Neal Clinic Confidential Medical History Information 2011

First Name: _____ Nickname: _____		❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr.	Marital status (circle one) Sngl Mar Wid Div Spouse's Name: _____
Last Name: _____	Middle: _____		
Email: _____		Birth date: _____	Age: ____ Sex:___
Home Address: _____	City:_____		State:____ ZIP:_____
Occupation: _____	Years at this job?____	Employer: _____	

Previous Health Care Information:

Do you have a **family Medical Doctor**?: ☐ No ☐ Yes- Name of MD: _____

Date of Last Visit: _____ Reason for Last Visit: _____

Have you seen a **Chiropractor** before?: ☐ No ☐ Yes- Name of Chiropractor:_____

Date of last Visit: _____ Date of your last spinal x-ray, MRI or CT scan: _____

Any **surgeries in the last 5 Years**?: ☐ No ☐ Yes - If Yes, Date of Last Surgery: _____

List your surgeries in the last 5 years and the reason: _____

Have you ever had spinal surgery?_____

Your Present Conditions: Check all that apply to you currently.

☐ AIDS	☐ Cancer	☐ High Cholesterol	☐ HIV/ ARC	☐ Rheumatic fever/ heart problem	
☐ Anemia	☐ Cardiac Stimulator	☐ Heart Problem	☐ Multiple Sclerosis	☐ Scoliosis	☐ Thyroid
☐ Arthritis	☐ Diabetes	☐ High blood pressure	☐ Pacemaker (Heart)	☐ Sinus trouble	☐ Ulcer
☐ Asthma/ Emphysema	☐ Fracture or Dislocation	☐ Mental/ Emotional Difficulty	☐ Polio or Hip Joint Fracture / Disease	☐ Spinal Disc Bulge/ Herniation	☐ Viral Hepatitis

Other Important Conditions:

_____

Check All of Your System Problems in the Past Year: ☐ Unexplained Weight Loss	☐ Recurring Heart Burn or Chest Pains	☐ Heart Palpitations or Irregular Heartbeat	☐ Fibromyalgia or Chronic Fatigue Syndrome	
☐ Fainting	☐ Tremors	☐ Difficulty Breathing	☐ Falls/ Balance Problems	☐ Chronic Diarrhea/ Constipation
☐ Dizziness	☐ Convulsions	☐ Swollen Extremities	☐ Ringing in Your Ears	☐ Vision Problems

Health History of Your Immediate Family:

☐ Alzheimer's	☐ Diabetes	☐ High blood pressure	☐ Spinal Disc Disease	☐ Mental/ Emotional Difficulty
☐ Cancer	☐ Heart Problems	☐ Scoliosis	☐ Spinal Arthritis	☐ Rheumatoid Arthritis

What is the primary reason for today's visit?: _____

_____ **Date your symptoms began:** _____

Social History:

Alcohol? ☐ No ☐ Yes Drinks per week?	Cigarettes? ☐No ☐ Yes Packs per day?	Caffeine? ☐ No ☐ Yes Drinks per day?	Exercise? ☐ No ☐ Yes Hours per week? (circle one) Light / Moderate / Strenuous

Would you like to have a nutritional consultation as well? ☐ No ☐ Yes

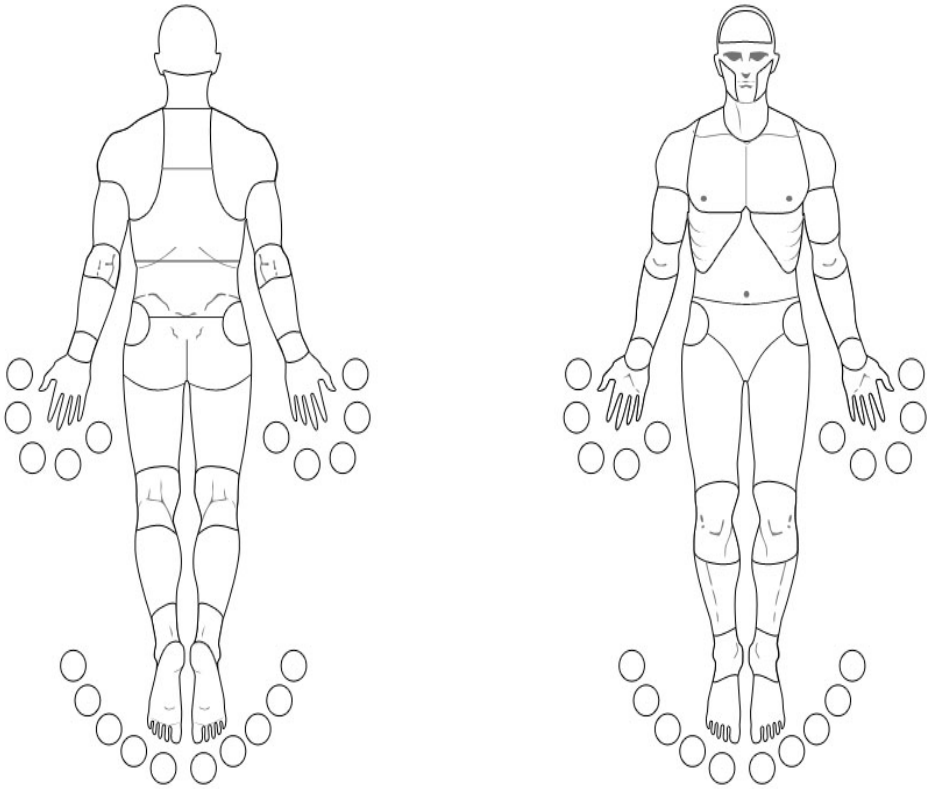
Patient or Adult Guardian Signature: _____ **Date:** _____

YOUR CURRENT COMPLAINTS

Patient's Name: _____ Date: _____

Please indicate your current complaints by marking the areas on the images, and the list below.

1. Headaches
2. Neck
3. Upper back
4. Mid Back
5. Lower Back
6. Hip
7. Buttock
8. Shoulder
9. Arm
10. Elbow
11. Forearm
12. Wrist
13. Hand
14. Fingers
15. Leg
16. Knee
17. Calf
18. Shin
19. Ankle
20. Foot
21. Toes
22. Chest
23. Ribs
24. Abdomen
25. Pelvis/Groin



REVIEWING THE AREAS YOU HAVE MARKED ABOVE, PLEASE LIST THE 3 PRIMARY AREAS IN THE ORDER OF CONCERN TO YOU:

#1 _____ #2 _____ #3 _____

RATING PAIN ON A SCALE OF 1 TO 10 - (1 IS VERY MILD, 5 IS MEDIUM PAIN, 10 IS UNBEARABLE PAIN)

WHAT RATING WOULD YOU GIVE YOUR PRIMARY PAIN AT ITS WORST? 1 2 3 4 5 6 7 8 9 10

HOW OFTEN DOES IT BOTHER YOU? _____

WHAT MAKES IT WORSE? _____

WHAT MAKES IT BETTER? _____

_____ _____

PATIENT OR ADULT GUARDIAN SIGNATURE **DATE** 11-2010 REVISION

NEAL CLINIC COMPREHENSIVE HEALTHCARE - PATIENT DATA FORM

TODAY'S DATE: _____ DATE YOUR SYMPTOMS BEGAN (OR ACCIDENT HAPPENED): _____

NAME:_____ DATE OF BIRTH:_____ AGE:_____

PATIENT'S EMPLOYER: _____ SPOUSE'S EMPLOYER: _____

PT HOME ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____

WORK PHONE: (_____)_____ HOME PHONE: (_____)_____

CELL CONTACT #: (_____) _____ PATIENT'S SOCIAL SECURITY #: _____-_____-_____

EMERGENCY CONTACT:_____ PHONE #:(_____)_____ RELATION:_____

MARITAL STATUS: □SNGL □MAR □WID □DIV NAME OF SPOUSE: _____

SHOULD WE SEND YOUR FAMILY MD YOUR X-RAY AND TEST RESULTS? (NO CHARGE) _____YES _____NO

HOW WILL PAYMENT BE MADE? □HEALTH INS. □AUTO INS. □MEDICARE □CASH/ CHECK □CREDIT CARD

Payment for services is due at the time they are rendered unless you have insurance, or other arrangements are made. If your case is fully covered by insurance (Automobile Insurance, Worker's Compensation, Multiple insurance coverages, etc.), we will collect directly from your insurance company and you will not be required to pay at the time of service.

ASSIGNMENT, LIEN AND AUTHORIZATION FOR INSURANCE BENEFITS AND ATTORNEY

I hereby authorize and direct you, my insurance company and/or my attorney to pay to Neal Clinic Comprehensive Healthcare, also known as the Neal Clinic, and hereafter referred to as Neal Clinic, at 2629 Creighton Road, Suite 1, Pensacola, FL 32504 such sums as may be due and owing this office for services rendered me or my spouse, child or legal charge, both by reason of accident or illness and by reason of any other bills that are due this office by myself or my immediate family. You are to withhold such sums from any disability benefits, medical payments benefits, no-fault benefits, health and accident benefits, worker's compensation benefits, or any other benefits obligated to reimburse me or from any settlement, judgment or verdict on my behalf as may be necessary to adequately protect The Neal Clinic's balance owed. I hereby further give lien to said office against any and all insurance benefits herein, and any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of the injuries or illnesses for which I or my immediate family have been treated by said office. This is to act as an assignment of my rights and benefits to the extent of the services provided at the Neal Clinic.

In the event the insurance company obligated to make payments upon the charges made by this office for their services refuses to make such payments, upon demand by me or The Neal Clinic, I hereby assign and transfer to The Neal Clinic any and all causes of action that I might have or that might exist in my favor against such company and authorize this office to prosecute said cause of action either in my name or in The Neal Clinic's name and further I authorize this office to compromise, settle or otherwise resolve said claims or cause of action as they see fit.

I further understand and agree that this Assignment, Lien and Authorization does not constitute any consideration for this Clinic to await payments, and they may demand immediate payment for services provided, at their option.

I authorize this office to release any information pertinent to my case to any insurance company, adjuster or attorney to facilitate collection under this Assignment, Lien and Authorization. I agree that The Neal Clinic be given power of attorney to endorse/ sign my name on any and all checks for payment of my doctor bill.

I UNDERSTAND THAT ANY TYPE OF HEALTH CARE INCLUDES SOME DEGREE OF RISK AND I ASSERT THAT I AM AT THIS CLINIC FOR THE PURPOSE OF EXAMINATION AND TREATMENT. BY MY SIGNATURE HERE AND MY WILLING PROGRESS THROUGH THE PROCEDURES PERFORMED AT THIS CLINIC, I AGREE TO TREATMENT AS PERFORMED WITHIN THE LEGAL SCOPE OF THE PRACTITIONERS HERE.

I Understand That Insurance Policies Are an Arrangement Between an Insurance Company and Myself and That I Am Personally Responsible for Payment of Any or All Services. I Recognize That X-rays Made at this Clinic Remain the Property of this Clinic and That Copies of My Records, Including X-rays, Can Be Released to Me upon Payment of a Reasonable Charge for Copying.

IF THE PATIENT IS A MINOR OR NOT CAPABLE OF AUTHORIZING TREATMENT, I GRANT PERMISSION TO THE DOCTORS OF THIS CLINIC AND THEIR DESIGNATES TO EXAMINE AND TREAT THIS PATIENT. I AM HIS/HER LEGAL GUARDIAN.

_____ _____

SIGNATURE OF PATIENT (OR LEGAL GUARDIAN, IF A MINOR) **DATE**

- INFORMED CONSENT FORM -

Dear Patient,
Please read this entire page and sign to indicate that you understand this informed consent.
If you do not understand this or have questions, please ask.

The material risks in chiropractic adjustment -
Every health care procedure, no matter how simple, has some degree of risk. While the risk is low, there are certain complications which could possibly arise during chiropractic adjusting and therapy. The complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, rib sprains and separations, and burns. Some types of manipulation of the neck have very rarely been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke.

Many patients will feel some different stiffness or soreness following the first few days of treatments. This is a normal response of the body to the structural changes. Obviously, I will make every reasonable effort during the examinations and during our treatment process to screen for contraindications to care (reasons that you should not have treatment). If you have a condition that you think might possibly be a contraindication to care that has not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring -
Except for a brief initial increase in pain or soreness as we begin your treatment, these complications are rare. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between 1 in 1.5 million and 1 in 5 million cervical spine adjustments. This is the equivalent of one incident in 214 years of practice. I suggest you compare this to the rates of serious complications in long-term use of NSAIDs (anti-inflammatory medications), or the risks from spinal surgery.

Other treatment options -
Other options for your condition may include:
- Bed rest and over-the-counter drugs
- Medical prescription for anti-inflammatories, muscle relaxants, and pain medications
- Steroid injections - usually known as “pain management.”
- Surgical consultation

It is always the patient’s option to consider other treatments. If you want to consider one of the above treatments, let us know who your primary medical physician is and we will forward the pertinent parts of your records to them to help with your future care.

Risks and dangers of remaining untreated -
Remaining untreated may allow formation of adhesions and reduce mobility, which may set up a pain reaction that further reduces your mobility. The longer your treatment is postponed, this process may complicate your treatment, making it more difficult and less effective.

PLEASE DO NOT SIGN UNTIL YOU UNDERSTAND THE ABOVE.
I HAVE READ (OR HAD READ TO ME) THE ABOVE EXPLANATION OF THE CHIROPRACTIC ADJUSTMENT AND RELATED TREATMENT. I HAVE HAD MY QUESTIONS ANSWERED AND HAVE DECIDED THAT IT IS IN MY BEST INTEREST TO UNDERGO EVALUATION AND THE TREATMENT RECOMMENDED. I GIVE MY CONSENT TO EVALUATION AND TREATMENT.

PRINTED NAME_____ ❑ PATIENT ❑ CUSTODIAL PARENT

SIGNATURE_____ DATE_____