Ponte Vedra Beach Chiropractic, Inc.

820 A1A N, Ste. W12, Ponte Vedra Beach, FL 32082 www.PonteVedraBeachChiro.com

NEW PATIENT INFORMATION

Patient's Name____ Date __________________

Address ___________________________________ City ________________ Zip Code ________

Home or Cell Phone ___________________________ Work Phone ________________________

E-mail _____________________________________ Date of Accident _____________________

Employer ___________________________________ Job Title _________________________

Date of Birth ___________ Age____ Gender ❑ Male ❑ Female Handedness? R L

Weight_____ Height ______ Marital Status S M W D Smoker Y N (Former)

Ethnicity: ❑ Hispanic __ Latino ❑ Non-Hispanic / Non-Latino

Race: ❑ Caucasian ❑ African American ❑ Asian ❑ Native American ❑ Latin American ❑ Other

Person responsible for this account_________________________ Relation_________________

Health Insurance ____________________________ *Please provide your health insurance card.*

Auto Insurance _____________________________ *Please provide your auto insurance card.*

Claim # ____________________________ Driver's License # ____________________________

In case of emergency, whom should we contact?____

Phone #____

Family physician___________________________ Phone #_______________________________

Address__________________________________ City______________ Zip Code_____________

Did you consult with any healthcare provider within the first 14 days after the accident, if so who?

Hospital_________________________________ Medical Doctor ___________________________

Chiropractor_____________________________ Physical Therapist _________________________

Medications prescribed: ____

Allergies to medications: ____

Have you been in any previous accidents of any kind within the past 5 years? Y N

Have you ever been treated for neck pain, back pain or headaches prior to this accident? Y N

If yes, please explain ____

Previous surgeries? ____

☐ May be pregnant ☐ Yes, I am definitely pregnant ☐ No, I am definitely not pregnant at this time

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ACCIDENT QUESTIONNAIRE

Patient's Name________________________________ Date of accident __________Today's Date_____________

CIRCLE ALL THAT APPLIES

Driver Front Passenger
Back Passenger Driver's side
Back Passenger Right Side
Back Passenger Middle

Alone or With Others

Aware or Unaware of impending accident

Description of Accident: ______________________
____
____
____

Patient Vehicle: Compact Car Mid-Sized Car
Full Sized Car Sport Utility Vehicle Pick-up Truck
Bus Other __________________________________

Other Vehicle: Compact Car Mid-Sized Car
Full Sized Car Sport Utility Vehicle Pick-up Truck
Bus Other __________________________________

Speed of Patient's Vehicle:
Slow Moderate Fast Stopped

Speed of Other Vehicle:
Slow Moderate Fast Stopped

Type of restraint: Lap Belt Shoulder Belt

Did Airbags deploy: Yes No

Damage to patient's vehicle: Complete
Extensive Minimal Moderate

Where did the accident happen: Highway
City Road Neighborhood Road Intersection
On / Off Ramp Making RT Turn Making LT Turn

How was the patient's vehicle hit: Head-on
Hit on Left Front Hit on Right Front
Hit on Left Rear Hit on Right Rear
Rear-Ended Other _________________

Head position at time of impact: Leaning Forward
Looking Straight Turned Left Turned Right

Did any portion of your body hit an object in the vehicle? Yes No If Yes, please explain
____

After the accident, what did you do? Go Home
Go About Your Business Hospital by Ambulance
Driven to Hospital Drove Self to Hospital
Other _______________________________________

Hospital or Medical Facility: ___________________
____

Received: X-rays MRI CAT Scan Stitches
Other _______________________________________
Medications ___________________________________

Is there any other information that the doctor should know about your accident? _______________________
____
____
____
____

INJURIES & SYMPTOMS

Patient's Name____________________________________

CIRCLE ALL YOUR INJURIES / COMPLIANTS

1. Please list any **CUTS, LACERATIONS OR BRUISING**:
____

Seat belt bruising: Yes No   Injury from the air bag: Yes No

2. **HEAD:** *(now or at the time of the accident)*

Were you knocked out or unconscious   Headaches   Face pain   Dizziness   Room spins

Balance problems   Difficulty walking   Visual Disturbances, blurry or double vision   Sleep Difficulty

Very tired or fatigued   Nausea / Vomiting   Flashbacks to accident   Memory problems   Confusion

Difficulty speaking   Problems to read or write   Hearing problems   Change in sense of smell or taste

3. **JAW:** Jaw pain   Jaw clicking   Pain while chewing   Pain while talking

4. **NECK:** Neck pain   Neck pain that causes headaches

Neck pain that travels into the RIGHT: Shoulder Arm Hand Upper Back *(Circle all that apply)*

Neck pain that travels into the LEFT: Shoulder Arm Hand Upper Back *(Circle all that apply)*

5. **SHOULDER:** Shoulder pain LEFT RIGHT BOTH

6. **UPPER EXTREMITY:** Upper arm pain LEFT RIGHT BOTH

Elbow pain LEFT RIGHT BOTH   Forearm pain LEFT RIGHT BOTH

Wrist pain LEFT RIGHT BOTH   Hand pain LEFT RIGHT BOTH

7. **BACK:** Upper back pain   Upper back pain into the neck   Mid-back pain

Mid-back pain into the RIGHT rib cage   Mid-back pain into the LEFT rib cage

8. **LOWER BACK:** Lower back pain LEFT RIGHT BOTH

Lower back pain that travels into the RIGHT: hip buttock thigh knee leg foot toes *(Circle all that apply)*

Lower back pain that travels into the LEFT: hip buttock thigh knee leg foot toes *(Circle all that apply)*

9. **HIP:** Hip pain LEFT RIGHT BOTH

Hip pain that travels into RIGHT: buttock thigh knee leg foot toes *(Circle all that apply)*

Hip pain that travels into LEFT: buttock thigh knee leg foot toes *(Circle all that apply)*

10. **LOWER EXTREMITY:** Thigh pain LT RT BOTH   Knee pain LT RT BOTH

Leg pain LT RT BOTH   Ankle pain LT RT BOTH   Foot pain LT RT BOTH

11. **CHEST PAIN**   12. **STOMACH PAIN**

Is there any other information that the doctor should know about your injuries or complaints?
____
____

Patient Signature: ________________________________   Date: __________________

Health History

Who is your primary care physician? (doctor and/or practice) ______________________

CHECK ANY OF THE FOLLOWING PAST MEDICAL PROBLEMS YOU HAVE HAD:

	Now	Past		Now	Past		Now	Past
Diabetes			Thyroid Disease			Osteoporosis		
Ulcers			Goiter			Polio		
Gastric Reflux/ GERD			Kidney Disease			Fractures		
Colitis / IBD			Pneumonia			Multiple Sclerosis		
Heart Disease			Tuberculosis			Parkinson's		
Congestive Heart Disease			Influenza			Prostate Problems		
Blood Clots (DVT)			Asthma			Immune Disorder		
Peripheral Vascular Disease			Emphysema			Migraine Headaches		
Stroke			COPD			Seizure Disorder		
Pacemaker			Bronchitis			AIDS/HIV		
High Cholesterol			Liver Disease			Chemical Dependency		
High Cholesterol			Osteoarthritis			Mental Disorders		
Bleeding Disorder			Rheumatoid Arthritis			Depression		
Anemia			Gout			Alcoholism		
Cancer: ❑ Now ❑ Past	Type: Bone	Colon	Breast	Prostate	Stomach	Brain Lung	Skin	Other:

CHECK ANY OF THE FOLLOWING DISEASES / SYMPTOMS YOU HAVE HAD IN THE PAST SIX MONTHS:

GENERAL
- ❑ Fatigue
- ❑ Fever/Chills
- ❑ Unexpected weight loss
- ❑ Unexpected weight gain

EYES
- ❑ Corrective lens
- ❑ Eye pain
- ❑ Visual problems
- ❑ Eye redness

HEMATOLOGIC / LYMPH
- ❑ Easy bleeding
- ❑ Bruising
- ❑ Swollen Glands

SKIN
- ❑ Skin Changes
- ❑ Poor skin healing
- ❑ Rash
- ❑ Itching

ENDOCRINE
- ❑ Heat/Cold intolerance
- ❑ Hot flashes
- ❑ Thinning/Losing hair

MUSCULO-SKELETAL
- ❑ Neck Pain
- ❑ Back Pain
- ❑ Limb Pain
- ❑ Headaches
- ❑ Joint Pain / Stiffness/Swelling
- ❑ General Stiffness

GASTROINTESTINAL
- ❑ Heartburn/GERD/reflux
- ❑ Black/Bloody Stool
- ❑ Abdominal Cramps/Pain
- ❑ Constipation
- ❑ Diarrhea
- ❑ Nausea / Vomiting

CARDIOVASCULAR
- ❑ Chest pain
- ❑ Palpitations
- ❑ Faintness
- ❑ Ankle swelling
- ❑ Pain upon exertion
- ❑ Leg pain with exercise

EAR/NOSE/THROAT
- ❑ Frequent sore throat
- ❑ Hearing problems
- ❑ Sinus pain
- ❑ Ear pain
- ❑ Ringing in ears
- ❑ Vertigo

GENITOURINARY
- ❑ Bladder Trouble
- ❑ Painful Urination
- ❑ Prostate Problems
- ❑ Sexual Dysfunction
- ❑ Discharge

NERVOUS SYSTEM
- ❑ Balance Problems
- ❑ Loss of strength
- ❑ Paralysis
- ❑ Dizziness
- ❑ Tremors

RESPIRATION
- ❑ Shortness of breath
- ❑ Cough
- ❑ Wheezing
- ❑ Congestion
- ❑ Difficulty breathing

PSYCHIATRIC
- ❑ Loss of Memory
- ❑ Difficulty sleeping
- ❑ Anxiety
- ❑ Depression

FEMALES ONLY
- ❑ Menstrual problems
- ❑ Breast pain/lumps
- ❑ Pelvic pain

Last period? __________

Pregnant? ❑ Yes ❑ No

Medications (unrelated to accident): ____

Under medical care? ❑ Yes ❑ No Type: _________________ On a special diet? ❑ Yes ❑ No Type: ___________

Have you had Covid? Yes NO Have you had the Covid vaccine? Yes No

Have you had any of the following symptoms in the last 6 months: If Yes, please circle.
Severe headaches, head pain, change in vision, dizziness or balance problems, confusion, memory loss, pins and needles anywhere, ringing in the ears, ear pain, nose bleeds, persistent sore throat, difficulty swallowing, chest pain, shortness of breath, chronic cough, coughed up blood, heart racing, heart skipping beats, breathing problems, severe abdominal pain, severe nausea, vomiting, or a significant change in bowels or urinary habits.

Do you exercise: ❑ Yes ❑ No How often? _______ Work: ❑ Desk job ❑ Moderate activity ❑ Heavy Labor

Is there a family history of any of the following conditions? (P = Parents, G = Grandparents, S = Siblings)

❑ Heart Disease ________ ❑ Diabetes ________ ❑ Autoimmune Disease ________ Other ______________________________
❑ Cancer ________ ❑ Arthritis ________ ❑ Blood Disorder or Anemia _______

What is your daily/weekly intake of the following: Caffeine ______ cups/day Alcohol drinks/week ________
Cigarettes ____ packs/day Ever a Smoker Yes / No / Former

- **I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health**

SIGNATURE (X) ____ **DATE** _____________

Ponte Vedra Beach Chiropractic, Inc. Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care. It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure.

A patient coming to the doctor gives him/ her permission and authority to care for them in accordance with appropriate test, diagnosis, and analysis. We may conduct some diagnostic or examination procedures and clinical procedures if indicated, which rarely may cause some discomfort. These are usually beneficial and seldom cause any problem. In rare cases underlying physical defects, deformities or pathologies, may render the patient susceptible to injury. The doctor or healthcare provider, of course, will not provide specific healthcare, if he/ she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/ she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the physician.

Chiropractic care involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection.

Response to care and interventions varies from person to person; hence, it is not possible to accurately predict your response to a specific modality, procedure, exercise protocol, or treatment. Ponte Vedra Beach Chiropractic, Inc. and Dr. Slossberg, do not guarantee what your reaction will be to a specific treatment, nor does it guarantee that the treatment will help resolve the condition that you are seeking treatment for. Furthermore, there is a possibility that the care may result in aggravation of existing symptoms and may cause pain or injury.

It is your right to decline any part of your treatment at any time before or during treatment, should you feel any discomfort or pain or have other unresolved concerns. It is your right to ask your doctor or healthcare provider about the treatment they have planned based on your individual history, diagnosis, symptoms, and examination results. Consequently, it is your right to discuss the potential risks and benefits involved in your treatment.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive treatment as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek treatment from this office.

I agree to settle any claim or dispute I may have against or with any of these persons or entities, whether related to the prescribed care or otherwise, will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

________________________________ Patient's Signature

____________________ Date