pitts chiropractic

(352) 732 0200 • 801 NE 25th Avenue • Ocala, Florida • 34480

1 ABOUT YOU

Today's Date: ___ /___ /_____

Patient Name: ____
LAST FIRST MIDDLE INITIAL

Birthdate: ___ /___ /_____ Age: ____ SS#: ____________________ ○ MALE ○ FEMALE

Email Address: ____

Mailing Address: ____

____
CITY STATE ZIP

Home Phone: ____________________ Cell Phone: ____________________

Work Phone: ____________________ Occupation: ____________________

Employer: ____________ How long: ______ Ok to contact you at work: ○ YES ○ NO

Employer Address: ____

____
CITY STATE ZIP

How did you hear about us: ____

Friend *(Please give their name, so we can thank them)*: ______________________________

Status: ○ MINOR ○ SINGLE ○ MARRIED ○ DIVORCED ○ SEPARATED ○ WIDOWED

Spouse's Name: ____

Do you have children: ○ YES ○ NO How many: ______________________

What is your current weight: ___LBS. Height: ___FT. ___IN.

2 INSURANCE INFO

Is this condition due to:

A work related injury? ○ YES ○ NO An automobile accident? ○ YES ○ NO

Do you have major medical health insurance? ○ YES ○ NO

Medicare# *(if applicable)*: ______________________________

Company Name: ______________________________

Contract# *(mbr, cust.#)*: ______________________________

Insured's name *(if other than self)*: ______________________________

Relation: ____________________ Birthdate: ___ /___ /_____

Insured's Employer: ______________________________

(Please inform front desk if you have a 2nd insurance source)

_____ INITIALS I hereby authorize assignment of my insurance rights and benefits directly to Pitts Chiropractic for services rendered. I fully understand that I am solely responsible for any balance not paid by my insurance company.

PLEASE CONTINUE TO BACK

3 HEALTH INFORMATION

Have you had previous chiropractic care? ❍ YES ❍ NO

Main Complaint: ______________________________

____

Other Complaints: ______________________________

____

How long have you had this condition? ______________________________

Have you had similar condition in the past? ______________________________

____

Does your pain radiate to other areas? ❍ YES ❍ NO If so, where? ______________________________

____

What aggravates this condition? ______________________________

Other Doctors seen for this condition? ❍ YES ❍ NO

List any medication you are currently taking: ______________________________

____

Have you had any surgery, falls, or accidents? ❍ YES ❍ NO

When? Please describe: ______________________________

____

____

For women: Are you pregnant? ❍ YES ❍ NO

Date of last menstrual period: ___ /___ /_____

Does anyone in your family have a history of heart disease, stroke, diabetes, cancer or hypertension? If yes, please specify: ______________________________

____

4 IN CASE OF EMERGENCY

Whom should we contact: ______________________________

Relation: ______________________________

Home Phone: ______________________________

Work Phone: ______________________________

Cell Phone: ______________________________

Who is your medical doctor: ______________________________

Phone Number: ______________________________

PLEASE CONTINUE TO NEXT PAGE

5 HEALTH HISTORY

In any case of abnormal posture, there is interference or damage being caused to your Central Nervous System. *Please check any of the following you are currently experiencing:*

NECK: Problems in your neck will weaken the nerves into your arms, hands and head and affect organs.

- ○ HEADACHES
- ○ STIFF NECK
- ○ NECK PAIN
- ○ EARACHE
- ○ NERVE PAIN
- ○ NUMBNESS/TINGLING IN ARMS/HANDS
- ○ PAIN AROUND THE EYES
- ○ PAIN IN ARMS/HANDS
- ○ NERVOUSNESS
- ○ WEAKENED GRIP
- ○ ACNE OR PIMPLES
- ○ PAIN IN SHOULDERS
- ○ ADENOIDS
- ○ ALLERGIES/HAY FEVER
- ○ VISUAL DISTURBANCES
- ○ HIGH BLOOD PRESSURE
- ○ MIGRAINE HEADACHES
- ○ RECURRENT COLDS/FLUS
- ○ NERVOUS BREAKDOWNS
- ○ CHRONIC TIREDNESS
- ○ THYROID CONDITIONS
- ○ DIZZINESS/FAINTING
- ○ HEARING DISTURBANCES
- ○ COLDNESS IN HANDS/FEET
- ○ CHRONIC COUGH
- ○ SINUS TROUBLE
- ○ INSOMNIA
- ○ SORE THROAT
- ○ HEAD COLDS

UPPER BACK: Problems in your upper back will weaken the nerves to your heart and lungs and affect the organs.

- ○ ASTHMA/WHEEZING
- ○ COUGH
- ○ BRONCHITIS
- ○ SHORTNESS OF BREATH
- ○ DIFFICULT OR PAINFUL BREATHING
- ○ HEART ATTACKS/ANGINA
- ○ HEART PALPITATIONS
- ○ TACHYCARDIA
- ○ HEART MURMURS
- ○ POOR CIRCULATION
- ○ INFLUENZA
- ○ PNEUMONIA
- ○ CONGESTION
- ○ RECURRENT LUNG INFECTIONS/BRONCHITIS
- ○ PAIN IN LOWER ARMS AND HANDS
- ○ BLOOD PRESSURE PROBLEMS

MID BACK: Problems in your mid back will weaken the nerves into your ribs/chest and upper digestive track and other organs.

- ○ MID BACK PAIN
- ○ PAIN INTO YOUR RIBS/CHEST
- ○ HEARTBURN/INDIGESTION
- ○ HYPOGLYCEMIA
- ○ KIDNEY TROUBLES
- ○ CERTAIN TYPES OF STERILITY
- ○ TIRED/IRRITABLE AFTER EATING OR WHEN YOU HAVEN'T EATEN FOR AWHILE
- ○ NAUSEA
- ○ ULCERS/GASTRITIS
- ○ DYSPEPSIA
- ○ HARDENING OF THE ARTERIES
- ○ GAS PAINS
- ○ CHRONIC TIREDNESS
- ○ GALL BLADDER CONDITIONS
- ○ JAUNDICE
- ○ SHINGLES
- ○ LIVER CONDITIONS
- ○ FEVERS
- ○ ARTHRITIS
- ○ HIVES
- ○ ALLERGIES
- ○ ECZEMA
- ○ PIMPLES/BOILS

LOW BACK: Problems in your low back will weaken the nerves into your legs/feet and pelvic/reproductive organs, bowel, bladder, and other organs.

- ○ BACKACHES OR PAIN
- ○ PAIN IN YOUR HIPS/LEGS/FEET
- ○ POOR CIRCULATION IN THE LEGS
- ○ COLDNESS IN YOUR LEGS/FEET
- ○ SWOLLEN ANKLES WEAK ANKLES & ARCHES
- ○ NUMBNESS/TINGLING IN YOUR LEGS/FEET
- ○ MUSCLE CRAMPS IN LEGS/FEET
- ○ WEAKNESS/INJURIES IN YOUR HIPS/LEGS/ANKLES
- ○ CONSTIPATION
- ○ DIARRHEA
- ○ SOME RUPTURES OR HERNIAS
- ○ DIFFICULT BREATHING
- ○ MINOR VARICOSE VEINS
- ○ SEXUAL DYSFUNCTION/IMPOTENCE
- ○ RECURRENT BLADDER INFECTIONS
- ○ PAINFUL/IRREGULAR PERIODS
- ○ BED WETTING
- ○ BLADDER TROUBLES
- ○ MISCARRIAGES
- ○ SCIATICA
- ○ WEAKNESS IN LEGS
- ○ COLITIS
- ○ DYSENTERY

PLEASE CONTINUE TO BACK

6 TERMS OF AGREEMENT

- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the provider. If account balance has not been paid within 90 days of the date of service and no financial arrangements have been made, you will solely be financially responsible for any expenses incurred in collecting your account.

- Appointments for massage therapy that are not cancelled two hours in advance are subject to a "no show" fee. A $20.00 charge for 30 minute appointments and a $40.00 charge for 60 minute appointments will be applied to your account unless decided otherwise by the provider. You will be financially responsible for "no show" fees and they will not be covered by your insurance company.

- I hereby state that all information that I have given to Pitts Chiropractic and is complete and truthful. I will not misrepresent the severity or cause of my health concern. I further state that I have disclosed my full health history. I present myself for health reasons only and it is not my intent to mislead defraud or coerce this office or any third party or misrepresent myself in any manner. I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy and diagnostic x-rays on me by licensed doctors of chiropractic who may now or in the future treat me while employed at Pitts Chiropractic. I acknowledge that results are not guaranteed or assured. I understand that I will have an opportunity to discuss with my doctor the nature and purpose of chiropractic adjustments and other procedures. I understand and am informed that as in the practice of medicine, the practice of chiropractic has some risks to treatment including but not limited to: muscle strains and sprains, disc injuries, fractures, strokes, and dislocations. I do not expect the doctor to anticipate and explain all risks and complications and I wish to rely on the doctor to exercise judgement during the course of the procedure which the doctor feels at the time based upon all factors then known is in my best interests.

- I also authorize Pitts Chiropractic to release any information required to process insurance claims. (If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk).

- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Adult Patient:

____ ___/___/_____

PRINT NAME SIGNATURE DATE

Parent/Guardian:

____ ___/___/_____

PRINT NAME SIGNATURE DATE

Witness:

____ ___/___/_____

PRINT NAME SIGNATURE DATE

AUTO ACCIDENT QUESTIONNAIRE

ABOUT THE ACCIDENT

Date of accident: ___ /___ /_____

Please explain in detail how your accident happened: ______________________________

____

____

Make/model of your vehicle: ______________________________

You were ○ DRIVER ○ PASSENGER; You were in ○ FRONT SEAT ○ BACK SEAT

Using Seat Belts: ○ YES ○ NO; You were heading: ○ NORTH ○ SOUTH ○ EAST ○ WEST

Street/road/highway: ______________________________

Speed: ______________ Speed of other vehicle: ______________

Did the impact to your vehicle come from the ○ FRONT ○ REAR ○ RIGHT ○ LEFT

During the impact, were you facing ○ RIGHT ○ LEFT ○ FORWARD ○ BACKWARD

Were you ○ AWARE OF ○ SURPRISED BY accident

AFTER THE INJURY

Were you knocked unconscious: ○ YES ○ NO; If so, how long? ______________

Where did you feel the pain immediately after the accident? ______________

Where were you taken after the accident? ______________

What treatment was given, if any? ______________

Was any other doctor consulted after your accident? ○ YES ○ NO

If so, what was the doctor's name? ______________ ○ D.C. ○ M.D. ○ D.O. ○ D.D.S.

What was the diagnosis? ______________

Have you ever had any complaints in the involved area before? ○ YES ○ NO

If so, what were the complaints? ______________

Before the injury, were you capable of working equally with others your age? ○ YES ○ NO

Are your work activities restricted as a result of this accident? ○ YES ○ NO

If so, what activities? ______________

Since the injury, are your symptoms: ○ IMPROVING ○ GETTING WORSE ○ SAME

Do you have an attorney: ○ YES ○ NO; If so, name and phone #: ______________

YOUR INSURANCE

Company Name: ______________________________

Address: ______________________________

____

CITY STATE ZIP

Phone: ______________________________

Person handling your claim: ______________________________

Claim #: ______________________________

PLEASE CONTINUE TO BACK

8 TERMS OF AGREEMENT

For our auto accident patients

- The state of Florida is a "NO-FAULT" state, which means we must file your auto insurance.
- Your insurance company will send you a "PIP" or "NO-FAULT" application. They will not consider payment on your claim until they have this completed and returned to them. It is your responsibility to do this in a timely fashion.
- If your insurance has a deductible or does not pay at 100% YOU ARE RESPONSIBLE FOR THIS AMOUNT.
- If you have health insurance that will pick up the amount covered by your auto insurance please provide us with a copy of your health insurance card so we can verify your benefits on that policy.
- If you obtain an attorney at any time during your treatment with our office please let us know HIS/HER name and address. If you change attorney's at any time we also must be informed.
- If your auto insurance does not pay your medical bills at 100% and we accept a "letter of protection" from your attorney, it is your responsibility to contact our office at the time of your settlement to find out what your account balance is, because some cases take up to two years to settle it is impossible for us to keep up with all of them. If your case does not settle or if your attorney no longer represents you at any time the "letter of protection" becomes null and void and you are responsible for the balance on your account. If this happens please contact us immediately.
- If you discontinue treatment and/or if you move out of the area and your case cannot be settled you are responsible for your account balance.
- You will receive a monthly statement from our office which will show you your current account balance. We will file with your insurance twice a month. If you become concerned about your balance please contact your insurance company to see why they have not paid. We try to keep up with all of our patients accounts but there are so many that it is impossible to stay on top of all of them. We would greatly appreciate any help you could give us.
- If your accident occurred out-of-state please make sure you have given us this information. We are required by law to follow the rules of the state in which the accident occurred. This means your insurance benefits may vary depending on the rules of that state.
- If you were a passenger in the car or if you were driving another person's car please give us this information. (this may also affect the way your insurance company pays.)
- Sometimes orthopedic supplies are recommended by the doctor to aid in the healing process of our patients. It is our policy to collect the amount due for these supplies at the time of service. If your insurance company pays for these supplies we will gladly refund you the amount you paid.

Adult Patient:

____ ____/____/______

PRINT NAME SIGNATURE DATE

Parent/Guardian:

____ ____/____/______

PRINT NAME SIGNATURE DATE

Witness:

____ ____/____/______

PRINT NAME SIGNATURE DATE