# WELCOME

820 A1A N, Suite W12, Ponte Vedra Beach, FL 32082
(904) 285-2243 fax: (904) 285-9022
www.PonteVedraBeachChiro.com

Date:_____

## Patient Information

Name: _____ Date of Birth: _____ Sex: ❑ Male ❑ Female
Last First MI

Address: _____ City: _____ State: _____ Zip Code: _____

Email: _____ Ph # _____ W#_____

Occupation: _____ Employer: _____ Can we call you at work? ❑ Yes ❑ No

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑ Minor

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

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

Emergency contact: _____ Relation: _____ Ph #: _____

How did you hear about our practice? _____

Primary Physician: _____

What is your main reason(s) for your visit? _____
_____

Please use an X to mark any areas of pain or discomfort.

Please use an arrow to show the symptoms radiate to another part of the body.

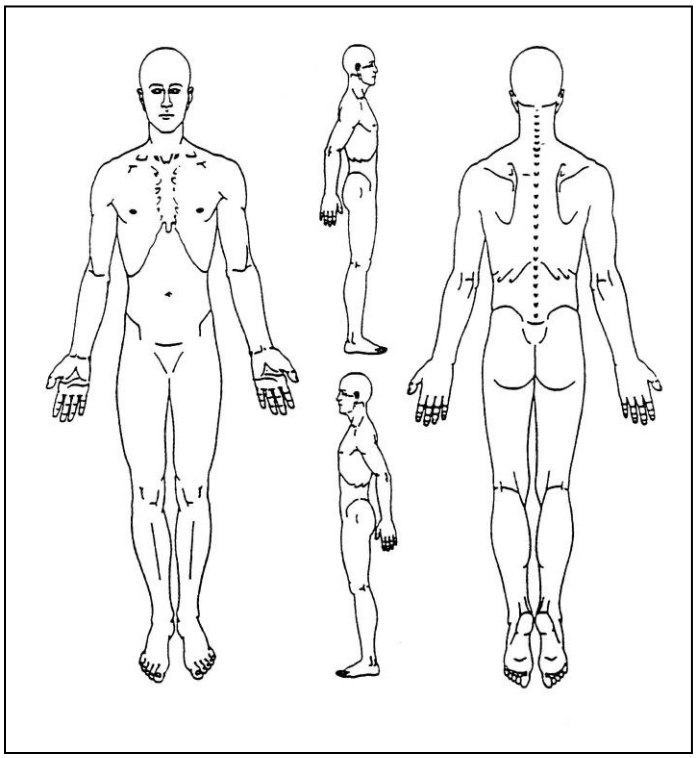
Please use a circle to mark any areas where there is numbness or tingling.

On a scale of 1-10, with 10 being most severe, how severe is the chief complaint at its worst? _____

When did the problem start? _____

How often do you experience the symptoms?
Constant Frequently Occasionally Comes & Goes

Have you had any injuries, falls, or auto accidents in the last 5 years? _____



## Accident Information

Is this visit due to an accident? ❑ Yes ❑ No If yes, what type? ❑ Auto ❑ Work ❑ Other _____
Reported? ❑ Yes ❑ No If Yes, Please see front desk

## Insurance Information

Policy Holder Name: _____ Date of Birth: _____

Relationship to patient: _____ Health insurance? ❑ Yes ❑ No Insurance: _____

Do you have secondary insurance? ❑ Yes ❑ No Insurance: _____

**PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR INSURANCE CARD(S)**

## Assignment and Release (insured patients)

I certify that I (or my dependent) have insurance coverage with _____ and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PHYSICIAN/MEDICAL PRACTICE, INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

Patient/Parent/Guardian Signature: _____ Date: _____

Print Patient Name: _____ Print Parent/Guardian Name: _____

## X-ray Questionnaire: For women only

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

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

| _____ | _____ | _____ |
|---|---|---|
| Patient Name | Patient Signature | Date |

## Health History

| | 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 Blood Pressure | | | 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

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.

Medications: _____

Surgeries: _____

Allergies: _____

Work: ❑ Desk job ❑ Moderate activity ❑ Heavy Labor ❑ Retired

Do you exercise: ❑ Yes ❑ No How often? _____

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

❑ Heart Disease _____ ❑ Diabetes _____ ❑ Autoimmune Disease _____
❑ Cancer _____ ❑ Arthritis _____ ❑ Blood Disorder or Anemia _____
❑ Other _____

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: _____**

**DATE: _____**

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# 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