pines wellness center

CHIROPRACTIC & FUNCTIONAL REHABILITATION

CONFIDENTIAL PATIENT INFORMATION

Personal Information

Full Name:	**Date:**
Address: City State Zip	
Cell phone:	**Home phone:**
Occupation:	**Work phone:**
Email address:	
Date of birth:	**Age:**
No. of children:	**Pregnant? Yes □ No □**
Weight:	**Height:**
Driver's license number:	**Social Security Number:**
Marital status: M S W D	**Spouse/guardian name:**
Emergency Contact:	**Phone:**
Name of person responsible for account:	
Do you have insurance that covers Chiropractic care? Yes □ No □	**Do you have Medicare coverage?** Yes □ No □

Who may we thank for referring you? ____

COMPLAINTS			
1.			
2.			
3.			
4.			
5.			
Have you experienced any serious accidents or falls within the Past year? 5 years? Over 5 years? Never?			
If you have experienced an accident, what type was it? Auto Work Home Leisure Sports Other			
1. Are you interested in a weight loss program?	**YES**	**NO**	**MAYBE**
2. Would you take nutritional supplements if indicated?	**YES**	**NO**	**MAYBE**
3. Are you interested in knowing more about how your nutrition affects your overall health and well being?	**YES**	**NO**	**MAYBE**
4. If Dietary changes are indicated would you be willing to make changes to your diet?	**YES**	**NO**	**MAYBE**
5. If specific exercises or stretching would help, would you consider adding them to your program?	**YES**	**NO**	**MAYBE**

Medical History Form

Name: ____ Age:_______ Date of Birth:________

Medications and dosages:

______________________ ______________________ ______________________
______________________ ______________________ ______________________
______________________ ______________________ ______________________
______________________ ______________________ ______________________

Allergies/Reactions:

______________________ ______________________ ______________________
______________________ ______________________ ______________________

Past Medical History

Do you have or have you had any of the following medical conditions? (Please circle)

Cancer	Kidney Disease	Blood Disorders	Gout
Bladder problems	Neurological Disorders	High Blood Pressure	Urinary Tract
Infections	Stomach Ulcers	Stroke	Liver Disease
Heart Attack	Hepatitis	Tuberculosis	Thyroid Problems
Heart Disease	Emphysema/ COPD	Pacemaker	Congestive Heart Failure
Asthma	Diabetes	Depression	Anxiety
HIV/AIDS	High Cholesterol	Osteoporosis	Psychiatric disorder
Arthritis	Rheumatoid Arthritis	Headaches	

Other:____

Surgical History

Have you had any of the following surgical procedures? (Please Circle and Include dates)

Back Surgery ____________________________________ Neck Surgery __________________________
Knee Surgery ____________________________________Shoulder Surgery _________________________
Heart Surgery ____________________________________Other: __________________________________

Family History

Does anyone in your family suffer from any of the following medical conditions? (Please circle)

Cancer	Kidney Disease	Blood Disorders	Gout
Bladder problems	Neurological Disorders	High Blood Pressure	Urinary Tract
Infections	Stomach Ulcers	Stroke	Liver Disease
Heart Attack	Hepatitis	Tuberculosis	Thyroid Problems
Heart Disease	Emphysema/ COPD	Pacemaker	Congestive Heart Failure
Asthma	Diabetes	Depression	Anxiety
HIV/AIDS	High Cholesterol	Osteoporosis	Psychiatric disorder
Arthritis	Rheumatoid Arthritis	Headaches	

Other:____

Social History

Social History: Are you: Married Single Divorced Widowed
Do you smoke? YES or NO Packs per day _____________
Do you drink alcohol? YES or NO Drinks per week ___________
Do you use street drugs? YES or NO

Occupation: Are you working? YES or NO Job Description:_____________________________
Work Restrictions? YES or NO List Restrictions: _____________________________
Do you like your job? YES or NO

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Informed Consent

Patient: ____________________ Date: ___________

To the patient: Please read this entire document prior to signing. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment:

The primary treatment used by the doctors of chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. They may cause an audible "pop" or "click", much as you have experienced when you "crack" your knuckles. You may sense a feel of movement.

Analysis/Examination/Treatment:

As a part of the analysis, examination, and treatment, you are consenting to the following procedures:

*Spinal Manipulative Therapy *Palpation *Vital Signs
*Range of Motion Testing *Orthopedic Testing *Basic Neurological Testing
*Muscle Strength Testing *Posture Analysis *EMS
*Radiographic Studies *Hot/Cold Therapy *Other ____________

The material risks inherent in chiropractic adjustments:

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of 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 Doctor will make every reasonable effort during examination to screen for contraindications to care; however if you have a condition that would otherwise not come to the Doctor's attention, it is your responsibility to inform the Doctor.

<u>The probability of those risk occurring:</u>

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 X-ray. Stroke has been a subject of tremendous disagreement. The indications of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described are rare.

<u>The availability and nature of other treatment options:</u>

Other treatment options for your condition may include:

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

If you choose the above noted "other treatment options" you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

<u>The risk and dangers of remaining untreated:</u>

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer postponed.

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. Robert Kustin 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 decided that it is my best interest to undergo the treatment recommended. Having been informed of the risks, I herby give my consent to that treatment.

Date: ______________________________

Patient Name: ______________________________

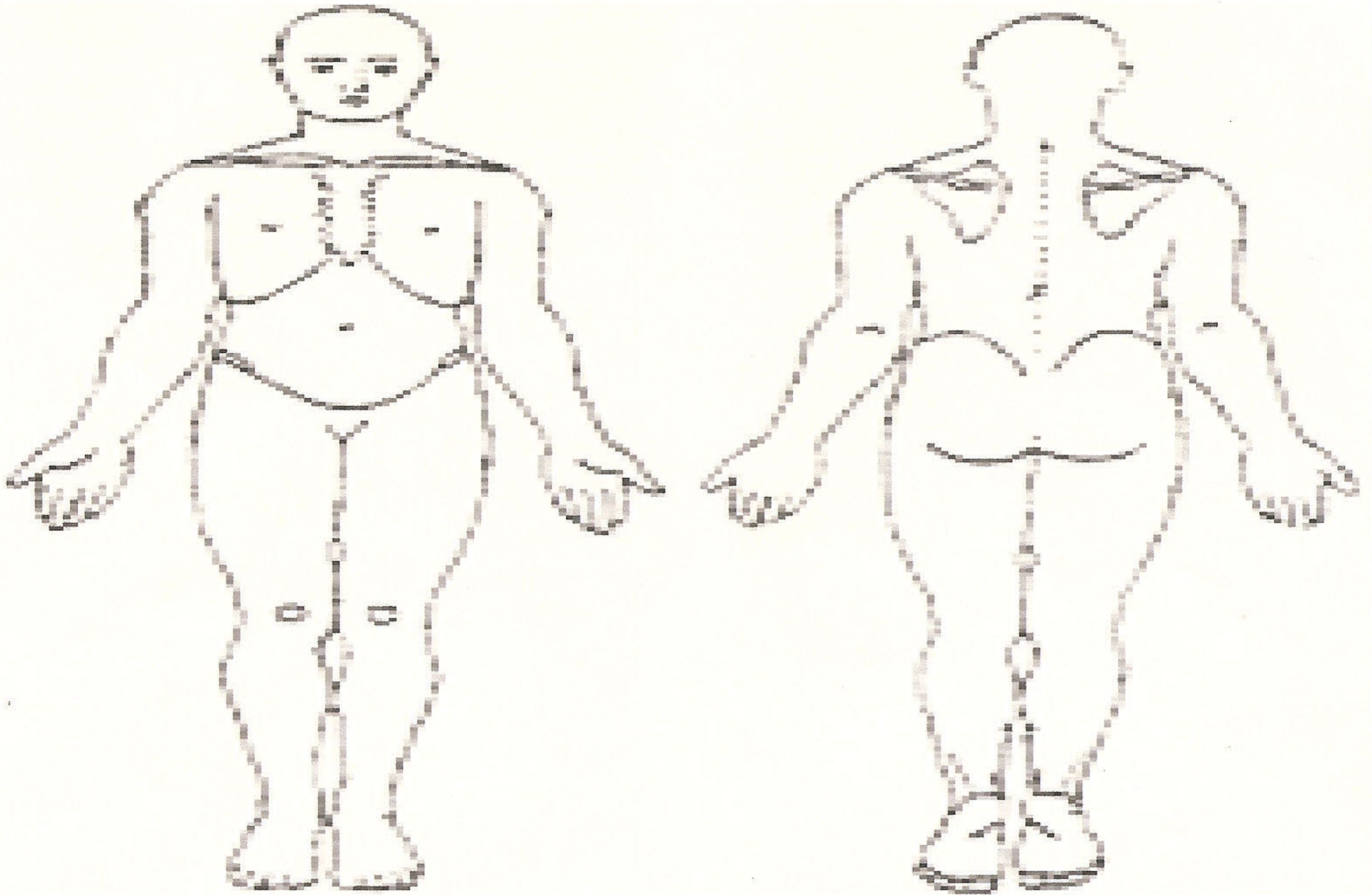
Patient Signature: _______________________________

Doctor's Signature: _______________________________

SHOW ME WHERE IT HURTS

Mark these drawings according to where your pain is located. Indicate with the symbols the types of pain you experience.

Stabbing = ** Burning = XXX Numbness = \\\ Weakness = +++ Pin & Needles = OOOOO



ABOUT YOUR PAIN

How Long has the pain been present?							
The pain is increased when I:	Sit	Stand	Walk	Run	Bend	Lay	Exercise
The pain is Improved when I:	Sit	Stand	Walk	Run	Bend	Lay	Exercise
Do any of the following help alleviate the pain?		Ice	Heat	Massage		Stretching	

PEMBROKE PINES PHYSICIANS ASSOCIATES, INC.

MEDICAL RELEASE AND ASSIGNMENT OF BENEFITS

RELEASE AUTHORIZATION TO PEMBROKE PINES PHYSICIANS ASSOCIATES TO ENDORSE CHECKS AND/OR TO SIGN ANY PIECE OF PAPER WHICH WILL ENHANCE OR EXPEDITE PAYMENT TO THE PROVIDER FOR SERVICES RENDERED, INCLUDING BUT NOT LIMITED TO A RELEASE OF MEDICAL RECORDS and ASSIGNMENT OF BENEFITS/AUTHORIZATION TO PAY.

Know by all these present that: The undersigned has made, constituted and appointed, and by these presents does herby make, constitute and appoint PEMBROKE PINES PHYSICIANS ASSOCIATES, INC., and any of it's duly authorized agents and employees as and to be the undersigned's true and lawful attorney for and in the undersigned's name, place and stead to endorse any and all checks, drafts or money orders which are made payable to the undersigned alone or to the undersigned and the said PEMBROKE PINES PHYSICIANS ASSOCIATES, INC., which checks, drafts or money orders are made payable for services which have been made by PEMBROKE PINES PHYSICIANS ASSOCIATES, INC., at the request or with the knowledge and approval of the undersigned and/or the maker of the check, draft of money order.

Furthermore, the undersigned allows PEMBROKE PINES PHYSICIANS ASSOCIATES, INC., or any of its agents to sign any paper that will be necessary to enhance, expedite and/or allow payment to said provider. This may include affidavits of non-ownership of vehicles, insurance forms and other statements.

The undersigned by these presents does give and grant the said PEMBROKE PINES PHYSICIANS ASSOCIATES, INC. as the attorney the full power and authority to do and perform all and every act whatsoever requisite and necessary to be done in and about the premises as fully to all intents and purposes as the undersigned might or could do to personally present insofar as the endorsing and cashing of said checks are concerned as well as any other document.

MEDICAL RELEASE

A photocopy of this document shall be sufficient to authorize any person having records of medical treatment, services, or supplies pertaining to me to release true copies of same to PEMBROKE PINES PHYSICIANS ASSOCIATES, INC. or any insurer providing coverage to mi in connection with the processing of any claim for benefits made by me or by the assignee herein. A photocopy of this document shall be as binding as an original signature page.

The undersigned does hereby ratify and confirm any and all actions taken by the said attorney in accordance with this special power and which the said attorney shall do or cause to be done by virtue of there presents.

ASSIGNMENT OF BENEFITS

I, ________________________________ Hereby authorize ________________________________
(Name of Insured/Patient) (Name of Insurance Carrier)

to make medical benefits payments otherwise payable to me for services rendered by PEMBROKE PINES PHYSICIANS ASSOCIATES, INC, but not to exceed the charges of those services, payable to and mailed to:

PEMBROKE PINES PHYSICIANS ASSOCIATES, INC.
17743 SW 2ND STREET
PEMBROKE PINES, FL 33029

I herby instruct the insurance carrier that in the event the subject medical benefits are disputed for any reason, including medical reasonableness and/or necessity that the amount of unpaid benefits claimed by PEMBROKE PINES PHYSICIANS ASSOCIATES, INC. is to be set aside and not disbursed until the dispute is resolved. Furthermore, I hereby IRREVOCABLY ASSISN to PEMBROKE PINES PHYSICIANS ASSOCIATES, INC. the rights and benefits and any and all causes of action resulting from non payment under any policy of insurance, indemnity agreement, or any other collateral source as defined in Florida Statutes for any service and or charges provided by PEMBROKE PINES PHYSICIANS ASSOCIATES, INC.
IN WITNESS WHEREOF the undersigned have hereunto set their hands, this _____ day of _____________, 20___.

______________________________ ______________________________
PATIENTS SIGNATURE PATIENT'S NAME (PLEASE PRINT