Application for Patient Care

PATIENT INFORMATION

First Name: _____ M.I.: _____ Last Name: _____ Date:_____

Address: _____ City: _____

State: _____ Zip:_____ Email: _____

Home #:_____ Cell #: _____ Work #: _____

SS#:_____-_____-_____ Age:_____ DOB: __ __ /__ __ /__ __ Male / Female

Primary Care Physician:_____

Do we have permission to contact your doctor regarding your care in our office? ____Yes ____No

Your preferred method of contact for appointment reminders? Email / Text by Cell Phone

Occupation:_____ Employer:_____

Type of Tasks Performed/Common Movements:_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Minor

Spouse's Name:_____ # of Children?_____ Children's Ages:_____

Emergency Contact Name:_____ Relation: _____ Phone #:_____

Smoking Status: Never smoked / Former Smoker / Occasional Smoker / Daily Smoker Preferred Language: _____

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) / Native Hawaiian or Pacific Islander / Other / Decline to Answer **Ethnicity (Circle one)**: Hispanic or Latino / Not Hispanic or Latino / Decline to Answer

ACCIDENTS

Have you had an auto accident? (X if applies): ☐ 0-6mo ☐ 6 mo-1 yr ☐ 1-3yrs ☐ 3+yrs ☐ Never

Had a recent fall/other accident? (X if applies) : ☐ 0-6mo ☐ 6 mo-1 yr ☐ 1-3yrs ☐ 3+yrs ☐ Never

Have You Ever Received Physical Therapy ☐ Chiropractic Care ☐ or Pain Management ☐? Last Visit:_____

REFERRALS

How Did You Hear About This Office?

☐ Existing Patient: _____ ☐ Walk-In/Drive-By

☐ Radio: _____ ☐ Internet: _____ ☐ Attorney

☐ Ad:_____ ☐ Community Event: _____ ☐ LifeStyles

☐ Social Media:_____ ☐ Other: _____ ☐ Insurance Comp.

INSURANCE

Do you have health insurance? ☐ Yes ☐ No Name of Carrier: _____

Do you have secondary insurance? ☐ Yes ☐ No Name of Carrier: _____

PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR INSURANCE CARD(S)

Assignment and Release

Method of payment for today's charges: ___Cash ___Check ___Visa / MC

I certify that I (or my dependent) have insurance coverage with _____ and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PHYSICIAN PRACTICE, Integrative Health of Tampa, LLC, INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

I choose to decline receipt of my clinical summary after every visit (These summaries are often blank as a result of the nature and frequency of care.)

SIGNATURE (X) _____ **DATE** _____

Patient Name: _____ Date: _____

PRIMARY COMPLAINTS: Please list in order of most severe (#1) to least severe (#4). *Sample complaints: Low Back, Left Knee, Right Shoulder, Neck, etc.* **MOST SEVERE ◄——————————► LEAST SEVERE**

You have the following complaints (WRITE-IN)	1.	2.	3.	4.
Circle the word that best describes this complaint.	Sharp dull achy throbbing numb shooting other	Sharp dull achy throbbing numb shooting other	Sharp dull achy throbbing numb shooting other	Sharp dull achy throbbing numb shooting other
How often do you feel this complaint?	Constant Daily Weekly "Off and On"	Constant Daily Weekly "Off and On"	Constant Daily Weekly "Off and On"	Constant Daily Weekly "Off and On"
How long have you had this complaint?	____ Days / Weeks / Months / Years	____ Days / Weeks / Months / Years	____ Days / Weeks / Months / Years	____ Days / Weeks / Months / Years
Is it getting better, worse, or staying the same?	Better Worse Same	Better Worse Same	Better Worse Same	Better Worse Same
What makes it better, if anything?				
What makes it worse, if anything?				
On a scale of 0 – 10, rate your discomfort. ***(0 = no pain, 10 = excruciating)***	**Circle response** 0 1 2 3 4 5 6 7 8 9 10	**Circle response** 0 1 2 3 4 5 6 7 8 9 10	**Circle response** 0 1 2 3 4 5 6 7 8 9 10	**Circle response** 0 1 2 3 4 5 6 7 8 9 10
How have you taken care of this in the past? Has that worked for you?				
Circle the ways this issue is affecting your life. *(all that apply)*	job children sex marriage household hobbies finances sports exercise walking standing bowels urinary fatigue loss of sleep moody poor attitude loss of productivity	job children sex marriage household hobbies finances sports exercise walking standing bowels urinary fatigue loss of sleep moody poor attitude loss of productivity	job children sex marriage household hobbies finances sports exercise walking standing bowels urinary fatigue loss of sleep moody poor attitude loss of productivity	job children sex marriage household hobbies finances sports exercise walking standing bowels urinary fatigue loss of sleep moody poor attitude loss of productivity
Improving this issue in my life would improve my quality of life by: *(Circle best response)*	10-20% 30-40% 50-60% 70-80% 90% 100%	10-20% 30-40% 50-60% 70-80% 90% 100%	10-20% 30-40% 50-60% 70-80% 90% 100%	10-20% 30-40% 50-60% 70-80% 90% 100%

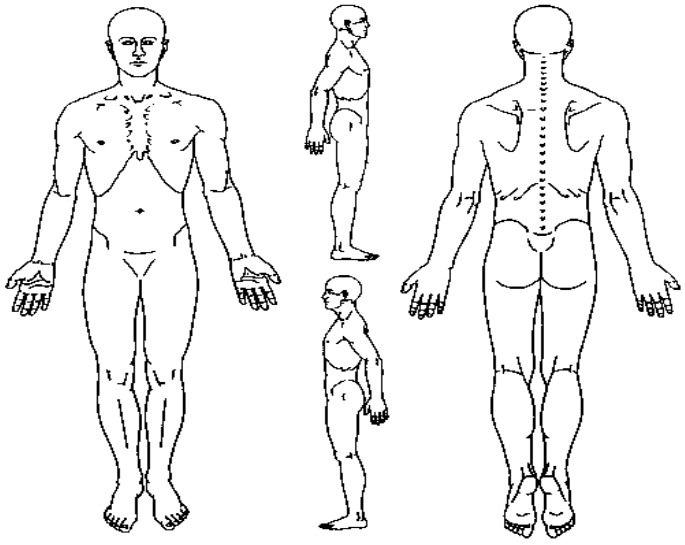
Have you taken any of the following for the above complaints in the last 6 months? ❑ Tylenol ❑ Ibuprofen/NSAIDs ❑ Aspirin
Have you tried any of the following? ❑ Physical Therapy/Rehab ❑ Occupational Therapy ❑ Chiropractic ❑ Pain Mngt ❑ Ice/Heat

How long ago, or how often did you attempt the selected therapies? _____

PATIENT HEALTH HISTORY

Please check if you are currently experiencing any of the following conditions and then circle problematic areas on body to right:

❑ Neck Pain/Stiffness	❑ Pins/Needles in Arms	❑ Nausea
❑ Back Pain/Stiffness	❑ Pins/Needles in Legs	❑ Night Pain
❑ Arm/Hand Pain	❑ Light Bothers Eyes	❑ Fatigue
❑ Leg/Knee Pain	❑ Recent Weigh Change	❑ Fever
❑ Headaches	❑ Loss of Memory	❑ Tension
❑ Loss of Taste	❑ Cold Extremities	❑ Chest Pain
❑ Nervousness	❑ Sleeping Difficulties	❑ Asthma
❑ Jaw Problems	❑ Bowel/Bladder Changes	❑ Cold Sweats
❑ Dizziness/Fainting	❑ Constipation/Diarrhea	❑ Loss of Smell
❑ Blurred/Double Vision	❑ Loss of Balance	❑ Swollen Joints
❑ Mood Changes	❑ Trouble Concentrating	❑ Foot Trouble



Patient Name: _____ Date: _____

PATIENT HEALTH HISTORY continued…. *Please check if you have ever had any of the following:*

- ❑ ADD/ADHD
- ❑ Aids/HIV
- ❑ Alcoholism
- ❑ Allergy Shots
- ❑ Anemia
- ❑ Anorexia
- ❑ Appendicitis
- ❑ Arthritis
- ❑ Asthma/Wheezing
- ❑ Bad Breath/Taste
- ❑ Bleeding Disorders
- ❑ Blood Pressure: High or Low (circle)
- ❑ Breast Lump
- ❑ Broken Bones
- ❑ Bronchitis
- ❑ Bulimia
- ❑ Cancer
- ❑ Cataracts
- ❑ Chemical Dependency
- ❑ Chicken Pox
- ❑ Colon Trouble
- ❑ Contacts/Glasses
- ❑ Depression
- ❑ Diabetes
- ❑ Dry Skin
- ❑ Ear Infections
- ❑ Epilepsy
- ❑ Fibromyalgia
- ❑ Fractures
- ❑ Gall Bladder
- ❑ Glaucoma
- ❑ Goiter
- ❑ Gonorrhea
- ❑ Gout
- ❑ Heartburn
- ❑ Heart Attack
- ❑ Heart Problems
- ❑ Hemorrhoids
- ❑ Hepatitis
- ❑ Hernia
- ❑ Herniated Disc
- ❑ Herpes
- ❑ High Cholesterol
- ❑ Hormone/Gland Problems
- ❑ Insomnia
- ❑ Kidney Problems
- ❑ Liver Disease
- ❑ Measles
- ❑ Menopausal Prob.
- ❑ Migraines
- ❑ Miscarriage
- ❑ Mononucleosis
- ❑ Mouth Sores or Bleeding Gums
- ❑ Multiple Sclerosis
- ❑ Mumps
- ❑ Nosebleeds
- ❑ Osteoporosis
- ❑ Pacemaker
- ❑ Parkinson's Disease
- ❑ Pinched Nerve
- ❑ Pneumonia
- ❑ Polio
- ❑ Prostate Problems
- ❑ Prosthesis
- ❑ Psychiatric Care
- ❑ Rheumatoid Arthritis
- ❑ Rheumatic Fever
- ❑ Scarlet Fever
- ❑ Sexual Difficulty
- ❑ Stroke
- ❑ Suicide Attempt
- ❑ Thyroid Problems
- ❑ TMJ Pain
- ❑ Tonsillitis
- ❑ Tremors
- ❑ Tuberculosis
- ❑ Tumors/Growths
- ❑ Typhoid Fever
- ❑ Ulcers
- ❑ Vaginal Infections
- ❑ Venereal Disease
- ❑ Whooping Cough
- ❑ Other: _____
- _____
- _____

Are you currently under drug and/or medical care? ❑ Yes ❑ No If yes, explain _____

Please list any and all medications, supplements/vitamins, herbs etc. you are currently taking:

Name	Strength/Dosage	Frequency	What are you taking it for?

Please list any surgeries and/or hospitalizations you have had (type & date): _____

_____

ALLERGIES (food/drug/etc.): _____

Is there a family history of any of the following conditions? *(indicate family member including parents, grandparents & siblings)*

❑ Heart Disease_____ ❑ Diabetes _____
❑ Cancer _____ ❑ Arthritis _____ ❑ Other _____

Do you exercise: ❑ 5-7x/week ❑ 3-4x/week ❑ 1-2x/week ❑ Occasionally ❑ None

Do your work activities mostly involve: ❑ Sitting ❑ Standing ❑ Light Labor ❑ Heavy Labor

Do you sleep on your: ❑ Back ❑ Side ❑ Stomach Do you use a cervical pillow? ❑ Yes ❑ No

What is your daily/weekly intake of the following: Caffeine ____ cups/day Alcohol ____ drinks/week Cigarettes _____ pks/day

I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health. I will give complete & accurate information during my exam.

Signature (X) _____ Date_____

Patient Name: _____ Date: _____

TERMS OF ACCEPTANCE AND CONSENT FOR CARE

The clinic will attempt to identify and diagnose any ailments you may have that may be corrected through physical medicine, massage therapy, chiropractic care, and/or active/passive rehabilitation. If any condition or disease appears to be present out of our scope of practice, we will refer you to an appropriate physician to diagnose and/or treat that condition. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases underlying physical defects, deformities or pathologies, may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known these things which otherwise might not come to the attention of the physician (deformities, illnesses, etc).

I agree to settle any claim or dispute I may have against or with any of these persons or entities, whether related to the prescribed care or not, by binding arbitration under the current malpractice terms which can be obtained by written request.

I also understand that the fee paid for treatment x-rays is for analysis only. The file itself is the property of this office. Once films are taken, they cannot be released, but may be copied. There is a fee for copying of the xrays.

Also, for your protection, portions of our office where patients do not disrobe are under video surveillance, specifically, but not limited to, the front desk check-out stations.

I have read and I accept the terms above and understand them fully. I hereby give consent to the clinic to evaluate me to determine my condition and treat me for such conditions. I also understand that I may at any time discontinue with the exam and/or x-rays or any treatment if I so choose.

I also understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered to me will be immediately due and payable. I agree that I will be responsible for all attorney and legal fees if legal action becomes necessary to collect this amount.

I, _____ have read and fully understand the above statements.
(PRINT NAME)

_____ _____
(SIGNATURE) (DATE)

FOR MINORS: I, _____ being the parent or legal guardian of _____,
(Print Guardian Name) *(Print Minor's Name)*
have read and fully understand the above terms of acceptance & grant permission for my child to receive treatment.

_____ _____
(SIGNATURE) (DATE)

X-ray Questionnaire: For women only Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

Name: _____ Date of last menstrual period: _____

☐ There is a possibility that I may be pregnant at this time
☐ No, I am definitely not pregnant at this time
☐ Yes, I am definitely pregnant
☐ I request that x-ray films not be taken because:

_____ _____
Patient's Signature Date

NEUROLOGICAL/MRI/VASCULAR PATIENT QUESTIONNAIRE

1. Weakness, numbness or burning in your shoulder, arms or hands? NO YES
2. Do your hands or arms fall asleep regularly? NO YES
3. Reduced feeling (sensation) or swelling in your hands or arms? NO YES
4. Loss of handgrip strength? NO YES
5. Weakness, numbness or burning in your buttocks, legs or feet? NO YES
6. Do our legs or feet fall asleep regularly? NO YES
7. Reduced feeling (sensation) or swelling in your legs, feet? NO YES
8. Cold Hands/Feet? NO YES
9. Have you had an MRI? NO YES

If yes to MRI, When? Who ordered it?
What was it ordered for?
_____
_____
_____

INTEGRA MEDICAL
Medical Chiropractic Rehab

Patient Name: _____ Date: _____

Allergy, Food, Chemical Sensitivity, & Inflammation

Gender: M / F Height: Feet _____Inches _____ Weight: _____lbs.

Please complete the following allergy, food and chemical sensitivity questionnaire. Score each symptom based upon your experiences over the last 90 days. Circle appropriate number 0-5 according to severity.

0=No Problem at All
1=Extremely Mild Symptoms
2=Mild to Moderate Symptoms Occasionally
3=Moderate Symptoms Frequently
4=Moderate to Severe Symptoms
5=Very Severe Symptoms

Digestive Symptoms
0 1 2 3 4 5 Stomach Pains or Cramping
0 1 2 3 4 5 Constipation
0 1 2 3 4 5 Diarrhea
0 1 2 3 4 5 Reflux or Heartburn
0 1 2 3 4 5 Bloating
0 1 2 3 4 5 Gas
0 1 2 3 4 5 Nausea or Vomiting

Weight
0 1 2 3 4 5 Inability to Lose Weight
0 1 2 3 4 5 Food Cravings
0 1 2 3 4 5 Binge Eating
0 1 2 3 4 5 Water Retention

Sinus/Respiratory
0 1 2 3 4 5 Stuffy or Runny Nose
0 1 2 3 4 5 Asthma
0 1 2 3 4 5 Chest Congestion
0 1 2 3 4 5 Chronic Cough
0 1 2 3 4 5 Wheezing
0 1 2 3 4 5 Frequent Sneezing or Nasal Discharge

Head/Ears
0 1 2 3 4 5 Migraines
0 1 2 3 4 5 Headaches
0 1 2 3 4 5 Earaches
0 1 2 3 4 5 Sinus or Ear Infections
0 1 2 3 4 5 Ringing in Ears

Eyes/Throat
0 1 2 3 4 5 Itchy Eyes
0 1 2 3 4 5 Watery Eyes
0 1 2 3 4 5 Sore Throats or Colds
0 1 2 3 4 5 Persistent Canker Sores

Emotional/Mental
0 1 2 3 4 5 Depression
0 1 2 3 4 5 Anxiety
0 1 2 3 4 5 Mood Swings
0 1 2 3 4 5 Irritability
0 1 2 3 4 5 Poor Concentration/Memory

Energy
0 1 2 3 4 5 Fatigue
0 1 2 3 4 5 Hyperactivity
0 1 2 3 4 5 Lethargy
0 1 2 3 4 5 Restlessness
0 1 2 3 4 5 Insomnia

Skin Disorders
0 1 2 3 4 5 Eczema
0 1 2 3 4 5 Dermatitis
0 1 2 3 4 5 Excessive Sweating
0 1 2 3 4 5 Rashes
0 1 2 3 4 5 Hives

Other Symptoms:
0 1 2 3 4 5 Joint Pain
0 1 2 3 4 5 Arthritis
0 1 2 3 4 5 Irregular Heartbeat
0 1 2 3 4 5 Chest Pains
0 1 2 3 4 5 Muscle Aches

Please list any symptoms not mentioned above:
_____
_____

TOTAL SCORE: _____

Patient Name: _____ Date: _____

PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In the course of your care as a patient Integra Medical, we may use or disclose personal and health related information about you in the following ways:

- Your personal health information, including your clinical records, may be disclosed to another healthcare provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
- Your healthcare records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or may be responsible for the payment of your services.
- Your name, address, phone number, and healthcare records may be used to contact you regarding appointment reminders, information about alternative to your present care, or other health related information that may be of interest to you.

If you are not at home to receive an appointment reminder, a message may be left on your answering machine. Furthermore, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provided to you or the reimbursement avenues associated with your care.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in the following circumstances:

- If we are providing healthcare to you based on the orders of another healthcare provider.
- If we provide healthcare services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain our consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
- If we are ordered by the courts or another appropriate agency.

Any use or discloser of your protected health information, other than as outlined above, will only be made upon your written authorization.

We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your healthcare or about the status of your account. If you would like to receive this information at an address other than your home or if you would like the information in a different form, please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. In addition you have the right to request an amendment to your health information. Requests to inspect, copy or amend our health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the Information that we use or disclose based on this privacy notice may be subject to re-discloser by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to: Dr. Brice Neff. If you would like further information about our privacy policies and practices please contact: Dr. Brice Neff.

This notice is effective as of December 1, 2011. This notice, and any alterations or amendments made hereto will expire seven (7) years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

_____ _____ _____

Name (Print) *Signature* *Date*