

CONFIDENTIAL PATIENT INFORMATION

FEDERAL AND STATE LAWS REQUIRE ALL HEALTH CARE PROVIDERS TO COLLECT THE FOLLOWING INFORMATION AND KEEP IT ON FILE FOR FOUR (4) YEARS. PLEASE COMPLETE THE FOLLOWING FORMS. THANK YOU.

(PLEASE PRINT)

NAME _____ TODAY'S DATE _____
HOME PHONE _____ CELLULAR/PAGER _____
ADDRESS _____ E-MAIL ADDRESS _____
CITY _____ STATE _____ ZIP _____
AGE _____ BIRTH DATE _____ MARITAL STATUS M S W D
NUMBER OF CHILDREN _____
OCCUPATION _____ PHONE _____
EMPLOYER _____
ADDRESS _____
NAME OF SPOUSE _____ OCCUPATION _____
EMPLOYER _____ PHONE _____
NEAREST RELATIVE _____ PHONE _____
WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____
NAME OF PERSON RESPONSIBLE FOR PAYMENT _____
NAME OF HEALTH PLAN _____

AUTHORIZATION TO PROVIDE TREATMENT AND BILL HEALTH PLAN:

THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US. WE UNDERSTAND THAT YOUR HEALTH INFORMATION IS PERSONAL AND WE ARE COMMITTED TO PROTECTING IT. WE CREATE A RECORD OF YOUR CARE AND SERVICES YOU RECEIVE AT OUR CLINIC. WE NEED THIS RECORD TO PROVIDE YOU WITH QUALITY CARE AND COMPLY WITH FEDERAL AND STATE LAWS. COPIES OF YOUR RECORDS ARE AVAILABLE FOR A NOMINAL FEE. COPIES OF X-RAYS ARE AVAILABLE FOR \$35.00 PER X-RAY, OR HIGH RESOLUTION PHOTOGRAPHS ARE AVAILABLE IN CD FORMAT FOR \$5.00. WE WILL MAINTAIN YOUR RECORDS IN ACCORDANCE WITH STATE LAW FOR NO LESS THAN SIX YEARS.

THE INFORMATION OBTAINED FROM YOU WILL ALWAYS BE HELD IN STRICT CONFIDENCE. BY SIGNING BELOW, YOU ARE AGREEING TO ALLOW US TO PROVIDE YOU APPOINTMENT CONFIRMATIONS, BIRTHDAY CARDS, AND OTHER SUCH INFORMATION THAT WILL MAKE YOUR TREATMENT MORE ENJOYABLE AND PRODUCTIVE.

I AUTHORIZE DR. MARK A. BROWN TO PROVIDE TREATMENT TO ME. I UNDERSTAND THAT AMELIA ISLAND HEALTH & WELLNESS WILL VERIFY MY INSURANCE COVERAGE AND PREPARE NECESSARY REPORTS AND FORMS, AND ASSIST IN MAKING COLLECTION FROM MY HEALTH PLAN. BY SIGNING BELOW, I AM AUTHORIZING AMELIA ISLAND HEALTH & WELLNESS TO RELEASE MY HEALTH INFORMATION INCLUDING MY MEDICAL HISTORY, X-RAY RESULTS, AND PHYSICAL EXAMINATION FINDINGS, DIAGNOSIS AND PROGNOSIS TO MY HEALTH PLAN.

UNFORTUNATELY, THERE IS NO GUARANTEE MY HEALTH PLAN WILL MAKE PAYMENT AND I UNDERSTAND THAT CHARGES FOR TREATMENT ARE ULTIMATELY MY RESPONSIBILITY. ANY AMOUNT PAID BY THE HEALTH PLAN WILL BE PAID DIRECTLY TO AMELIA ISLAND HEALTH & WELLNESS AND WILL BE CREDITED TO MY ACCOUNT. A SERVICE CHARGE OF 1% PER MONTH WILL BE ASSESSED ON ALL ACCOUNTS OLDER THAN 60 DAYS. ANY FEES NECESSARY FOR THE COLLECTION OF THIS ACCOUNT WILL ALSO BE MY RESPONSIBILITY. IF I SUSPEND OR TERMINATE MY CARE AND TREATMENT, ANY FEE FOR PROFESSIONAL SERVICES RENDERED WILL BE IMMEDIATELY DUE AND PAYABLE.

MY HEALTH PLAN (S) IS HEREBY DIRECTED AND AUTHORIZED TO MAKE PAYMENTS DIRECTLY TO AMELIA ISLAND HEALTH & WELLNESS

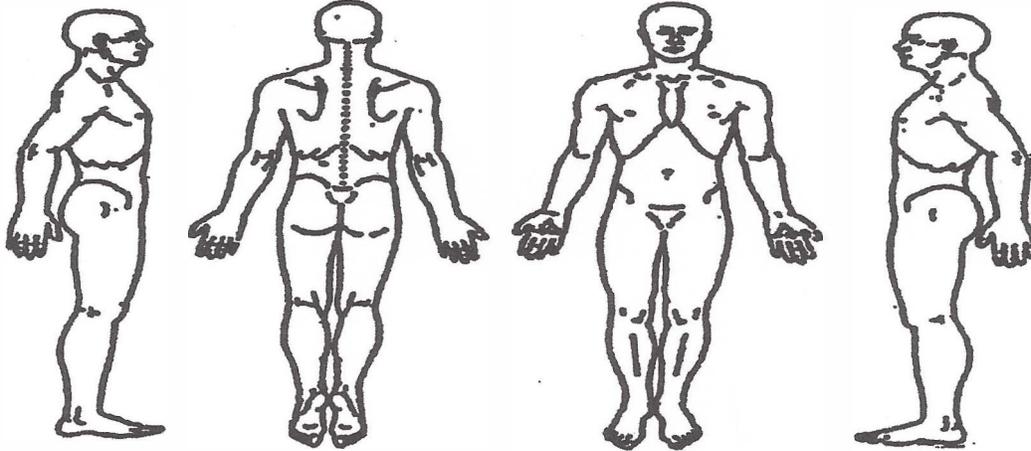
PATIENT'S SIGNATURE _____ PARENT/ GUARDIAN _____

SIGNATURE AUTHORIZING CARE _____ DATE _____

Confidential Patient Information

Patient Name: _____ Date _____

1. Indicate on the drawings below where you have pain/symptoms



2. How often do you experience your symptoms?

- Constantly (76-100% of the time) Occasionally (26-50% of the time) Frequently (51-75% of the time) Intermittently (1-25% of the time)

3. How would you describe the type of pain?

- | | | | |
|----------------------------------|---|-----------------------------------|--|
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Numb | <input type="checkbox"/> Dull | <input type="checkbox"/> Tingly |
| <input type="checkbox"/> Diffuse | <input type="checkbox"/> Sharp with motion | <input type="checkbox"/> Achy | <input type="checkbox"/> Shooting with motion |
| <input type="checkbox"/> Burning | <input type="checkbox"/> Stabbing with motion | <input type="checkbox"/> Shooting | <input type="checkbox"/> Electric like with motion |
| <input type="checkbox"/> Stiff | <input type="checkbox"/> Other _____ | | |

4. How are your symptoms changing with time?

- Getting Worse Staying the Same Getting Better

5. Using a scale of 0-10 (10 being the worst), how would you rate your problem?

(Please circle) 0 1 2 3 4 5 6 7 8 9 10

6. How much has the problem interfered with your work?

__Not at all __A little bit __Moderately __Quite a bit __Extremely

7. How much has the problem interfered with your social activities?

__Not at all __A little bit __Moderately __Quite a bit __Extremely

8. Who else have you seen for your condition?

- | | | | |
|---------------------------------------|--|---|---------------------------------------|
| <input type="checkbox"/> Chiropractor | <input type="checkbox"/> Neurologist | <input type="checkbox"/> Primary Care Physician | <input type="checkbox"/> ER physician |
| <input type="checkbox"/> Orthopedist | <input type="checkbox"/> Massage Therapist | <input type="checkbox"/> Physical Therapist | <input type="checkbox"/> Other _____ |

9. How long have you had this problem? (i.e. date of onset?) _____

10. How do you think your problem began? (i.e. accident or injury) _____

11. What aggravates your problem? _____

12. What alleviates your problem (makes it better)

13. What concerns you the most about your problem; what does it prevent you from doing? _____

14. What is your: Height _____ Weight _____

15. Indicate if you have any immediate family members with any of the following:

- Rheumatoid Arthritis Diabetes Lupus Heart Problems Cancer ALS

16. List all medications you are currently taking: _____

17. Please check any of the conditions below that may apply to you.

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Heart Attack |
| <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Stroke | <input type="checkbox"/> Smoking/Tobacco Use |
| <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Angina | <input type="checkbox"/> Drug/Alcohol Dependence | <input type="checkbox"/> Kidney Stones |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Kidney Disorders | <input type="checkbox"/> Depression | <input type="checkbox"/> Bladder Infection |
| <input type="checkbox"/> Systemic Lupus | <input type="checkbox"/> Painful Urination | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Loss of Bladder Control |
| <input type="checkbox"/> Dermatitis/Eczema/Rash | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Abnormal Weight Gain/Loss |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Loss of Appetite | <input type="checkbox"/> Ulcer | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Liver/Gall Bladder Disorder | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> General Fatigue | <input type="checkbox"/> Tumor | <input type="checkbox"/> Loss of muscle coordination | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Visual Disturbances | <input type="checkbox"/> Chronic Sinusitis | <input type="checkbox"/> Abdominal Pain | |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Other _____ | | |

18. List all surgical procedures you have had: _____

19. Have you ever been hospitalized? No Yes if yes, why? _____

20. What activities do you do at work?

- Sit: most of the day Half of the day A little of the day
- Stand: most of the day Half of the day A little of the day
- Computer Work: most of the day Half of the day A little of the day
- On the Phone: most of the day Half of the day A little of the day

21. What activities do you do outside of work? _____

22. Have you had significant past trauma? No Yes

23. Anything else pertinent to your visit today? _____

Patient Signature _____ Date: _____

Amelia Island Health & Wellness

Informed Consent to Chiropractic Treatment

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to adjust your spine. Various therapeutic procedures, such as hot or cold packs, electric muscle stimulation, or other therapies may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic adjustment. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The therapeutic procedures could produce skin irritation, burns or minor complications. Should you have questions you will be given the opportunity to discuss them with the doctor before you receive treatment.

Probability of risks occurring: The risk of complications due to chiropractic treatment have been described as "rare", about as often as complications from taking a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be further reduced by screening procedures. The probability of adverse reaction due to therapeutic procedures is also considered "rare."

Other treatment options which could be considered may include the following:

- *Over-the-counter analgesics.* The risk of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- *Medical care,* typically anti-inflammatory drugs, tranquilizers and analgesics. Risk of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

I have read the explanation above of chiropractic treatment. I have fully evaluated the risks and benefits of undergoing treatment. I have decided to undergo chiropractic treatment, and hereby give my full consent to treatment. I intend this agreement to be in effect for all treatments from the date signed until I curtail treatment at this facility.

Patient Printed Name

Patient Signature

Date

Witness:

Printed Name

Signature

Date
