PLEASE TELL US ABOUT YOU

Today's Date _____/_____/_____

Full Name _____

Male __ Female __ Single___ Married___ Widow___ Divorced___

How do you prefer to be addressed? _____ Birthdate _____/_____/_____ Age_____

Cell Phone_____ is it okay to send you appt. reminder text messages? ☐Yes ☐No

Home Phone _____ E-mail address_____

Street Address _____ Employer _____

City _____ State _____ Zip Code _____

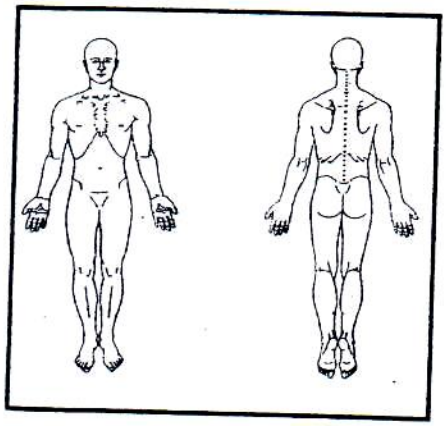
How did you hear about our office? _____

In Case of Emergency Contact _____ Phone _____ Relationship _____

Is your current condition the result of an accident/injury? Please circle: Yes No If yes please circle: Auto / Work / Slip/Fall

What are you current symptoms? 1. _____ 2. _____

3. _____ 4. _____



What is the average intensity of your pain?

Please *circle* one number for the last 24 hours, *square* one number for the past week

(not intense pain) *1 2 3 4 5 6 7 8 9 10 (severe pain)*

What "percent of the time" do you experience your symptoms? Please circle one:

Intermittent (0-25%) / Occasionaly (26-50%) / Frequently (51-75%) / Constant (76-100%)

←If you have pain, numbness, tingling, muscle tightness and/or muscle spasm, please circle below and shade/code this picture to indicate:

P=Pain N=Numbness T=Tingling S=tight/spasm

Symptoms began on what date? _____/_____/_____

Please briefly describe your primary symptom(s) _____

How did this start?_____

What is the quality of your pain/discomfort? (Sharp, Dull, Numb, etc.) _____

How much have your symptoms interfered with your daily activities? (including housework and work outside of home)

Please circle one of the following: 1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely

What makes your symptoms better or worse? _____

How is your condition changing since beginning care at this office? (Please circle one answer)

0. N/A – This is the initial visit 7. Much Better 6. Better 5. A little Better 4. No Change 3. A little worse 2. Worse 1. Much worse

In general, would you say your overall health right now is: (please circle one answer)

1. Excellent 2. Very good 3. Good 4. Fair 5. Poor

Environment

Please make a hash mark on the lines below as to where you believe your environment is closer to.

Stressed ——— *Peaceful*
Love filled ——— *Anger Filled*
Fulfillment ——— *Frustration*

Organized ——— *Chaotic*
Clean ——— *Filthy*

Review of Systems: Please mark the squares below for (x)past or (✓)present conditions you've had.

General	GI	Eye/Ear/Nose/Throat	Respiratory	Cardio-Vascular	Women
☐Consistent Fainting	☐Constipation	☐Asthma	☐Chest pain	☐Ankle Swelling	☐Cramps
☐Loss of weight	☐Diarrhea	☐Sore throat	☐Chronic cough	☐High blood pressure	☐Excessive flow
☐Weight Gain	☐Rectal bleeding	☐Pain in eyes	☐Difficulty breathing	☐Rapid heart beat	☐Hot flashes
☐Convulsions	☐Hemorrhoids	☐Hay fever		☐Slow heart beat	☐Irregular cycle
☐Depression	☐Vomiting	☐Earache	Skin/Allergies	☐Low blood pressure	☐Painful periods
☐Dizziness	☐Kidney Problems	☐Poor vision	☐dryness/itching	☐Pain over heart	
☐Loss of sleep	☐Stomach pain		☐Bruise easily		
☐Nervousness	☐Gallbladder problems		☐eczema/hives		

Insured's Information (Please include your spouse's or parent's information if you are using their insurance.)

Name: _____ (Last), _____ (First), _____ (M.I.)

Address: _____ (Street), _____ (City), _____ (State), _____ (Zip) Date of Birth: _____ ☐Male ☐Female

Employer: _____ Relationship to Insured: ☐self ☐spouse ☐dependant ☐other _____

I authorize the payment of charges be made directly to the doctor(s) of this clinic. This authorization includes:

1. **All insurance reimbursement for services rendered. Including those which may be payable to me under my insurance plan or policy.**
2. **Amounts owned on my behalf from proceeds of any settlement related to my case.**

_____ _____
Signature Date

I authorize the release of necessary information to my insurance companies, pre-paid health plan or account, or government managed health plan to request payment benefits to me or my assignee.

_____ _____
Signature Date

"Thank you so much for filling this form out completely and providing us with the necessary information to help you more adequately. We look forward to working with you in fulfilling your health needs."

-Dr. Darren Hollander

Office Use Only

Insurance Verification

Obtain cop of driver's license and insurance card.

Does the plan have a **deductible**? ☐yes ☐no
- Amount for an individual: _____
- Amount for the family: _____
- Amount currently met: _____

After deductible, % of services covered? _____

When does the deductible renew? _____

Does the patient have a **co-pay**? ☐yes ☐no
- Amount for the co-pay? _____

What is the max. yearly **benefit**? _____

What is the **yearly visit cap**? _____

Any special forms required to file claims? ☐yes ☐no

Auto collision or **Personal Injury** case? ☐yes ☐no
- Reported to the insurance company? ☐yes ☐no
- Has an application for benefits been filed? ☐yes ☐no
- Did the police write a report? ☐yes ☐no
- S&D form signed and on file? ☐yes ☐no
- Agent name & contact info: _____

Worker's comp case? ☐yes ☐no
- Has the injury been reported? ☐yes ☐no
- Name:
- Title:

Is patient currently employed at place of injury? ☐yes ☐no

Name of person authorizing care: _____

Does the plan cover the following **services**?

Chiro. Adjustments ☐yes ☐no Modalities by Chiro ☐yes ☐no
Therap. exercise ☐yes ☐no Therap. activities? ☐yes ☐no
Neuromuscular reedu ☐yes ☐no

Address to send claims:

Informed Consent

Chiropractic consists of adjustments to the spine and other joints, either by hand or instrument, to facilitate the body's normal range of motion and the proper function of the nervous system. In conjunction with chiropractic, therapies such as ice, heat, myofascial release, massage, mechanical traction, flexion distraction, and therapeutic exercise including stretching may also be utilized either singly or in combination. Our doctors may recommend nutritional supplements to assist in the healing. There can be interactions between nutritional/herbal supplements and prescription medication, please check with your physician or pharmacist for any possible interactions which may present problems relative to their specific medical conditions. Our staff will do their best to help during the course of treatment, but that no express guarantees are made regarding outcome.

As with all medical treatments, chiropractic treatment contains some degree of risk. There may be link between cervical (neck) manipulation and cerebrovascular accident (CVA); however this has not been conclusively established. Studies indicate that the incidence of CVA is estimated at between 1 to 3 incidents per million adjustments. The most commonly reported reactions to manipulation are: local discomfort, headache, tiredness, and radiating discomfort. Fractures have been reported, however these are rare. Most reactions appear within 4 hours of treatment and disappear within 24 hours. A cause-and-effect relationship between manipulation and the reactions has not been established and it is likely that some of the reactions attributed to manipulation are, in fact, coincidental. Using data from case reports on the number of complications produced by lumbar spinal manipulations it is possible to roughly estimate the rate of occurrence of the most serious complication of lumbar manipulation, the cauda equina syndrome, as about 1 case per 100 million manipulations (Shekelle, 1992). Serious complications of cervical and lumbar spinal manipulations are extremely rare.

It should be kept in mind that other forms of treatment for back and neck pain also carry risk. For example, medications commonly used for back pain can cause significant complications, as can surgery. However, most randomized clinical trials directly comparing spinal manipulation with other types of non-operative treatment have reported no complications in either group, suggesting that the risks of these non-operative treatments are low.

_____ _____

Signature of patient Date

Orlando Family Chiropractic

Notice of Privacy Practices

Updated June 2011

Your health information is private and protected under the Health Insurance Portability and Accountability Act (HIPAA) of 1996 Privacy Rule. Our office recognizes and respects the privacy of your information.

We are required by law to maintain the privacy of the protected health information in your records and to provide you with this notice of our legal duties and privacy practices with respect to that information.

Certain uses and disclosures will require you to sign an acknowledgement that you received this notice. These include treatment, payment, and health care operations. Certain disclosures that are required by law, or under emergency circumstances, may be made without your acknowledgement or authorization. Under any circumstance, we will use or disclose only the minimum amount of information necessary from your medical records to accomplish the intended purpose of the disclosure.

Treatment: We will use your health information to make decisions about the provision, coordination or management of your healthcare. It may also be necessary to share your health information with another health care provider.

Payment: We may need to use or disclose information in your health record to obtain reimbursement from your health-insurance carrier.

Except as indicated above, your health information will not be used or disclosed to any other person or entity without your specific authorization.

Web-based services: Please note this office uses web-based services by Google and Provolve Solutions to coordinate scheduling, documents, electronic billing, and general patient care. Your information is private, encrypted, and password protected.

Text Messaging: In this office appointment reminders and correspondence with the doctor and staff often occurs with SMS or text messaging via Google Voice. Text conversations are logged on a central server owned by Google. These conversations are private, password protected, and encrypted. If you wish to opt out of text messaging it is important that you communicate this to the doctor and/or the office manager. Please let us know if you have any questions.

By agreeing to our privacy practices, you consent to the use of your information in this way. Please bring any concerns to the attention of the office manager. You have the right to limit how your health information is handled. You can read about HIPAA and your rights in detail at **hhs.gov/ocr/hipaa**.

We reserve the right to change the privacy practices that are described herein. You may request a revised copy at any time.

Name: _____ Signature: _____

Date: _____

June 2011

Orlando Family Chiropractic
Dr. Darren Hollander
500 N. Mills Ave.
Orlando, FL 32803
www.orlandofamilychiropractic.com

ASSIGNMENT OF BENEFITS

I assign all of the rights and benefits of any applicable medical payments, or other coverage provided by any insurance policy issued pursuant to Florida Statutes §627.730 - §627.7405, to Orlando Family Chiropractic or Dr. Darren Hollander, for services and supplies provided to me related to personal injuries I have suffered or other illness or injury.

I agree to pay any co-payment or deductible not covered by the applicable medical payments, personal injury protection, or other insurance coverage.

This assignment includes, but is not limited to:

1. All rights to collect benefits directly from any insurance carrier obligated to provide benefits for services and supplies I have received;

2. All rights to take legal or other action against any insurance carrier obligated to provide benefits if for any reason the insurance carrier fails to pay any benefits due; and

3. All rights to recover attorney fees, legal assistant fees, costs, and any interest on fees and costs, for any legal or other action taken.

This is an assignment of rights only, and is not a delegation of any of my duties under the subject insurance policy.

I agree that Orlando Family Chiropractic/Dr. Darren Hollander may retain any attorney it chooses to bring legal action against any insurance carrier obligated to provide benefits for services and supplies I have received, and that the attorney chosen may be different than any attorney I may have handling any claim I may have for personal injuries.

I have read this assignment and I am satisfied that I fully understand the purpose and implications of executing this assignment and do so freely and voluntarily.

_____ _____

Patient Name Date

The undersigned, accepts the assignment of benefits as set forth above.

Neck Index

ACN Group, Inc. Form NI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ **Date** _____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
③ The pain is fairly severe at the moment.
④ The pain is very severe at the moment.
⑤ The pain is the worst imaginable at the moment.

Sleeping

⓪ I have no trouble sleeping.
① My sleep is slightly disturbed (less than 1 hour sleepless).
② My sleep is mildly disturbed (1-2 hours sleepless).
③ My sleep is moderately disturbed (2-3 hours sleepless).
④ My sleep is greatly disturbed (3-5 hours sleepless).
⑤ My sleep is completely disturbed (5-7 hours sleepless).

Reading

⓪ I can read as much as I want with no neck pain.
① I can read as much as I want with slight neck pain.
② I can read as much as I want with moderate neck pain.
③ I cannot read as much as I want because of moderate neck pain.
④ I can hardly read at all because of severe neck pain.
⑤ I cannot read at all because of neck pain.

Concentration

⓪ I can concentrate fully when I want with no difficulty.
① I can concentrate fully when I want with slight difficulty.
② I have a fair degree of difficulty concentrating when I want.
③ I have a lot of difficulty concentrating when I want.
④ I have a great deal of difficulty concentrating when I want.
⑤ I cannot concentrate at all.

Work

⓪ I can do as much work as I want.
① I can only do my usual work but no more.
② I can only do most of my usual work but no more.
③ I cannot do my usual work.
④ I can hardly do any work at all.
⑤ I cannot do any work at all.

Personal Care

⓪ I can look after myself normally without causing extra pain.
① I can look after myself normally but it causes extra pain.
② It is painful to look after myself and I am slow and careful.
③ I need some help but I manage most of my personal care.
④ I need help every day in most aspects of self care.
⑤ I do not get dressed, I wash with difficulty and stay in bed.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
④ I can only lift very light weights.
⑤ I cannot lift or carry anything at all.

Driving

⓪ I can drive my car without any neck pain.
① I can drive my car as long as I want with slight neck pain.
② I can drive my car as long as I want with moderate neck pain.
③ I cannot drive my car as long as I want because of moderate neck pain.
④ I can hardly drive at all because of severe neck pain.
⑤ I cannot drive my car at all because of neck pain.

Recreation

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

Headaches

⓪ I have no headaches at all.
① I have slight headaches which come infrequently.
② I have moderate headaches which come infrequently.
③ I have moderate headaches which come frequently.
④ I have severe headaches which come frequently.
⑤ I have headaches almost all the time.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Neck Index Score _____

Back Index

ACN Group, Inc. Form BI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ **Date** _____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain is very severe and does not vary much.

Sleeping

⓪ I get no pain in bed.
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

Sitting

⓪ I can sit in any chair as long as I like.
① I can only sit in my favorite chair as long as I like.
② Pain prevents me from sitting more than 1 hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

Standing

⓪ I can stand as long as I want without pain.
① I have some pain while standing but it does not increase with time.
② I cannot stand for longer than 1 hour without increasing pain.
③ I cannot stand for longer than 1/2 hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

Walking

⓪ I have no pain while walking.
① I have some pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

Personal Care

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing and dressing without help.
⑤ Because of the pain I am unable to do any washing and dressing without help.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

Traveling

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

Social Life

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
③ Pain has restricted my social life and I do not go out very often.
④ Pain has restricted my social life to my home.
⑤ I have hardly any social life because of the pain.

Changing degree of pain

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back Index Score