CONFIDENTIAL PATIENT HEALTH RECORD

Date:____/_____/_____

Circle One: Divorced / Married / Single / Separated / Widowed Age:_____ Birth Date: _____ /_____/_____

First:_____ Middle:_____ Last: _____

Gender: Male / Female Last Four of your Social Security #: XXX - XX -_____

Email:_____

Home Phone(_____)_____-_____ Cell Phone: (_____)_____-_____

Address: _____ City_____ Zip Code_____

Ethnicity: non-hispanic / Hispanic / not specified Preferred language: _____Race_____

Employer : Business Name: _____Occupation/JobTitle:_____

Business Phone: (_____)_____-_____Type of Work_____

How did you hear about us? _____

Emergency Contact

Name: _____ Phone Number: (_____)_____-_____

Address:_____ Relationship:_____

Who Is Responsible For Your Bill?

( )Self ( )Worker's Comp ( )Auto Insurance ( )Medicare ( )Medicaid Other (be specific):_____

Personal Health Insurance Carrier: _____Health ID Card #: _____

Insured Person's Name: _____Group #: _____

Insured Person's Date of Birth: _____/_____/_____Primary Care Physician: _____

Insured Person's Social Security #: _____-_____-_____

Workers Comp Injury/Auto/Personal Injury

Have you filed an injury report with your employer? Yes No Date:_____/_____/_____ Time:_____am/pm

Carrier: _____ Carriers Phone: (_____)_____-_____

Policy #:_____

Adjuster:_____Claim #: _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Chiropractic Clinic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Chiropractic Clinic will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care or treatment, any fees for professional services rendered me will be immediately due or payable.I hereby authorize the Doctor to treat my condition as he or she deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed the amount paid the Doctor, for x-rays, is for examination only and the x-ray negative will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office.

Patient Print Name: _____ Patient's Signature:_____ Date:_____

Consent to treat a Minor: _____ Date:_____

Guardian or Spouse's Signature of Authorizing Care:_____ Date:_____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for five years.

Patient Print Name: _____ Patient's Signature:_____ Date:_____

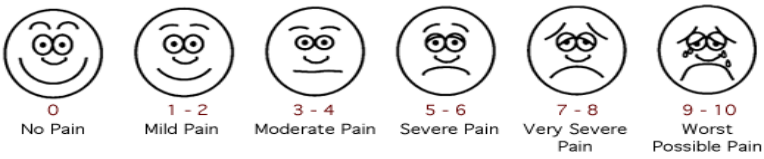
TELL US YOUR PROBLEMS

Name_____

Problem: _____
When did this episode start _____
Has it happened in the past ?: _____
Describe the pain: sharp, etc:_____

How often? ☐ Intermittent (0-25%) ☐Occasional (26-50%)
☐Frequent (51-75%) ☐ Constant (76-100%)

What makes it worses:_____
What make it better :_____
What activities can't you do or have difficulties doing?
_____



_____
Problem:_____
When did this episode start _____
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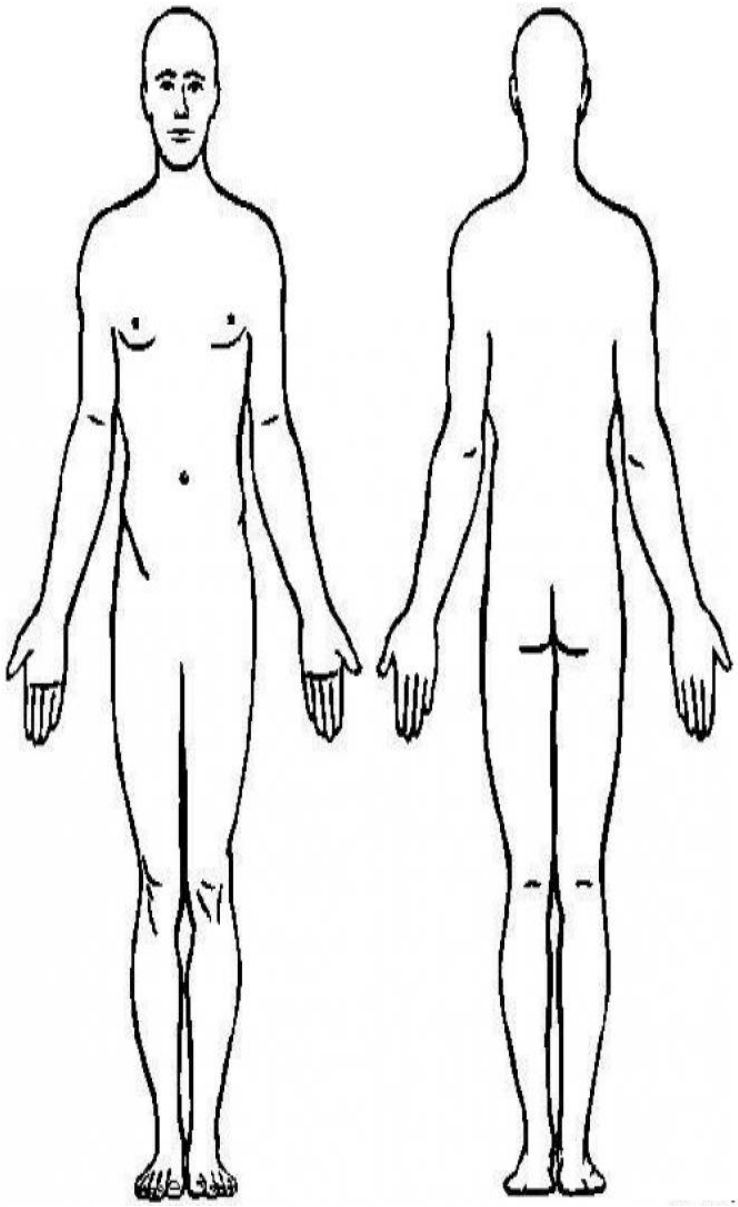
Describe the pain: sharp, etc:_____

How often? ☐Intermittent (0-25%) ☐Occasional (26-50%)
☐Frequent (51-75%) ☐ Constant (76-100%)

What makes it worses:_____
What make it better :_____
What activities can't you do or have difficulties doing?
_____

Use the letters below to indicate the type and location of your sensations right now:
A= Ache B=Burning N= Numbness
P=Pins & Needles S= Stabbing O= Other



What treatment have you already received for your condition?

☐Medications ☐ Surgery ☐Physical Therapy ☐Chiropractic Care ☐None

Name of other doctor (s) who have treated you for this condition and how_____

Were you satisfied with the results of your treatment?☐ Yes ☐ No Explain _____

MEDICAL HISTORY FORM

Name: _____ Age: _____ Date of Birth: _____

PAST MEDICAL HISTORY

a. **Surgeries**

Type: _____ Date Performed: _____

Type: _____ Date Performed: _____

b. **Fractures**

Type: _____ Date Performed: _____

Type: _____ Date Performed: _____

c. **ER Visits**

Type: _____ Date Performed: _____

Type: _____ Date Performed _____

FAMILY HISTORY

d. Mother: Age *(if living)* _____ Age *(at death)* _____ Cause of death_____

List any medical Problems she had or lived with:_____

_____

e. Father: Age *(if living)* _____ Age *(at death)* _____ Cause of death_____

List any medical Problems he had or lived with: _____

_____

LIFESTYLE HISTORY

f. Have you ever been pregnant? Yes _____ No____ N/A____

If yes, how many births? _____ Cesarean Birth? Yes_____ No _____ *Any complications:* _____

g. Smoking Status: _____Unknown _____Every Day_____ Former Smoke____ Never Smoked _____ Unknown if ever smoked____ Heavy Smoker____ Light Smoker _____ *When you Quit:* _____ *Date*

h. Do you drink alcohol? Yes___ No _____ *(If yes how much?_____how often?_____)*

i. Do you take street or recreational drugs? Yes _____ No _____

j. Do you currently take medications? Yes No *What are the medications?*

_____

k. Herbal or Dietary Supplements? Yes ___No ____ *What are the supplements?*

_____

l. Number of meals per day: _____ *Number of "fast food" meals per week?* _____

m. Exercise Regularly? Yes _____No_____ *how long?_____how often?_____*

n. Are you employed or self employed? Yes _____ No _____

o. Have you had any work related illness or injuries? Yes _____ No _____

p. *If yes please explain:_____ Injury/Illness_____Date*

Are there any Hobbies you do or would like to do that are affected by your condition? Yes __No

1) Hobby: _____ How much: Mildly ____ Moderately_____ Significantly____ Can't Do_____

2) Hobby: _____ How much: Mildly_____ Moderately ____ Significantly _____ Cant Do____

3) Hobby: _____ How much: Mildly_____ Moderately ____ Significantly _____ Cant Do____

Are there any daily activities that you do or need to do that are affected by your condition? Yes ____ No ___

1) Activity: _____ How much: Mildly___ Moderately ____ Significantly ____Cant Do____

2) Activity: _____ How much: Mildly___ Moderately ____ Significantly ____Cant Do____

3) Activity: _____ How much: Mildly___ Moderately ____ Significantly ____Cant Do____

PAST OR PRESENT MEDICAL CONDITIONS

Have you had or presently have any of the following conditions? *(Please check and date)*

CONDITION	DATE(s)	CONDITION	DATE(s)
Musculoskeletal:		**Blood/Immune System**	
Θ Neck pain		Θ High cholesterol/triglycerides	
Θ Mid back pain		Θ High glucose	
Θ Low back pain		Θ Hypothyroidism	
Θ Headaches ___Mild____ Mod._____Severe_____ Daily ___ Weekly____ Monthly____		Θ Diabetes Θ Allergies	
Θ Numbness/Tingling Arm___ Hand____ Thighs ___ Leg ___ Foot___		Θ Sinus Infections Θ Ear Infections	
Θ Foot/Ankle Pain		**Digestive System:**	
Θ Hip Pain		Θ Acid Reflux/GERD	
Θ Knee Pain		Θ Peptic ulcer *(gastric/duodenal)*	
Θ Elbow Pain		Θ Constipation	
Θ Carpal Tunnel		Θ Irritable bowel syndrome	
Θ Dizziness		Θ Nausea	
Θ Arthritis		Θ Vomiting	
Θ Rheumatoid Arthritis			
Θ Sciatica		**Vasculature:**	
Θ Herniated/Degenerative Disc Condition		Θ Varicose veins	
Θ Fibromyalgia		Θ Blood clots	
Θ Ear Aches		Θ Stroke/TIA	
Θ Abnormal X-Ray or MRI findings		Θ Peripheral Artery Disease (PAD)	
Θ Shoulder Pain		Θ Hardening of the arteries	
Θ Wrist Pain			
Heart:		**Lungs:**	
Θ High blood pressure		Θ Pneumonia	
Θ Heart Attack		Θ Asthma	
Θ Angina		Θ Bronchitis	
Θ Congestive heart failure		Θ COPD	
Nervous system:		Θ Emphysema	
Θ Neuralgia			
Θ Migraines		**Other Conditions:**	
Θ Cluster Headaches		Θ Chest pressure/tightness with exertion	
Θ Pinched nerves		Θ Chest pressure/tightness with rest	
Θ Depression		Θ Generalized weakness	
Θ Panic Attacks/Anxiety		Θ Cancer: Type:	
		Θ Night Sweats	
Organ System:		Θ Trouble breathing	
Θ Kidney Stones		Θ Feeling faint or passing out	
Θ Gallstones		Θ Pain in legs while walking	
Θ Hepatitis		Θ Recent Weight loss: # pounds lost	
Θ Bladder infections		Θ Recent weight gain: # pounds gained	
Θ Enlarged Prostate		Θ Swollen feet or ankles	

List any other problems not mentioned above:

_____

Dr. Robert Rosenberg D.C., P.A
(Chiropractic Physician)
250 S. Ronald Reagan Blvd. Suite 104
Longwood, Fl 32750
Phone number:407-767-6466
Fax number: 407-767-2437

Authorization to Release Medical Records to Dr. Rosenberg for:

Patient :_____ Date(s) of Service_____

Date of Birth_____ Social Security Number_____

I, the undersigned, authorize the release of, or request access to the information specified below from the medical record(s) of the above name patient.

__INFORMATION TO BE RELEASED OR ACCESSED:

__Complete records __Progress notes
__Labs/ Path reports __Imaging Reports and Images (x-rays, MRI, CT etc.)
__Clinical summaries
__Consultation notes __other_____

The above information may be released (specify name or title of the individual or the name of the organization to which records are to be released and at the appropriate address):

FROM: _____
(Doctor, Hospital, Clinic, Imaging center etc.) Phone number

_____
Address (Street, City, State and ZIP)

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected. I understand that the specified information to be released may include but is not limited to history, diagnoses, and/or treatment of drugs or alcohol abuse, mental illness, or communicable disease, including HIV and AIDS.

I understand that i may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization.
The authorization will expire six (6) months from the date of my signature, unless i revoke the authorization prior to that time.

Date: _____ Signature:_____
Patient or Legally Authorized Representative

_____ Print Name:_____
Relationship to Patient Patient or Legally Authorized Representative

Automobile Accident Description

Please answer the questions below. If you do not know the answer to a question, do not answer it.

Vehicle type (i.e. car, truck, van) _____ **Date of Accident:**_____

Position in vehicle: Θ Driver Θ Front Passenger Θ Left Rear Passenger ❑ Right Rear Passenger ❑ Other_____

What was your vehicle doing at the time of the accident? Θ Stopped at Intersection Θ Stopped in Traffic Θ Stopped at Light ❑ Making a right Turn Θ Making a Left Turn Θ Parking Θ Proceeding Along Θ Slowing Down Θ Accelerating Θ Other_____

Time/Speed/Damage
Time of accident: _____
Your vehicle's speed: _____ **mph**
Their vehicle's speed: _____ **mph**

Details of Accident:
Visibility at time of accident: Θ Poor Θ Fair Θ Good
Who hit who/what? _____
Road conditions at time of accident (i.e. dry, wet, dark, sunny) _____
Point of impact: Θ Head-on Θ Left Front Θ Right Front Θ Rear-end Θ Left Rear Θ Right Rear

Body Position, etc.
Did you see the accident coming? Y / N
Were you braced for the impact? Y / N
Did you have a seat belt on? Y / N
Did you have a shoulder harness on? Y / N

Headrest Position
Does your vehicle have headrests? Y / N
What was your position of your headrest at the time of the impact?
Θ Even with top of head Θ Even with bottom of head Θ Middle of neck
What was the direction of your head at the time of the impact?
Θ Facing straight fwd Θ Turned to the right Θ Turned to the left

Did driver side airbags deploy? Y / N **Did passenger side airbags deploy?** Y / N **Did side airbags deploy?** Y / N

During the Accident
Did your body strike the inside of your vehicle? Y / N
If yes, describe _____
Did you lose consciousness during the injury? Y / N
If yes, for how long? _____

Your vehicle's est. damage? _____
Damage to their vehicle? Θ Mild Θ Moderate Θ Severe
Did police show up at the scene? Y / N
Was an accident report filled out? Y / N
After the accident
What symptoms have occurred following the accident? (i.e. headaches, stiff neck, achy lower back)
_____
Emergency Room
Where did you go after the accident? (i.e home, work, ER, private doctor) _____

How did you get there? (i.e. drove self, ambulance, police) _____

Were x-rays done? Y / **N If yes, what body parts?** _____

Treatment History
Fill in other doctor(s) seen prior to your first visit to this office.
Dr. _____
Specialty _____
Treatment(s) _____

Activities of Daily Use Questionnaire

We would like to know how much your condition presently prevents you from doing what you would normally do. Regarding each category, please indicate the overall impact your present pain has on your life, not just when the pain is at its worst.

Please circle the number which best describes how your condition affects these six categories of activities.

1- Family / At-Home Responsibilities: yard work, chores around the house, driving the kids to school, etc

0 1 2 3 4 5 6 7 8 9 10

2-Recreation: including hobbies, sports, or other leisure activities

0 1 2 3 4 5 6 7 8 9 10

3-Social Activities: including parties, theater, concerts, dining-out, and attending other social functions

0 1 2 3 4 5 6 7 8 9 10

4-Employment: including volunteer work, computer, and homemaking tasks

0 1 2 3 4 5 6 7 8 9 10

5-Personal Hygiene: such as taking a shower, getting dressed, brushing hair/teeth, and putting on shoes

0 1 2 3 4 5 6 7 8 9 10

6-Life-Support Activities: such as sleeping

0 1 2 3 4 5 6 7 8 9 10

Patient Name: _____ Date: /
/Score: _____ [60] Bench Mark
=_____