Ponte Vedra Beach Chiropractic, Inc.
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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_____

ACCIDENT QUESTIONNAIRE

Patient's Name_____ Date of accident _____Today's Date_____

Description of accident: _____
_____
_____
_____
_____

Injured Areas: Areas where you felt immediate pain. *(Check all that apply)*

__ head	__ neck R L	__ upper back R L	__ right shoulder
__ right arm	__ right forearm	__ right wrist / hand	__ left shoulder
__ left arm	__ left forearm	__ left wrist / hand	__ mid-back R L
__ low back R L	__ right pelvis	__ right thigh	__ right leg
__ right ankle	__ right foot	__ left pelvis	__ left thigh
__ left leg	__ left ankle	__ left foot	

Did you feel? *(Check all that apply)*

__ disoriented	__ stunned	__ frightened
__ lost consciousness	__ loss of memory	__ fuzzy / confused
__ blurred vision	__ nausea	__ light headed

Other injuries: *(Check all that apply)*

__ bruising on the: __ chest __ arms R L __ legs R L __ head __ face
__ cuts on the: __ chest __ arms R L __ legs R L __ head __ face

Pain was felt: __ immediately __ 1-3 days later __ 1-2 weeks later __ 2-4 weeks later
__ other _____

After the accident, did you
( ) go home ( ) go about your business ( ) go to hospital, name of hospital_____

If taken to the hospital, how?

( ) Ambulance	( ) Driven by relative/friend	( ) Drove self
( ) Did not go to the hospital	( ) Home first and later taken or drove to the hospital	
( ) walked to hospital	( ) hospital next day	( ) hospital days later

What was done in the emergency room or hospital? *(Check all that apply)*

( ) Examination ( ) Stitches ( ) X-Rays ( ) MRI ( ) CAT Scan
( ) Cervical collar ( ) Complete bed rest ( ) Medication ( ) Physiotherapy
( ) Other:_____

Were you admitted into the hospital? ( ) Yes ( ) No
If Yes, how long? _____

When did you first consult a physician?
( ) Same day ( ) Following day ( ) Within a few days
( ) Other:_____

Who did you consult (please write name):_____
( ) Family physician ( ) Chiropractor ( ) Orthopedist ( ) Osteopath
( ) Neurologist ( ) Neurosurgeon ( ) Pain Mngmt. ( ) Other:_____

What did the doctor do? *(Check all that apply)*
( ) Chiropractic adjustment ( ) Examination ( ) Injections ( ) X-Rays
( ) Traction ( ) Prescriptions ( ) Physiotherapy
( ) Other:_____

How long were you under this doctor's care?_____ Are you still under their care? ( ) Yes ( ) No
Frequency of visits now?_____

Did the doctor refer you to or have you seen any other physicians? ( ) Yes ( ) No
If yes, please explain:_____

Past History:
Have you ever been in any previous accidents of any kind within the past 5 years? ( ) Yes ( ) No
If yes, please give dates and details:_____
_____

Have you ever been treated for neck pain, back pain, or headaches by any other physicians prior to this accident?
( ) Yes ( ) No If yes, please explain:_____
_____

Have you had any previous surgery or any other condition the doctor should know about? ( ) Yes ( ) No
If yes, please explain:_____
_____

Is there any other information that the doctor should know about your injuries or accident that was not covered by this form? If so please explain below. _____
_____
_____

Allergies:_____

Are you currently taking any medications:
_____

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

Patient's Name:_____ Date:_____

Patient's Signature:_____

Health History

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 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
- ❑ Always Tired / 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