas

_ Colon Problems

_ Constipation

_ Diarrhea

_ Excessive Hunger

_ Excessive Thirst

_ Gall Bladder Trouble

_ Hemorrhoids

_ Liver/Gallbladder

_ Nausea

_ Abdominal Pain

_ Ulcer

_ Poor Appetite

_ Poor Digestion

_ Vomiting

_ Vomiting Blood

_ Black Stool

_ Bloody Stool

_ Weight Loss/Gain

GENITO-URINARY

_ Blood in Urine

_ Frequent Urination

_ Kidney Infection

_ Painful Urination

_ Prostate Problems

_ Loss of Bladder Control

SKIN OR ALLERGIES

_ Boils

_ Bruising Easily

_ Dryness

_ Eczema/Rash/Dermatitis

_ Hives

_ Itching

_ Sensitive Skin

_ Allergy _____

FOR WOMEN ONLY

_ Birth Control _____

_ Hormone Replacement

_ Cramps/Backaches

_ Excessive Flow

_ Hot Flashes

_ Irregular Cycle

_ Miscarriage

_ Painful Periods

_ Vaginal Discharge

_ Breast Pain

Pregnant at this Time Y/N

If yes, due date? _____

EMERGENCY CONTACT

Name _____ Phone _____

Relationship to _____

I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this office of any changes in my health.

I agree to allow this office to examine me for further evaluation.

Patient Signature_____Date_____

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FINANCIAL RESPONSIBILITY AGREEMENT

At Caloosahatchee Chiropractic, we want to render the best quality health care at an affordable price. In order to accomplish this goal, we have some business procedures that help keep our fees low. Please read over these procedures below to understand how our office functions. If you have any questions or concerns, please feel free to express them.

- You may choose to submit receipts to your insurance company or other third party health care programs, but payment for such services by insurance companies is neither implied nor agreed to by this office. We take no responsibility for non-payment by insurance companies for services rendered at our office.
- This office will not respond to any requests for paperwork for insurance purposes or even acknowledge insurance requests for information on any patient's case. However, patients may have a copy of their records at any time they request.
- No balances can be kept or run by patients at any time.
- All services rendered are paid for upon *completion* of these services.
- Our office reserves the right to deny services to anyone for any reason, or if the doctor feels that the patient's health is not being best served.

I have read and understand the Financial Responsibility Agreement and agree to all terms. I also understand that I am under no obligation to receive or continue care.

_____ _____

Printed Name Date

_____

Signature

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WORK INJURY AND AUTOMOBILE INJURY NOTICE AND DISCLOSURE

By signing below, I acknowledge that I am aware that Caloosahatchee Chiropractic and Dr. Brittney Warren do not provide care for **work related injuries, automobile accident injuries, or personal injuries**. I also acknowledge that I must inform this office if I am in a work related or automobile injury and must seek care at my medical doctor's office or another healthcare provider for injuries or conditions sustained. I am also aware that Caloosahatchee Chiropractic and Dr. Brittney Warren will not bill, submit claims, nor prepare or submit reports for any work related, automobile, or personal injury. I understand that I am responsible to pay each visit myself at the time of service.

_____ _____
Printed Name Date

_____
Signature

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Acknowledgement of Privacy Practices

Our Notice of Privacy Practices (NPP) provides information about how Caloosahatchee Chiropractic may use and disclose protected health information (PHI) about you. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act (HIPAA). The NPP contains a Patient Rights section describing your rights under the law. Please review the Notice of Privacy Practices thoroughly before signing this acknowledgement form. In the event that terms of the Notice change, a revised copy will be made available to you.

By signing this form, you acknowledge that our Practice may use and disclose PHI about you for treatment, payment and healthcare operations. You have the right to request that we restrict how PHI about you is used or disclosed for treatment, payment or healthcare operations.

I give permission for Caloosahatchee Chiropractic to:
___ Leave a message regarding an appointment
___ Leave a message regarding test results _____

Share medical information with:
(1) Name_____ Relationship_____
Phone_____
(2) Name_____ Relationship_____
Phone _____

I assume responsibility to inform the practice of any changes in the above information.
___ I have received the Notice of Privacy Practices

Signature_____
Date_____

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INFORMED CONSENT

The primary treatment used by doctors of chiropractic is the spinal adjustment. I will use that procedure to treat you.

The nature of the chiropractic adjustment. I will use my hands or a mechanical device upon your body in such a way as to move your joints that may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel or sense movement.

The material risks inherent in chiropractic adjustment. As with any health care procedure, there are certain complications which may arise during a chiropractic adjustment. Those complications include: fractures, disc injuries, dislocations, and muscle strain, cervical myelopathy and costovertebral (rib) strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment.

The probability of those risks occurring. Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination and possibly, X-ray. Stroke has been the subject if tremendous disagreement within and without the profession with one prominent authority saying that there is at most a one-in-a-million chance of such an outcome. Since even that risk should be avoided if possible, we employ tests in our examination which are designed to identify if you may be susceptible to that kind of injury. The other complications are also generally described as "rare."

Additional Treatment.
In addition to chiropractic adjustments, the following treatments and/or modalities may be used:

- Transcutaneous Electrical Nerve Stimulation (TENS)
- Trigger Point Therapy/Manual Therapy
- Instrument Assisted Soft Tissue Mobilization (IASTM)
- Heat/Cryotherapy
- Kinesiology Taping

These treatments involve the following additional significant risks:

- Skin irritation (possible with adhesive from tape or electrodes), bruising, redness, burns, and/or soreness

Other treatment options for your condition include:

- Self-administered, over-the-counter analgesics and rest
- Medical care with prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
- Surgery

The material risks inherent in such options and the probability of such risks occurring include:
Overuse of over-the-counter medications produces undesirable side-effects. If complete rest is impractical, premature return to work and household chores may aggravate the condition and extend the recovery time. The probability of such complications arising is dependent upon the patient's general health, severity of the patient's discomfort, his pain tolerance and self-discipline in not abusing the medicine. Professional literature describes highly undesirable effects from long term use of over-the-counter medicines.
Prescription muscle relaxants and pain-killers can produce undesirable side effects and patient dependence. The risk of such complications arising is dependent upon the patient's general health, severity of the patient's discomfort, his pain tolerance, self-discipline in not abusing the medicine and proper professional supervision. Such medications generally entail very significant risks — some with rather high probabilities.
The risks inherent in surgery include adverse reaction to anesthesia, iatrogenic (doctor caused) mishap, all those of hospitalization and an extended convalescent period. The probability of those risks occurring varies too many factors.

The risks and dangers attendant to remaining untreated.
Remaining untreated allows the formation of adhesions and reduces mobility which sets up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed. The probability that non-treatment will complicate a later rehabilitation is very high.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW:
I have read [ ] or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Brittney Warren and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

_____ _____
Patient Printed Name Date

_____
Patient Signature

_____
Signature of Parent or Guardian (if a minor)

_____
Signature of Witness