

CHIROPRACTIC REGISTRATION AND HISTORY

1

PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____ First Name _____ Middle Initial

Address _____

E-mail _____

City _____

State _____ Zip _____

Sex M F Age _____

Birthdate _____

Married Widowed Single Minor

Separated Divorced Partnered for _____ years

Patient Employer/School _____

Occupation _____

Employer/School Address _____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

2

INSURANCE INFORMATION

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? Yes No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE
 I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to _____
 Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits of the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

 Signature of Patient, Parent, Guardian or Personal Representative

 Please print name of Patient, Parent, Guardian or Personal Representative

 Date

 Relationship to Patient

3

PHONE NUMBERS

Cell Phone (_____) _____ Home Phone (_____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone (_____) _____ Work Phone (_____) _____

4

ACCIDENT INFORMATION

Is condition due to an accident? Yes No Date _____

Type of accident Auto Work Home Other

To whom have you made a report of your accident?
 Auto Insurance Employer Worker Comp. Other

Attorney Name (if applicable) _____

5

PATIENT CONDITION

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? Yes No Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

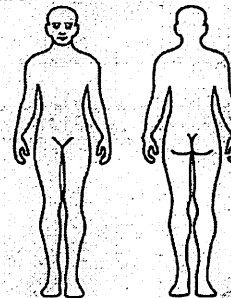
Type of pain: Sharp Dull Throbbing Numbness Aching Shooting
 Burning Tingling Cramps Stiffness Swelling Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your Work Sleep Daily Routine Recreation

Activities or movements that are painful to perform Sitting Standing Walking Bending Lying Down



Infinite Health & Spine Center
 820 Palmway Street
 Kissimmee, FL 34744
 Phone 407-931-3700
 Fax 407-567-7900



HEALTH HISTORY

What treatment have you already received for your condition? Medications Surgery Physical Therapy

Chiropractic Services None Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____

Spinal Exam _____ Chest X-Ray _____ Urine Test _____

Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chicken Pox	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatoid Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Alcoholism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Measles	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergy Shots	<input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Migraine Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Miscarriage	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anorexia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fractures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mononucleosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Suicide Attempt	<input type="checkbox"/> Yes <input type="checkbox"/> No
Appendicitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Multiple Sclerosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Goiter	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mumps	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gonorrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumors, Growths	<input type="checkbox"/> Yes <input type="checkbox"/> No
Breast Lump	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Parkinson's Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Typhoid Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bronchitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pinched Nerve	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bulimia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hernia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pneumonia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vaginal Infections	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herniated Disk	<input type="checkbox"/> Yes <input type="checkbox"/> No	Polio	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cataracts	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prostate Problem	<input type="checkbox"/> Yes <input type="checkbox"/> No	Whooping Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prosthesis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other _____	
		Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	

EXERCISE

- None
- Moderate
- Daily
- Heavy

WORK ACTIVITY

- Sitting
- Standing
- Light Labor
- Heavy Labor

HABITS

- Smoking _____ Packs/Day
- Alcohol _____ Drinks/Week
- Coffee/Caffeine Drinks _____ Cups/Day
- High Stress Level _____ Reason _____

Are you pregnant? Yes No Due Date _____

Injuries/Surgeries you have had	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____



MEDICATIONS

ALLERGIES

VITAMINS/HERBS/MINERALS

Pharmacy Name _____
Pharmacy Phone (____) _____

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INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and any other chiropractic procedures, including a comprehensive exam, diagnostic x-rays, physical therapy techniques, on me (or on the patient named below for which I am legally responsible) by the licensed doctors of chiropractic at this office.

I understand that, as with any health procedure, there are certain conditions that may arise during a chiropractic adjustment. Those complications include but are not limited to: fractures, dislocations, muscle strain, costovertebral strains and separations. Some types of manipulations of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. This is a very rare occurrence (a one in three million chance). We screen our patients for indications that they are candidates for chiropractic adjustments to the best of our ability. I do not expect the doctor to be able to anticipate all risk and complications during the course of the procedure(s) that the doctor feels at the time, based upon the facts then known, are in the best interest.

I have had an opportunity to discuss with the doctor the nature, purpose, and risk of chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed.

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. By signing below, I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the chiropractic treatment recommended. Having being informed of the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition (s) for which I seek treatment.

Printed name of patient

Signature of Patient

Date

Signature of patient's representative (if minor)

Date

Infinite Health & Spine Center
820 Palmway Street
Kissimmee, FL 34744

FEDERALLY MANDATED PRIVACY REGULATION REQUIREMENT
PATIENT CONSENT FORM

I hereby give my consent for **Infinite Health and Spine Center, PA** or my physician(s) to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by **Infinite Health and Spine Center, PA** or my physician(s) describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. **Infinite Health and Spine Center, PA**. Or my physician(s) reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **Infinite Health and Spine Center, PA** at 820 Palmway Street Kissimmee, FL 34744.

With this consent, **Infinite Health and Spine Center, PA** or my physician(s) may call my home or other alternative location and leave a message on voice mail or in person in reference to any item that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, **Infinite Health and Spine Center, PA** or my physician(s) may e-mail my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that **Infinite Health and Spine Center, PA** or my physician(s) restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

With this consent, **Infinite Health and Spine Center, PA** or my physician(s) may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder card and patient statements as long as they are marked "Personal and Confidential."

By signing this form, I am consenting to allow **Infinite Health and Spine Center, PA** or my physician(s) to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, **Infinite Health and Spine Center, PA** or my physician(s) may decline to provide treatment to me.

Patient Signature

Date

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MagnaCharger: Pulsed Magnetic Cellular Exerciser
Consent for Demonstration or Session

Disclaimer

The MagnaCharger produces magnetic energy, which passes freely through tissue for the purpose of cellular exercise to promote and support a sense of wellbeing. The MagnaCharger is not a medical device. The MagnaCharger has not been evaluated by the FDA. It is not intended for the diagnosis, treatment or cure of any medical condition. If you are experiencing the symptoms of a medical condition you should seek the advice of a medical professional. If you are unsure whether a demonstration or exercise program of pulsed magnetic cellular exercise is right for you, consult with your licensed health care provider(s).

As with any exercise program, you may experience natural reactions that include but are not limited to; nausea, headache, fatigue or muscle aches.

Precautions & Recommendations

- ❖ Additional hydration is recommended before and after a session with the MagnaCharger
- ❖ Do not use the MagnaCharger if you have an implanted electronic device including: **pacemaker, defibrillator, cochlear hearing device, etc.**
- ❖ Remove all the following from your person: **Electronic or battery operated devices, keys, wallets, jewelry and hearing aids**
- ❖ **Do not use the MagnaCharger if you are pregnant**
- ❖ **Do not use during active bleeding, hemorrhaging or during heavy menstruation**

Informed Consent

I understand that the MagnaCharger creates a fully adjustable pulsed magnetic field. I understand that the information shared by the demonstrator are his/her personal opinions and are intended for educational purposes only.

Beyond what is stated above, I understand that other risks associated with a pulsed magnetic exercise session are unforeseeable and that the demonstrator, the manufacturer, the marketer, employees, agents and affiliates cannot accept any liability for loss or damages incurred as the result of the MagnaCharger session. I reserve the right to use the knowledge I have gained in the care of my own body in any legal manner I may choose. I have read this form and voluntarily agree to the MagnaCharger session on my person assuming all liability for any and all results or consequences.

Print Name _____ Signature _____

Date _____



Consent for appointment reminders via e-mail & text message

Date: _____

Patient Name: _____

DOB: _____

Cell Phone: (____) _____

Cell Phone Company: _____

Email Address: _____

I understand that by signing this form, I may receive appointment reminders via e-mail or text message in addition to receiving them via phone calls. I further understand that the provider e-mail & text system is not encrypted. I understand that I am responsible for access to my e-mail and text messages and will not hold the provider's office responsible for any breach that may occur. Any changes to my email address or phone number must be delivered in writing, and not, by e-mail or text to the provider. Communications will be limited and used only for receiving and responding to appointment reminders. Except for the applicable names and times and dates of appointments, no other personal information about the Patient shall be included in any e-mail or text message.

Patient Signature

Date