

Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your health.

Patient Information

Name _____ Soc. Sec.# _____
Last Name First Name Initial
Address _____
City _____ State _____ Zip _____ Home Phone _____
Cell Phone _____ Email _____
Sex M F Age _____ Birth Date _____
 Single Married Widowed Separated Divorced
Patient employed by _____ Occupation _____
Business Address _____
Business Phone _____ Business Email _____
Notify in case of emergency _____ Home Phone _____ Work Phone _____
Cell Phone _____ Email _____
Whom may we thank for referring you? _____

Primary Insurance

Person Responsible for Account _____
Last Name First Name Initial
Relation to Patient _____ Birth Date _____ Soc. Sec.# _____
Address (if different from patient) _____ Home Phone _____
City _____ State _____ Zip _____
Cell Phone _____ Email _____
Person responsible employed by _____ Occupation _____
Business Address _____
Business Phone _____ Business Email _____
Insurance Company _____
Phone _____ Email _____
Contract # _____ Group # _____ Subscriber # _____
Name of other dependents under this plan _____

Reason for Visit

Have you ever seen a chiropractor? Yes No If yes, when and why? _____
Your reason for *this* visit: _____
Please describe your current pain and its location: _____
When did symptoms begin (date)? _____ Have you had similar conditions in the past? _____
Is pain getting: Worse Better Same Comes and goes How often do you have this pain? _____
Have you been treated by a medical physician for this condition? _____
If so, when and where? _____
Activities or movements that are difficult/painful to perform: Sitting Walking Bending Lying down Lifting
Type of pain: Sharp Dull Throbbing Aching Burning Tingling Numbness Cramping
 Stiffness Swelling Other _____
Is pain interfering with: Work Sleep Daily Routine Recreation

Please complete both sides.

Health History

Please list any medication (including pain killers) you are taking: _____

Please list any serious injuries or surgeries you have had in the last 10 years:

	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____
Other Serious Injuries	_____	_____

Women: Are you pregnant? Y N If so, how far along? _____ Nursing? Y N

Medical Conditions

Have you ever had or do you currently have any of the following medical conditions?

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Heart Attack/Stroke | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Ulcer/Colitis |
| <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Frequent Neck Pain | <input type="checkbox"/> Severe/Frequent Headaches | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Alcohol/Drug Abuse | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Diabetes/Tuberculosis | <input type="checkbox"/> Numbness, where? _____ |
| <input type="checkbox"/> Fainting/Seizures/Epilepsy | <input type="checkbox"/> Wrist Pain | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Tingling, where? _____ |
| <input type="checkbox"/> Shingles | <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Emphysema/Glaucoma | <input type="checkbox"/> Muscle Spasms, where? _____ |
| <input type="checkbox"/> Psychiatric Problems | <input type="checkbox"/> Arm Pain | <input type="checkbox"/> Kidney Problems | |
| <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Leg Pain | <input type="checkbox"/> Artificial Bones/Joints | |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Lower Back Problems | <input type="checkbox"/> Cancer | |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Severe/Frequent Earaches | <input type="checkbox"/> HIV Positive/AIDS | |

Personal Habits

	Heavy	Moderate	Light	None
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the chiropractor to help determine appropriate and healthful chiropractic treatment. If there is any change in my medical status, I will inform the chiropractor.

I authorize my insurance company to pay to the chiropractor or chiropractic group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the chiropractor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____

Payment is due in full at time of treatment unless prior arrangements have been approved.

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

DR. MARK FIGLER, D.C.

I hereby give my consent for DR. MARK FIGLER to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

DR. MARK FIGLER's Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Dr. MARK FIGLER reserves the right to revise its notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Carol Shain at 525 Northlake Blvd., North Palm Beach, FL 33408.

With this consent, DR. MARK FIGLER and staff may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, DR. MARK FIGLER and staff may mail to my home or other alternative location any items that assist the practice in carrying TPO, such as appointment reminder cards and patient statements as long as they are marked Person and Confidential.

With this consent, DR. MARK FIGLER and staff may email to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that DR. MARK FIGLER restrict how it uses or discloses my PHI to carry our TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to DR. MARK FIGLER'S use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, DR. MARK FIGLER may decline to provide treatment to me.

Signature of Patient or Legal Guardian

Print Name of Patient or Legal Guardian

Patient's Name

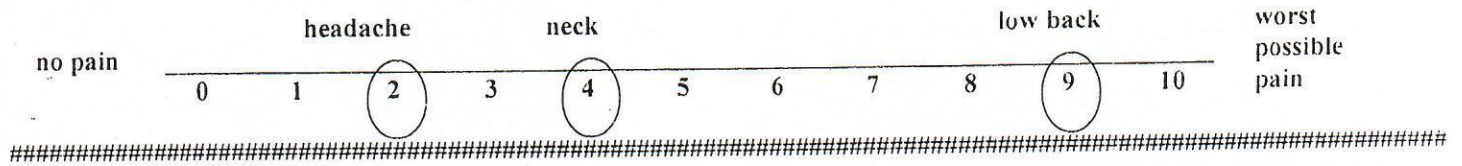
Date

QUADRUPLE VISUAL ANALOGUE SCALE

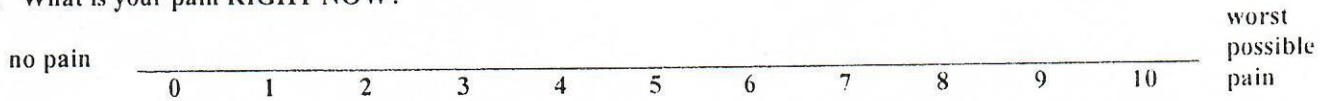
INSTRUCTIONS: Please circle the number that best describes the question being asked.

NOTE: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your average pain levels and pain at minimum / maximum using the last 3 months as your reference. If you have completed this form before, indicate your average pain level since the last time you completed this form.

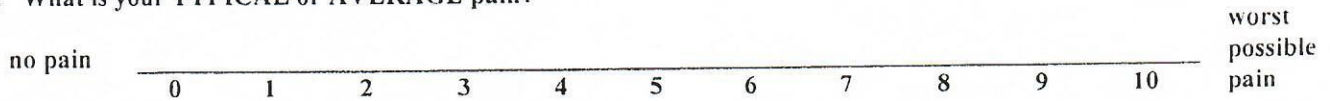
EXAMPLE:



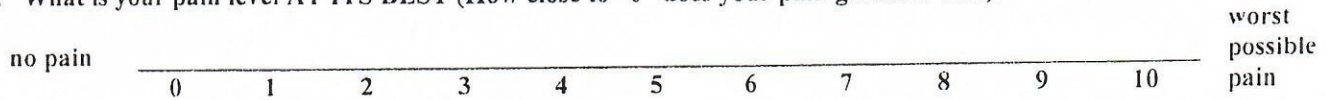
1. What is your pain **RIGHT NOW**?



2. What is your **TYPICAL** or **AVERAGE** pain?

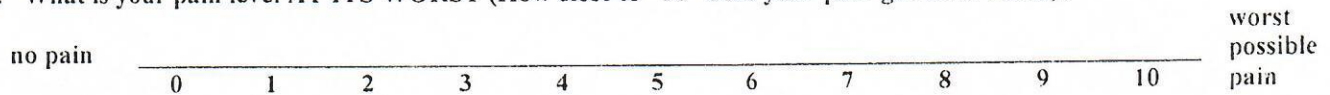


3. What is your pain level **AT ITS BEST** (How close to "0" does your pain get at its best)?



What percentage of your awake hours is your pain at its best? _____ %

4. What is your pain level **AT ITS WORST** (How close to "10" does your pain get at its worst)?



What percentage of your awake hours is your pain at its worst? _____ %

NAME _____ AGE _____ DATE _____ SCORE _____

SCORE: #1 _____ + #2 _____ + #4 _____ $\times 10^{-1}$ (Low intensity = 50; High intensity = 50)

Informed Consent for Chiropractic Treatment

TO THE PATIENT: You have a right to be informed about your condition, the recommended chiropractic treatment, and the potential risks involved with the recommended treatment. This information will assist you in making an informed decision whether or not to have the treatment. This information is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or refuse to give your consent to treatment.

I request and consent to chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays. The chiropractic treatment may be performed by the Doctor of Chiropractic named below and/or other licensed Doctors of Chiropractic working at this clinic or office. Chiropractic treatment may also be performed by a Doctor of Chiropractic who is serving as a backup for the Doctor of Chiropractic named below

I have had the opportunity to discuss with the Doctor of Chiropractic named below, my diagnosis, the nature and purpose of my chiropractic treatment, the risks and benefits of my chiropractic treatment, alternatives to my chiropractic treatment, and the risks and benefits of alternative treatment, including no treatment at all.

I understand that, there are some risks to chiropractic treatment including, but not limited to:

- | | |
|---|---|
| <input type="checkbox"/> Broken bones | <input type="checkbox"/> increased symptoms and pain |
| <input type="checkbox"/> Dislocations | <input type="checkbox"/> No improvement of symptoms or pain |
| <input type="checkbox"/> Sprains/strains | <input type="checkbox"/> Infection (acupuncture) |
| <input type="checkbox"/> Burns or frostbite (physical therapy) | <input type="checkbox"/> Punctured lung (acupuncture) |
| <input type="checkbox"/> Worsening/aggravation of spinal conditions | <input type="checkbox"/> Other _____ |

In rare cases there have been reported complications of arterial dissections n (stroke) when a patient receives a cervical adjustment. The complications reported can include temporary minor dizziness, nausea, paralysis, vision loss, locked in syndrome (complete paralysis of voluntary muscles in all parts of the body except for those that control eye movement), and death.

I do not expect ~~the~~ doctor to be able to anticipate and explain all risks and complications. I also understand that no guarantees or promises have been made to me concerning the results expected from the treatment.

TREATMENT PLAN: _____

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions. All of my questions have been answered to my satisfaction. By signing below, I consent to the treatment plan. I intend this consent form to cover the entire course of treatment for my current condition.

To be completed by the patient:

print name

signature of patient

date signed

To be completed by the patient's representative:

print name of patient

print name of patient's representative

signature of patient's representative

as: _____
relationship/authority of patient's representative

date signed

To be completed by doctor or staff:

witness to patient's signature

date

translated by

date