Preferred Family Chiropractic

628 Cagan View Rd, Suite #3
Clermont, FL 34714
Phone# 352-536-1300 Fax# 352-536-1305

PATIENT QUESTIONNAIRE

INSURANCE CARD MUST ACCOMPANY PATIENT ON INITIAL DAY OF SERVICE IN ORDER TO RECEIVE INSURANCE BENEFITS – OTHERWISE PAYMENT WILL BE DUE AT TIME OF SERVICE.

Section I: **Personal Information** **Date**______________

Name: ______________________________________ I prefer to be called: ________________________
Are you a permanent Florida resident ☐ or do you vacation here yearly? ☐
Address: ______________________________________City:______________State:_______Zip____________
Phone # (______) _____________ Work # (_____) ______________ Cell # (______) _________________
Date of Birth: __________________ Age_________ ☐ Male ☐ Female
Social Security Number: ___________________________ Height_____'______" Weight _________
Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Other
If Student, Name of School___________________________ City/State_________________ ☐ FT ☐ PT
Spouse or Parent's Name: ______________________________ Your Employer____________________
Emergency contact____________________________________ Phone___________________________
Whom may we thank for referring you? ___________________________
Email Address____ Do you prefer email ___ text ___ or both ___

Section II **FINANCIAL & INSURANCE INFORMATION**

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other
Name of party responsible for payment: __________________ Do you have insurance? ☐ Yes ☐ No
Name of Insurance Company: ____
Policy No: ___________________ Group Plan No: _____________ Medicare No:__________________
Date of Birth: ______________ SSN#______________________ Is Medicare PRIMARY insurance ☐ Yes ☐ No

Section III **CURRENT COMPLAINT SECTION**

Describe Complaint:
____
____
____
____
____
____

At the time of the current complaint, were you under any medically prescribed disabilities or self imposed restrictions?: ☐ Yes ☐ No (Describe)
____
____
____

Female: Are you or could you be pregnant? ☐ Yes ☐ No details:____

Section IV OTHER MEDICAL CARE

List any other doctors seen for this condition (include address):
Doctors name:______________________________________ Address:____
Doctors name:______________________________________ Address:____
Doctors name:______________________________________ Address:____
Did you go to the hospital?: ☐ Yes ☐ No
If yes, how did you get to the hospital? ☐ Ambulance ☐ Other ____
If admitted to hospital, how long did you stay? ____
What type of treatment did you receive? (include recommendation, x-ray, MRI's ,CT scans etc.):
____
____
____
Medication prescribed? ☐ Yes ☐ No List Name____

Section V: GENERAL HEALTH HISTORY

☐ Cancer ☐ Tuberculosis ☐ Hypertension ☐ Diabetes
☐ Sinus History ☐ Asthma ☐ Hepatitis ☐ Epilepsy
☐ Concussion ☐ Allergies ☐ Heart Attack ☐ Multiple Sclerosis
☐ Muscular Dystrophy ☐ Dizziness ☐ Convulsions ☐ Neuritis
☐ Digestive Problems ☐ Numbness ☐ Tingling ☐ Anemia
☐ Rheumatism ☐ Psoriasis ☐ Arthritis ☐ Migraine
☐ Back Problems

If female, are you pregnant?
☐ Yes ☐ No
Any prior hospitalization or **SURGERIES**? (please list)
____
____
____
____

Section VI PRESENT COMPLAINTS

☐ Headache ☐ Loss of taste ☐ Neck Motion Restricted ☐ Low Back Pain
☐ Concentration loss ☐ Pain behind Eyes ☐ Upper Back Pain/Stiff ☐ Right/Left Leg Pain
☐ Sensitive to light ☐ Fainting ☐ Mid Back Pain/Stiff ☐ Pins & Needles arms/legs
☐ Memory loss ☐ Palpitations ☐ Low Back Pain/Stiff ☐ Vision Problems
☐ Dizziness ☐ Neck Pain ☐ Right/Left Shoulder Pain ☐ Sinus Trouble
☐ Loss of balance ☐ Neck Stiffness ☐ Right/Left Arm Pain ☐ Nervousness
☐ Loss of smell ☐ Short of Breath ☐ Irritable ☐ Vomiting
☐ Chest Pain ☐ Anxiety ☐ Depression ☐ Insomnia
☐ Fatigue ☐ Flushed Face ☐ Pale Face ☐ Excess Perspiration
☐ Neuritis ☐ Constipation ☐ Digestive Trouble ☐ Nausea
☐ Diarrhea ☐ Numbness ☐ Swelling ☐ Cold Hands
☐ Cold Feet ☐ Broken Bones ☐ Jaw Pain ☐ Cuts
☐ Bruises ☐ Other ____________________ ☐ Other ____________________

NECK	☐ Pain ☐ Tightness ☐ Numbness ☐ Tingling ☐ Muscle spasm ☐ Burning
Location	☐ Right Front ☐ Left Front ☐ Right Back ☐ Left Back ☐ Center
Pain Ratings	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (Excruciating)
Frequency	☐ Infrequent < 25% ☐ Occasional 25% to 50% ☐ Frequent 50% to 75% ☐ Constant > 75%
Described as	☐ Aching ☐ Dull ☐ Sharp ☐ Stabbing ☐ Throbbing ☐ Stiffness ☐ Tightness
Associated with	☐ Numbness ☐ Tingling ☐ Increased sensitivity ☐ Decreased ROM ☐ Weakness
Radiates to	☐ Head ☐ Forehead ☐ Back of head ☐ Right side of head ☐ Left side of head ☐ Both sides of head ☐ Right shoulder blade ☐ Left shoulder blade ☐ Right shoulder ☐ Left shoulder ☐ Right arm ☐ Left arm ☐ Right forearm ☐ Left forearm ☐ Right hand ☐ Left hand ☐ Right fingers ☐ Left fingers
What makes it better?	☐ Lying Down ☐ Medication ☐ Nothing ☐ Range of Motion ☐ Sitting ☐ Standing ☐ Stretching ☐ Chiropractic Tx ☐ Heat ☐ Ice ☐ Resting
What makes it worse?	☐ Neck Move. Prolonged: ☐ Sitting ☐ Standing ☐ Walking ☐ Sneezing ☐ DLA ☐ Lat. Flex Lft ☐ Lat Flex Rt ☐ Rotation Lft ☐ Rotation Rt ☐ Laying to sitting ☐ Laying to standing ☐ Sitting to laying ☐ Sitting to standing ☐ Standing to laying ☐ Standing to sitting
At it's worst	☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ Light Activities ☐ Moderate Activities

HEADACHES	
Location	☐ Left ☐ Right ☐ Both ☐ Center
Specifics	☐ Frontal ☐ Coronal ☐ Occipital ☐ Parietal ☐ Temporal ☐ Throughout
Pain Ratings	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (Excruciating)
Frequency	☐ Infrequent < 25% ☐ Occasional 25% to 50% ☐ Frequent 50% to 75% ☐ Constant > 75%
Described as	☐ Aching ☐ Dull ☐ Sharp ☐ Stabbing ☐ Throbbing ☐ Stiffness ☐ Tightness
Associated with	☐ Dizziness ☐ Nausea ☐ Visual Problems ☐ Ringing/Buzzing ears ☐ Bright light ☐ Sensitivity ☐ Loss of balance
Radiates to	☐ Neck ☐ Right Eye ☐ Left Eye ☐ Right Ear ☐ Left Ear ☐ Right Jaw ☐ Left Jaw
At it's worst	☐ Morning ☐ Afternoon ☐ Evening ☐ Night After Activities: ☐ Light ☐ Moderate
What makes it better?	☐ Lying Down ☐ Medication ☐ Nothing ☐ Range of Motion ☐ Sitting ☐ Standing ☐ Stretching ☐ Chiropractic Tx ☐ Heat ☐ Ice ☐ Resting

UPPER or MID BACK	☐ Pain ☐ Tightness ☐ Numbness ☐ Tingling ☐ Muscle spasm ☐ Burning
Location	☐ Left ☐ Right ☐ Both ☐ Center
Pain Ratings	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (Excruciating)
Frequency	☐ Infrequent < 25% ☐ Occasional 25% to 50% ☐ Frequent 50% to 75% ☐ Constant > 75%
Described as	☐ Aching ☐ Dull ☐ Sharp ☐ Stabbing ☐ Throbbing ☐ Stiffness ☐ Tightness
Associated with	☐ Numbness ☐ Tingling ☐ Increased sensitivity ☐ Decreased ROM ☐ Weakness
Radiates to	☐ Neck ☐ Right Ribs ☐ Left Ribs ☐ Lower back
What makes it better?	☐ Lying Down ☐ Medication ☐ Nothing ☐ Range of Motion ☐ Sitting ☐ Standing ☐ Stretching ☐ Chiropractic Tx ☐ Heat ☐ Ice ☐ Resting
What makes it worse?	☐ Bending ☐ Coughing ☐ House work Prolonged: ☐ Sitting ☐ Standing ☐ Walking ☐ Sneezing ☐ Working ☐ DLA ☐ Lat. Flex Lft ☐ Lat Flex Rt ☐ Rotation Lft ☐ Rotation Rt ☐ Laying to sitting ☐ Laying to standing ☐ Sitting to laying ☐ Sitting to laying ☐ Standing to laying ☐ Bowel movements ☐ Reaching
At it's worst	☐ Morning ☐ Afternoon ☐ Evening ☐ Night After Activities: ☐ Light ☐ Moderate

LOWER BACK	☐ Pain ☐ Tightness ☐ Numbness ☐ Tingling ☐ Muscle spasm ☐ Burning
Location	☐ Left ☐ Right ☐ Both ☐ Center
Pain Ratings	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (Excruciating)
Frequency	☐ Infrequent < 25% ☐ Occasional 25% to 50% ☐ Frequent 50% to 75% ☐ Constant > 75%
Described as	☐ Aching ☐ Dull ☐ Sharp ☐ Stabbing ☐ Throbbing ☐ Stiffness ☐ Tightness
Associated with	☐ Numbness ☐ Tingling ☐ Increased sensitivity ☐ Decreased ROM ☐ Weakness
Radiates to	☐ Right Upper back ☐ Left Upper back ☐ Right Buttock ☐ Left Buttock ☐ Both Buttocks ☐ Right Hip ☐ Left Hip ☐ Right Thigh ☐ Left Thigh ☐ Right Calf ☐ Left Calf ☐ Right Foot ☐ Left Foot ☐ Right Toes ☐ Left Toes
What makes it better?	☐ Lying Down ☐ Medication ☐ Nothing ☐ Range of Motion ☐ Sitting ☐ Standing ☐ Stretching ☐ Chiropractic Tx ☐ Heat ☐ Ice ☐ Resting
What makes it worse?	☐ Bending ☐ Coughing ☐ Sneezing ☐ Lying down ☐ Lifting Prolonged: ☐ Sitting ☐ Standing ☐ Walking ☐ DLA ☐ Lat Flex Lft ☐ Lat Flex t ☐ Lat. Flex Rt ☐ Rotation Lft ☐ Rotation Rt ☐ Laying to sitting ☐ Laying to standing ☐ Sitting to Laying ☐ Sitting to standing ☐ Standing to laying ☐ Standing to sitting ☐ Bowel Movements
At it's worst	☐ Morning ☐ Afternoon ☐ Evening ☐ Night After Activities: ☐ Light ☐ Moderate

Preferred Family Chiropractic

628 Cagan View Rd, Suite #3, Clermont, FL 34714

Phone# 352-536-1300 Fax# 352-536-1305

Records Release / Request Form

Patient Name: ____ Social Security No.: __________________________

Address: ____

Date of Birth: ___________________ Date of Service: ___________________ Phone No.: ____________________________

I authorize and direct Preferred Family Chiropractic to release copies of my medical records, x-rays, exam results and any other protected health information to:

____
____
____
____
____

I authorize and direct Preferred Family Chiropractic to request copies of my medical records, x-rays, exam results and any other protected health information from:

____
____
____
____
____

This authorization is given to Florida Statute 456.057 and HIPPA regulations. Any third party that receives protected health information is prohibited from further disclosing any information contained in the medical records without the consent of the patient or the patient's legal guardian.

Patient Name: ____

Patient Signature: _______________________________________ Date: ____________

Patient Consent for Use and Disclosure

of Protected Health Information

I hereby give my consent for Preferred Family Chiropractic to use and disclose protected health information (PHI) about me to carry out treatment, payment, and health care operations (TPO). I have the right to review the Notice of Privacy Practices prior to signing this consent.

Preferred Family Chiropractic reserves the right to revise its Notice of Privacy Practices. I have the right to request that Preferred Family Chiropractic restrict how it uses or discloses my PHI to carry out TPO.

With this consent, Preferred Family Chiropractic may call, mail or email me PHI in reference to matters that assist in carrying out TPO, such as appointment reminders, patient statements, and insurance items pertaining to my care.

There are times when individuals other than staff may see me receive treatment at the clinic or overhear discussions of my condition or my insurance. I consent to others perceiving these interactions at the clinic. If additional privacy is required, I will inform the clinic staff.

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, Preferred Family Chiropractic may decline to provide treatment to me.

Patient Name: ____

Signature: ______________________________________ Date: ________________________

Doctor-Patient Relationship in Chiropractic / Privacy Statement

It is important to be an aware and informed patient. We have found that an understanding of chiropractic care is helpful. This page is to help inform you of what will be happening today and throughout your care.

Analysis: You will receive a chiropractic examination for the detection of vertebral Subluxations. A vertebral Subluxations is a misalignment of one or more of the 24 vertebra in the spinal column that causes obstruction of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's natural ability to express its maximum health potential.

During the examination, the chiropractor will evaluate how your spine moves and what it feels like. Based upon the results of the examination, X-rays of your spine may be taken. X-rays will tell the doctor how far and in what direction the vertebra is misaligned. The X-rays will also help determine the most efficient chiropractic techniques to effectively adjust and correct the spine.

Diagnosis: Only a chiropractor can determine if your case is a chiropractic case. Your diagnosis will reflect spinal nerve interference that is caused by vertebral Subluxations. Our doctors will work with any other health care provider for your benefit. Also, you should expect other health care providers to work with your chiropractor for your benefit. This team approach to your health care will serve you the best.

Chiropractic Adjustments: By coming to the chiropractor for care, you give the chiropractor permission to adjust you. In rare cases, physical defects, deformities, or pathology may render the patient susceptible to injury. The chiropractor will not provide chiropractic adjustments if he is aware of any such conditions. If the patient is aware of any latent pathological defects, illness or deformities that would not otherwise come to the attention of the chiropractor, it is the patient's responsibility to notify the chiropractor. A chiropractor does not treat or diagnosis disease. The chiropractor provides a specialized health service for the detection and correction of vertebral Subluxations. Upon request, alternatives to chiropractic care and any risks regarding chiropractic care will be explained in detail. Risks, although rare, may include increased muscle spasm, strain, and exacerbation of disc conditions, fractures or TIA.

Results: The goal of chiropractic is to adjust vertebral Subluxations for the purpose of allowing the proper transmission of nerve energy over nerve pathways so that every part of the body may have a proper nerve supply at all times. This allows the natural healing ability of the body to work at maximum efficiency. Since there are many variables, it is difficult to predict the time schedule or results of chiropractic care. The healing process takes time. The longer the problem has been in the body, the longer the healing process will take.

Assignment and Release: I authorize the release of any pertinent information necessary for me to receive treatment and for provider to timely process my insurance claims. I authorize and direct my insurance benefits to be billed by and paid directly to: Adrian M. Williams DC, Preferred Family Chiropractic, Clermont, FL.

Questions: We want to help you achieve your goal of health. Any time your progress is not satisfactory or you have any concerns, the chiropractor will gladly answer any questions that arise or assist you in choosing a referral doctor for another opinion. Your health is our number one priority.

Acknowledgment: I have read and understand the above.

Patient Name: _________________________ **Signature:** _________________________ **Date:** ___________

Payment Policy:

PAYMENT IS DUE AT TIME OF SERVICE

We are committed to providing you with the best possible care. This information is designed to guide you through the rapidly changing world of insurance plans.

Please read carefully and sign at the bottom of the page indicating your understanding and acceptance of our policies and procedures.

If you have health insurance, we can provide you with a receipt for you to submit or as a courtesy submit your claim for you. Our receipt is suitable for your insurance company. We will have you pay for any **deductibles and co-pays** required at the time of service.

PAYMENT IS DUE AT EVERY VISIT OF SERVICE UNLESS PAYMENT ARRANGEMENTS HAVE BEEN MADE AND APPROVED IN ADVANCE. YOU MUST REALIZE THAT:

1. Your insurance is a contract between you, your employer, and the insurance company. We are not included in your contract.
2. Not all services are covered by all insurance policies. Some companies select certain services that they will not cover.
3. The "Usual and Customary Charges" that may be quoted by your insurance company are charges that have been determined and set by your insurance company. They do not necessarily reflect our fees.

We must emphasize that as health care providers, **our relationship is with you**, not your insurance company. While filing your insurance claims for our patients is a courtesy that was extended,
ALL CHARGES ARE YOUR RESPONSIBILITY FROM THE DATE SERVICE IS RENDERED.
We do realize that there are times that a temporary financial problem may affect your payment of your account. In that case, PLEASE, contact our financial advisor for assistance so that we may be able to set up payment options for you. If you have any questions, feel free to ask us. We will be glad to help.

REGARDLESS OF ANY INSURANCE COVERAGE THAT I MAY HAVE, I AGREE THAT IT IS MY RESPONSIBILITY TO PAY MY BALANCE AND WILL PAY ANY BALANCE DUE.

Signature:___________________________________ Date:___________________