SURFSIDE CHIROPRACTIC NEW PATIENT QUESTIONNAIRE

Full Name		Age:	Birth Date:
Address:	City:	State:	Zip:
Gender: □Male □Female	Marital Status □Single □Married □Divorced □Widowed □Separated		SS#
Email:	Cell Phone:	Home Phone:	
Occupation:		Employer:	
Emergency Contact (Name, Relationship & Phone No.):			
Family Medical Doctor:		Who referred you to us?	
INSURANCE INFO: Please provide us with your insurance and ID card for us to copy for our records.			
Insurance Company Name:	Member/Subscriber ID#:		

COMPLAINT HISTORY

Rate your pain on a scale of 0-10 below. *(Example: 1-3 Mild pain, 4-6 Moderate pain, 7-9 Severe pain, 10 Excruciating pain)*

Neck (0-10): ____Mid Back (0-10): ___ Low Back (0-10): ____Headache (0-10): ___ Other (0-10): _____

How much have your complaints interfered with your daily activities in the past week? *(please circle):*

No interference ⓪①②③④⑤⑥⑦⑧⑨⑩ *Extremely affected*

Please List Affected Activities: _____

Please Answer the Following Questions in Regards to Your Main Complaint

Main Complaint ***(Mark Only One):*** □Neck Pain □Low Back Pain □Mid-Back Pain □Headache □Other: _____

1. Describe your Main complaint and how it started? _____
   _____
2. What percentage of the day are you experiencing pain? □<25% □26-50% □51-75% □76-100%
3. What does your pain feel like? □Sharp □Dull □Stiff □Tight □Throbbing □Shooting □Stabbing □Numbing □Tingling □_____
4. What relieves this complaint? _____
5. What aggravates this complaint? _____
6. When does this problem bother you most? □Morning □Night □After activities □During activities □Other: _____
7. With time is your complaint: □Improving □Worsening □Not changing
8. Have you seen another medical provider for this complaint? □Yes □No If so, who? _____

SECONDARY COMPLAINT: ***ONLY Answer the Following Questions if You Have an Additional Complaint***

Secondary Complaint(s): □Neck Pain □Low Back Pain □Mid-Back Pain □Headache □Other: _____

1. Describe your Secondary complaint and how it started? _____
2. What percentage of the day are you experiencing pain? □<25% □26-50% □51-75% □76-100%
3. What does your pain feel like? □Sharp □Dull □Stiff □Tight □Throbbing □Shooting □Stabbing □Numbing □Tingling □_____
4. What relieves this complaint? _____
5. What aggravates this complaint? _____
6. When does this problem bother you most? □Morning □Night □After activities □During activities □Other: _____
7. With time are you: □Improving □Worsening □Not changing

MEDICAL, SOCIAL AND FAMILY HISTORY

1. Do you have any of the following ailments? (*please mark*):

□Arthritis □Diabetes □Headaches □Osteoporosis □Epilepsy/ Seizures □Stroke □Digestive Problems
□Anxiety □Depression □Migraines □Osteopenia □High Blood Pressure □Liver Problems □Liver or Kidney Disease
□Anemia □Cancer □Heart Disease □Disc Herniation □High Cholesterol □Thyroid Disorders □Urinary/Prostate Problems

2. Do you have any other medical conditions? □Yes □No If so, please list? _____

3. Do you have pain in any of your joints of your arms or legs? □Yes □No If yes, please list? _____

4. Do any of the following conditions run in your family (*please mark*):

□Anemia □Cancer □Diabetes □Heart Problems / Stroke □High Blood Pressure □Genetic Disorders □Rheumatoid Arthritis

5. Past Injuries, Fractures, Accidents (*list and date*): _____

6. Past Surgeries (*list and date*): _____

7. Allergies (*list*): _____

8. Medications (*list*): _____

9. Do you exercise? □Yes □No Days per week? ____ Intensity? □Light □Moderate □Strenuous Type? _____

10. Do you smoke? □Yes □No □I Quit How many packs do you smoke per week? _____

11. How often do you drink alcohol? □Daily □Weekly □Monthly □Special Occasions □Never

12. How often do you take over-the-counter pain medications? □Daily □Weekly □Monthly □Rarely □Never

13. In general would you say your overall health right now is: □Excellent □Very Good □Good □Fair □Poor

14. Have you seen a chiropractor in the past? □Yes □No

15. Have you had and X-rays, MRIs or CT scans of the area of your complaint? *(list and date):* _____

_____

What are your hobbies? _____

Current Height: _____ Weight: _____

WOMEN ONLY
Currently Pregnant? □Yes □No #Weeks?
Painful/ Abnormal Menstrual Cycle? □Yes □No
Menopause? □Yes □No
Do you have children? □Yes □No
Circle: Vaginal Birth or C-Section
How many children do you have?
Taking Birth Control Pills? □Yes □No

AUTHORIZATION AND RELEASE: I certify the above information is complete and accurate to the best of my knowledge and give permission to Surfside Chiropractic to contact me. I give authorization to my chiropractor to contact my physician if necessary. I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with payers to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage.

Name: _____

Signature: _____ Date: _____

Area for Doctors Notes:

General Pain Index Questionnaire

We would like to know how much your pain presently ***prevents*** you from doing what you would normally do. Regarding each category, please indicate the ***overall*** impact your present pain has on your life, not just when the pain is at its worst.

Please ***circle the number*** which best describes how your typical level of pain affects these six categories of activities.

1. Family/at -home responsibilities such as yard work, chores around the house or driving the kids to school -

0 1 2 3 4 5 6 7 8 9 10

completely able to function — totally unable to function

2. Recreation including hobbies, sports or other leisure activities –

0 1 2 3 4 5 6 7 8 9 10

completely able to function — totally unable to function

3. Social activities including parties, theater, concerts, dining –out and attending other social functions with friends -

0 1 2 3 4 5 6 7 8 9 10

completely able to function — totally unable to function

4. Employment including volunteer work and homemaking tasks -

0 1 2 3 4 5 6 7 8 9 10

completely able to function — totally unable to function

5. Self -care such as taking a shower, driving or getting dressed -

0 1 2 3 4 5 6 7 8 9 10

completely able to function — totally unable to function

6. Life -support activities such as eating and sleeping -

0 1 2 3 4 5 6 7 8 9 10

completely able to function — totally unable to function

Print Name: _____Signature: _____ Date: _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

_____ _____
Patient Name (please print) Date

_____
Parent, Guardian or Patient's legal representative

_____
Signature

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.

List below the names and relationship of people to whom you authorize Surfside Chiropractic to release PHI.

_____ _____

_____ _____

_____ _____

CHIROPRACTIC INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic procedures, including various modes of physio therapy, diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with Dr. R. Nick Baiata and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures.

I understand and I am informed that, as is with all Healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all Healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I further understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if I wish to cancel the treatment.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Parent/Guardian and Relationship to Patient: _____

Parent/ Guardian Signature: _____ Date: _____

Patient Name: _____Signature: _____ Date: _____