STANFIELD CHIROPRACTIC NEW PATIENT INFORMATION

NAME:(F)_____(M)_____(L)_____

Nickname:_____ Date Of Birth: _____

SOCIAL SECURITY #:_____ SEX: Male / Female

MARITAL STATUS: Single Married Widow Divorced Other

SPOUSES NAME(F)_____(M)____(L)_____Date Of Birth:_____

SPOUSES SOCIAL SECURITY # _____

HOME PHONE: _____CELL PHONE: _____

EMAIL: _____@ _____

ADDRESS: _____

CITY: _____ STATE:_____ ZIP: _____

Name of Relative Not Living with You:_____

Phone #:_____ Relation: _____

EMPLOYMENT STATUS: Full Time Part Time Not Employed Self Employed Retired

Active Military Student

EMPLOYER: _____WORK PHONE_____

OCCUPATON: _____

INSURANCE: _____

Policy #:_____ Group# _____

WHO MAY WE THANK FOR REFERRING YOU? _____

HAVE YOU SEEN/HEARD ABOUT OUR OFFICE ON:

Radio Billboard Television Magazine Newspaper

OTHER: _____

I clearly understand that if I am accepted as a patient at Stanfield Chiropractic, Inc. I authorize them to proceed with necessary treatment. Any risks regarding such treatment will be explained upon request. I also understand and agree that I am personally responsible for payment of charges for the services and supplies rendered to me. If insurance verification is obtained, insurance claims may be filed on your behalf. I understand that the filing of insurance is not a guarantee of payment, and I remain responsible for any balance due in it's entirety. I also understand that if I terminate my care and treatment, any fees for professional services rendered to me prior to termination of care will be immediately due and payable. In the extent of default, I promise to pay legal interest on the indebtedness together with such collection costs and reasonable attorney fees as may be required to effect collection. I hear by attest that the above and all following information is true to the best of my knowledge.

_____ _____ _____

Signature of Patient or Patient's Guardian Date Witness

Who is your primary doctor?

_____

What major surgeries have you had?

_____

What specialists have you seen? CIRCLE Physical therapist, Orthopedic Surgeon, Neurosurgeon, Neurologist, Psychiatrist, Psychologist, Pain Management, Massage, Rheumatologist, Dentist, ENT, Oncologist, Gastroenterologist, Cardiologist?
Give Name, Diagnosis and Treatment:

_____

_____

_____

What other Chiropractor have you seen?_____
Did the treatment help?_____What type of treatment was received?_____

_____

What supplements/vitamins/Meds do you take?_____

_____

What diagnostic tests have you had?

Xrays- date:_____location_____
MRI date_____location_____
CT date_____location_____
Bone Scan date_____location_____
Bone Density date_____location_____
Nerve Conduction date_____location_____
Other_____

Are your symptoms getting? Better Worse Same

Do you have metal in your body? Yes No Where?_____
Do you have a communicable disease? Yes No What disease?_____
Do you have active cancer? Yes No Type?_____
Do you have a history of cancer? Yes No Type?_____
Do you have a Pacemaker? Yes No
Do you have a history of Smoking? Yes No
Do you have a history of oral contraceptives? Yes No
Other health problems? Diabetic, heart problems, liver problems?_____

Are you experiencing any of the following stroke symptoms at this time?

YES NO Sudden difficulty speaking (slurred speech) understanding what people are saying?
YES NO Sudden onset of confusion or altered mental status, such as loss of consciousness, or not recognizing people who should be familiar?
YES NO Sudden numbness or tingling on one side of face or body or both?
YES NO Sudden onset of dizziness or unsteadiness, loss of balance or coordination, or both?
YES NO Sudden difficulty walking or standing upright?
YES NO Sudden severe headache?
YES NO Sudden severe unexplained upper-neck pain?
YES NO sudden trouble with vision or sight?

Please CIRCLE 1 number on EACH scale.

PAIN DISABILITY QUESTIONNAIRE

Patient Name _____ Date _____

Instructions: These questions ask your views about how your pain now affects how you function in everyday activities. Please answer every question and mark the ONE number on EACH scale that best describes how you feel.

1. Does your pain interfere with your normal work inside and outside the home?
Work normally — Unable to work at all
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

2. Does your pain interfere with personal care (such as washing, dressing, etc.)?
Take care of myself completely — Need help with all my personal care
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

3. Does your pain interfere with your traveling?
Travel anywhere I like — Only travel to see doctors
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

4. Does your pain affect your ability to sit or stand?
No problems — Can not sit/stand at all
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

5. Does your pain affect your ability to lift overhead, grasp objects, or reach for things?
No problems — Can not do at all
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

6. Does your pain affect your ability to lift objects off the floor, bend, stoop, or squat?
No problems — Can not do at all
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

7. Does your pain affect your ability to walk or run?
No problems — Can not walk/run at all
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

8. Has your income declined since your pain began?
No decline — Lost all income
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

9. Do you have to take pain medication every day to control your pain?
No medication needed — On pain medication throughout the day
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

10. Does your pain force your to see doctors much more often than before your pain began?
Never see doctors — See doctors weekly
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

11. Does your pain interfere with your ability to see the people who are important to you as much as you would like?
No problem — Never see them
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

12. Does your pain interfere with recreational activities and hobbies that are important to you?
No interference — Total interference
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

13. Do you need the help of your family and friends to complete everyday tasks (including both work outside the home and housework) because of your pain?
Never need help — Need help all the time
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

14. Do you now feel more depressed, tense, or anxious than before your pain began?
No depression/tension — Severe depression/tension
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

15. Are there emotional problems caused by your pain that interfere with your family, social and or work activities?
No problems — Severe problems
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

Examiner

OTHER COMMENTS:

With Permission from: Anagnostis C et al: The Pain Disability Questionnaire: A New Psychometrically Sound Measure for Chronic Musculoskeletal Disorders. *Spine* 2004; 29 (20): 2290-2302.

Patient Health Questionnaire - PHQ

ChiroCare Form PHQ-202

ChiroCare Use Only rev 5/27/2003

Patient Name _____ **Date** _____

1. Describe your symptoms _____

_____

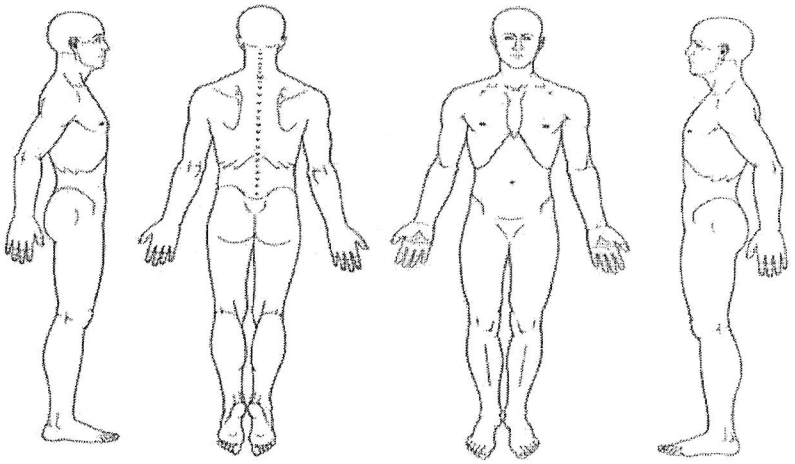
a. When did your symptoms start? _____

b. How did your symptoms begin? _____

2. How often do you experience your symptoms?

① Constantly (76-100% of the day)
② Frequently (51-75% of the day)
③ Occasionally (26-50% of the day)
④ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?

① Sharp ④ Shooting
② Dull ache ⑤ Burning
③ Numb ⑥ Tingling

4. How are your symptoms changing?

① Getting Better
② Not Changing
③ Getting Worse

5. During the <u>past 4 weeks:</u>

a. Indicate the average intensity of your symptoms

None ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ *Unbearable*

b. How much has pain interfered with your normal work (including both work outside the home, and housework)

① Not at all ② A little bit ③ Moderately ④ Quite a bit ⑤ Extremely

6. During the <u>past 4 weeks</u> how much of the time has your condition interfered with your social activities?
(like visiting with friends, relatives, etc)

① All of the time ② Most of the time ③ Some of the time ④ A little of the time ⑤ None of the time

7. In general would you say your overall health right now is...

① Excellent ② Very Good ③ Good ④ Fair ⑤ Poor

8. Who have you seen for your symptoms?

① No One ③ Medical Doctor ⑤ Other
② Other Chiropractor ④ Physical Therapist

a. What treatment did you receive and when? _____

b. What tests have you had for your symptoms and when were they performed?

① Xrays *date:* _____ ③ CT Scan *date:* _____
② MRI *date:* _____ ④ Other *date:* _____

9. Have you had similar symptoms in the past?

① Yes ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

① This Office ③ Medical Doctor ⑤ Other
② Other Chiropractor ④ Physical Therapist

10. What is your occupation?

_____

① Professional/Executive ④ Laborer ⑦ Retired
② White Collar/Secretarial ⑤ Homemaker ⑧ Other
③ Tradesperson ⑥ FT Student

a. If you are not retired, a homemaker, or a student, what is your current work status?

① Full-time ③ Self-employed ⑤ Off work
② Part-time ④ Unemployed ⑥ Other

Patient Signature _____ **Date** _____

INFORMED CONSENT FORM

Every type of health care is associated with some risk of potential problem. This includes chiropractic health care. We wish you to be informed about the possibility of any potential problems associated with chiropractic health care before consenting to treatment. This is called informed consent.

Consent To Treatment

The following points have been explained to me to my satisfaction and I have had the opportunity to discuss them with the doctor and/or other clinic personnel.

I. I understand that the chiropractor will use his/her hands or a mechanical device upon my body to adjust a joint, and there may be an audible "pop" or "click" as a result of joint movement.

II. The practice of health care is not an exact science, but relies upon information related by the patient, information gathered during the examination (and the doctor's interpretation thereof), as well as the doctor's judgement and expertise. Chiropractic health care is no different.

III. It is not reasonable to expect my doctor to be able to anticipate or explain all possible risks and complications of a given procedure on any particular visit, and I wish to rely on the doctor to exercise professional judgement during the course of any procedures which s/he feels at the time to be in my best interest.

IV. Though infrequent, as with any health procedure, there are certain complications which may arise during chiropractic health care. These complications include; but are not limited to: soreness, sprains/strains, dislocations, fractures, disc injuries, cerebral-vascular accidents, physiotherapy burns, or soft tissue injuries. These complications are extremely rare occurrences.

V. Chiropractic is a system of health care delivery; therefore, as with any other health care delivery system, we cannot promise a cure for any symptom, disease, or condition as a result of treatment in this facility. We will give you our best care.

VI. I understand that there are other forms of treatment, including drugs and surgery, which could be treatment options for my condition, but at this time, I choose chiropractic care.

I have read the above consent, or it has been read to me, have had an opportunity to ask questions and receive answers, am comfortable with the information provided, and consent to chiropractic treatment and management on that basis. I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy, and if necessary, diagnostic x-rays on me by the chiropractic physician and/or anyone working in this office authorized by the chiropractic physician. I further understand that such chiropractic services may be performed by the Physician and/or other health care providers who may treat me now, or in the future at Stanfield Chiropractic. In signing this document, I in no way compromise my protection against negligence.

Patient Signature _____ Date_____

Witness Signature _____ Date _____

Stanfield Chiropractic
2300 SE 17th Street, Bldg. 1100
Ocala, FL 34471

ACKNOWLEDGMENT OF RECEIPT
OF
HIPPA 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 six years.

By checking the boxes below, I authorize contact for practice reminders by:

Mail ☐ Phone/Voicemail ☐ Text ☐

Email ☐ Email Address (if different from intake form):_____

FaceBook address _____.

By checking the boxes below, I authorize contact for birthday greetings or promotions about the practice by:

Mail ☐ Phone/Voicemail ☐ Text ☐

Email ☐ Email Address (if different from intake form):_____

FaceBook address _____.

☐ **By checking this box, I authorize the doctor to personally discuss with me products that may benefit my health or condition.**

_____ _____

Patient Name (please print) Date

_____

Name of Parent, Guardian or Patient's legal representative

_____

Signature of Patient, Parent, Guardian or Patient's legal representative

RELEASE OF PERSONAL HEALTH INFORMATION

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.

List below the names and relationship of people to whom you authorize the Practice to release PHI.

_____	_____
_____	_____
_____	_____

STANFIELD CHIROPRACTIC

JOSEPH STANFIELD D.C.
2300 SE 17TH STREET
BUILDING 1100 (TEALBROOKE)
OCALA, FL 34471
P 352-873-7563 F 352-873-7519

REQUEST FOR RELEASE OF MEDICAL RECORDS

TO: _____

ADDRESS:

_____

_____

I HEREBY REQUEST THAT MY MEDICAL RECORDS BE RELEASED TO
DR. JOSEPH STANFIELD
2300 SE 17TH STREET, BLDG. 1100
OCALA, FL 34471
FAX # 352-873-7519

_____/_____/_____
PATIENT'S DATE OF BIRTH

_____
PATIENT'S NAME (PLEASE PRINT)

_____/____/_____
PATIENT'S SIGNATURE DATE

WWW.STANFIELDCHIROPRACTIC.COM