Bode Chiropractic Accident & Wellness

13694 W. Hillsborough Ave. Tampa, FL 33635

Initial Patient Questionnaire

Date: _____ HT:_____ WT:_____ SSN:___-___-_____ Sex: M / F

Name: _____ DOB: ___/___/_____ Age:_____

Address: _____ City:_____ State: _____ Zip:_____

Phone: Home:_____ Cell: _____ Work: _____

Marital Status: _____ Occupation: _____ Employer: _____

Emergency Contact: _____ Relation: _____ Phone: _____

Your Email: _____

Primary Care Physician: _____ Phone: _____

History of Condition

What problem(s) are you having that bring you to our office? Please list.

1.)_____ Date of Onset: _____

2.)_____ Date of Onset: _____

3.)_____ Date of Onset: _____

4.)_____ Date of Onset: _____

Current Medications: _____

_____

Current Allergies: _____

In general, what would you say your overall health is right now? (circle) Excellent Very Good Good Fair Poor

Please check any of the following that you have been diagnosed with or have experienced:

___ Diabetes	___ Asthma	___ Depression	___ Mumps	___ Arthritis/Osteoporosis
___ Heart Disease	___ Tuberculosis	___ Mental Disorder	___ Measles	___ Stroke
___ High Blood Pressure	___ Herpes	___ Liver Problems	___ Chicken Pox	___ Polio
___ Blood Clots	___ HIV/AIDS	___ Vascular Disease	___ Epilepsy/Seizures	___ Cancer
___ Alcohol/Drug abuse	___ Smoking	___ Bursitis	___ Head Concussion	___ Headaches/Migraines

___ Other (please explain): _____

List any surgeries you have had: _____

List any hospitalizations you have had: _____

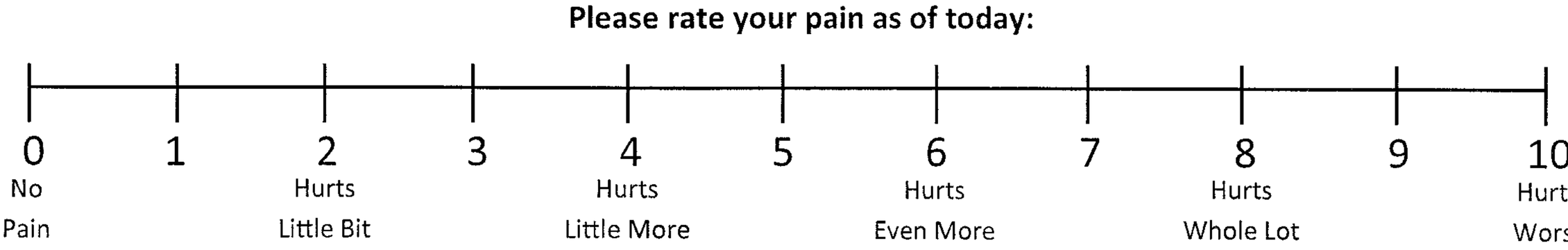
List any previous injuries/accidents you have had. Please list dates and treatment if any: _____

_____

Do you have a family history of chronic illness? If so, please describe: _____

_____

Please rate your pain as of today:



I certify to the best of my knowledge, the above information is complete and accurate. I agree to notify this practitioner immediately whenever I have changes in my health condition. I understand that my chiropractor may need to contact my physician if my condition needs to be co-managed. Therefore I give authorization to my chiropractor to contact my physician if necessary.

Patient Signature: _____ **Date:** _____

SYMPTOM SURVEY

Please circle all that apply

General Symptoms:
Nervousness Irritability Fatigue
Depression Loss of Sleep Tension PMS

Head:
Headache 1) Mild 2) Moderate 3) Severe
Scale of 1-10: _____
How often? _____ times per _____
1) Constant 2) Intermittent 3) Throbbing
Located: 1) Back of Head 2) Memory loss 3) Temples
4) Right Side 5) Left Side 6) Behind the eyes
With: 1) Lightheadedness 2) Memory loss
3) Fainting 4) Blurred vision 5) Double vision
6) Sensitivity to light 7) Loss of balance
8) Hearing loss 9) Ringing in the ears

Neck:
Pain: 1) Left side 2) Right side 3) Both
Level: 1) Mild 2) Moderate 3) Severe
Scale of 1-10: _____

Shoulders:
Pain in joint 1) Left 2) Right 3) Both
Pain across shoulder 1) Left 2) Right 3) Both
Limited movement 1) Left 2) Right 3) Both
Tension 1) Left 2) Right 3) Both

Arms:
Pain above elbow 1) Left 2) Right 3) Both
Pain in elbow 1) Left 2) Right 3) Both
Pain in forearm 1) Left 2) Right 3) Both
Pins & Needles (Upper Arm) 1) Left 2) Right 3) Both
Pins & Needles (Forearm) 1) Left 2) Right 3) Both
Numbness in upper arm 1) Left 2) Right 3) Both
Numbness in forearm 1) Left 2) Right 3) Both

Hands:
Pain in wrist 1) Left 2) Right 3) Both
Pain in hand 1) Left 2) Right 3) Both
Pins & needles 1) Left 2) Right 3) Both
Numbness 1) Left 2) Right 3) Both

Mid Back:
Pain 1) Left 2) Right 3) Both
Level: (Scale of 1-10) _____
Type: Sharp/stabbing or dull ache
Muscle spasms 1) Left 2) Right 3) Both

Chest:
Deep chest pain 1) Left 2) Right 3) Both
Pain around ribs 1) Left 2) Right 3) Both
Shortness of breath
Irregular heartbeat

Abdomen:
Pain: 1)Mild 2)Moderate 3)Severe
Nervous stomach Nausea Gas
Constipation Diarrhea Heartburn
Indigestion Loss of appetite

Low Back:
Upper lumbar: 1) Left 2) Right 3) Both
Lower lumbar: 1) Left 2) Right 3) Both
Sacroilliac: 1) Left 2) Right 3) Both
Muscle Spasms: 1) Left 2) Right 3) Both
Pain: 1) Mild 2) Moderate 3) Severe
Level: (Scale of 1-10) _____

Hips and Legs:
Pain in buttocks 1) Left 2) Right 3) Both
Pain in hip joint 1) Left 2) Right 3) Both
Pain down leg 1) Left 2) Right 3) Both
Radiating to 1) Knee 2) Calf 3) Foot
Numbness in leg 1) Left 2) Right 3) Both
Pins and needles 1) Left 2) Right 3) Both
Knee pain 1) Left 2) Right 3) Both
Leg cramps 1) Left 2) Right 3) Both
Pain 1) Mild 2) Moderate 3) Severe
Level: (Scale of 1-10) _____

Feet:
Ankle pain: 1) Left 2) Right 3) Both
Swollen ankles: 1) Left 2) Right 3) Both
Foot pain: 1) Left 2) Right 3) Both
Numbness: 1) Left 2) Right 3) Both

Other symptoms that you have: _____
Are all of the symptoms directly caused by the accident: YES NO

_____
Patient Signature

Rode Chiropractic
Accident & Wellness Center

Review of Systems

Please check YES or NO to ALL below.

Constitutional

YES	NO	
☐	☐	Excessive daytime sleepiness
☐	☐	Fatigue
☐	☐	Fevers
☐	☐	Low Energy
☐	☐	Trouble getting to sleep
☐	☐	Trouble staying asleep
☐	☐	Weight gain
☐	☐	Weight loss

Eyes

YES	NO	
☐	☐	Blurred vision
☐	☐	Double vision
☐	☐	Loss of vision

Ears, Nose, Mouth and Throat

YES	NO	
☐	☐	Loss of sense of smell
☐	☐	Hearing loss
☐	☐	Ringing in your ears

Cardiovascular and Respiratory

YES	NO	
☐	☐	Chest Pain
☐	☐	Palpitations
☐	☐	Shortness of breath

Gastrointestinal

YES	NO	
☐	☐	Constipation
☐	☐	Diarrhea
☐	☐	Heartburn
☐	☐	Nausea
☐	☐	Vomiting

Bladder & Sexual Function (Genitourinary)

YES	NO	
☐	☐	Discomfort or burning
☐	☐	Loss of bladder control
☐	☐	Loss or desire for sex
☐	☐	Menopause (women)
☐	☐	Trouble with erection (men)
☐	☐	Urgency to urinate

Skin

YES	NO	
☐	☐	Change in hair or nails
☐	☐	Change in skin color
☐	☐	Itching
☐	☐	Rash

Neurological

YES	NO	
☐	☐	Confusion
☐	☐	Falling down
☐	☐	Headaches
☐	☐	Incoordination
☐	☐	Involuntary movements or jerking
☐	☐	Lightheaded or dizzy
☐	☐	Loss of consciousness/fainting/passing out
☐	☐	Numbness
☐	☐	Seizure or convulsion
☐	☐	Spinning or vertigo
☐	☐	Tingling
☐	☐	Tremor
☐	☐	Trouble speaking
☐	☐	Trouble walking
☐	☐	Weakness
☐	☐	Trouble swallowing

Musculosketal

YES	NO	
☐	☐	Back pain
☐	☐	Double vision
☐	☐	Loss of vision

Memory, Thinking, Mood, Psychiatric

YES	NO	
☐	☐	Anxiety
☐	☐	Depressed mood
☐	☐	Hallucinations (seeing or hearing things)
☐	☐	Memory loss

Hematologic (blood) and lymphatic

YES	NO	
☐	☐	Anemia
☐	☐	Easy bruising or bleeding
☐	☐	Slow to heal after cuts

Allergic and Immune

YES	NO	
☐	☐	Allergic reaction to medicine or x-ray dye

Smoking, Alcohol and Drugs

YES	NO	
☐	☐	Do you use tobacco products? How much? _____ per _____
☐	☐	Do you drink alcohol? How much? _____ per _____
☐	☐	Do you use any drugs for recreation? How much? _____ per _____

Signature of patient **Date**

Signature of person completing form **Date**
(if not patient)

PATIENT INFORMED CONSENT

State law requires offices to obtain your informed consent prior to examination and treatment. The purpose of this form is to inform you. What your being asked to sign is simply a confirmation that you have been informed of the following.

EXAMINATIONS

X-RAYS: This office uses highly sensitive x-ray film, intensifying screens and filters that provide high quality x-rays with the lowest possible x-ray exposure. The only noteworthy risk with taking x-rays deals with pregnancy. **If there is any possibility that you are pregnant, inform us prior to any x-ray procedure.** If there is no possibility of this condition, the risks are so rare we have no available statistics to quantify their probability.

TREATMENT

Chiropractic adjustment/manipulation: The doctor will use his hands or a mechanical device upon your body in such a way as to move your joints in various directions. This procedure may cause an audible "pop" or "click" to be heard coming from your joints, this is not a cause for alarm. There are some material risks involved in doing these procedures they are as follows:

Pain: Chiropractic treatments may result in a temporary increase in soreness in the area receiving treatment.

Rib Fractures: Fractures caused by chiropractic treatments are rare. They occur most frequently in patients with osteoporosis or weakened bones. Evidence of osteoporosis can be noted on your x-rays, and if detected, the most appropriate and gentle treatments are used, minimizing the possibility of fractures to the ribs.

Disc Injury: Chiropractic treatment is appropriate for the treatment of many kinds of back problems, including some disc problems.[1] Occasionally, chiropractic may aggravate or cause a problem if the disc is in a severely weakened state. However, this occurs so rarely that statistics to quantify the probability are unavailable, but estimates place risk of serious injury at about 1 serous complication per 100 million low back manipulations.[2]

Stroke: The overall incidence of stroke in the general population is about 2 per 1000 people.[3] Although chiropractic adjustment/manipulation has been implicated as a possible cause of stroke, this possibility is extremely rare. The best available data suggests that stroke secondary to chiropractic adjustment/manipulation may occur in 1 per 100,000 patients[4] – a rate well below the overall average risk in the general population. In comparison, the overall average risk of death from taking non-steriodal anti-inflammatory drugs (aspirin, Ibuprofen, Naxproxen sodium etc.) is 4 per 100,000 patients.[5] The risk of serious complication or death from spine surgeries of the neck is 11.25 per 1000 patients.[5] As you can see, the risk of stroke from chiropractic treatments is much lower than other common medical treatments. Even though the risk is small, we have implemented procedures and test that will likely reduce the potential for stroke even more.

Chiropractic is a system of health care delivery. As with any health delivery system we cannot promise a cure for any symptom, disease, or condition as a result of treatment in this office. We will always give you our best care, and if your results are not acceptable, we will refer you to another health care provider who we feel will assist your situation.

If you have any questions on the above information, please ask the doctor. When you have a clear understanding, please sign and date below.

I HAVE READ OR HAVE HAD READ TO ME THIS CONSENT FORM AND I HAVE BEEN INFORMED OF THE MOST LIKELY COMPLICATIONS, OF THE POSSIBLE UNDESIRED RESULTS OF CHIROPRACTIC EXAMINATION AND TREATMENT IN THS OFFICE AND I UNDERSTAND THEM. I HEREBY AUTHORIZE AND DIRECT DR. GARRETT BODE, D.C. OR ASSISTANTS TO PROVIDE SUCH ADDITIONAL SERVICES AS THEY MAY DEEM REASONABLE AND NECESSARY.

Patient's Signature _____ Date _____

Patient's Printed Name _____ Date _____

Parent's/Guardian's Signature _____ Date _____
If patient is less than 18 years of age.

Parent's/Guardian's Printed Name _____ Date _____

References

1. Troyanovich SJ, Harrison DE. Low Back pain and the lumbar intervertebral disc: Clinical considerations for the doctor of chiropractic. *J Manipulative Physiol Ther* 1999; 22 (2): 96-104.
2. Shekelle PG, Spine update: Spinal Manipulation, *Spine* 1994; 19; 858-86
3. Clayman CB. *The American Medical Association Home Encyclopedia*. New York: Random House: 947-948
4. Dabbs V, Lauretti WJ. Risk Assesment of Cervical Manipulation vs. NSAIDS for the treatment of neck pain. *J Manipulative Physiol Ther* 1995; 18:530-536.
5. Harwitz El, Aker PD, Adams AH, Meeker WC, Shekelle PG. Manipulation and mobilization of the cervical *Spine*: A systematic review of the literature, *Spine* 1996; 21: 1746-1760.

BODE CHIROPRACTIC
Accident & Wellness Center
13694 W. HILLSBOROUGH AVE.
TAMPA, FL 33635
PH: (813) 891-1600
FAX: (813) 891-1660

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED. REVIEW IT CAREFULLY.

At Bode Chiropractic we have always kept your health information secure and confidential. The Health Insurance Portability and Accountability Act that requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice. The law permits us to use or disclose your health information to those involved in your treatment. For example, reviews of your file by a specialist doctor whom we may involve in your care. We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company.

We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer. We may use your information to contact you. For example, we may send newsletters or other information. We may also want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the phone. In an emergency, we may disclose your health information to a family member or another person responsible for your care. We may release some or all of your health information when required by law. If this practice is sold, your information will become the property of the new owner.

Except as described above, this practice will not use or disclose your health information without your prior written authorization. You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.

You have the right to transfer copies of your health information to another practice. We will mail your files for you. You have a right to receive a copy of your health information, with a few exceptions. Please provide us with a written request regarding the information you want to have copied, however, we may charge you a reasonable fee for the copies.

You have the right to request and amend your health information. Please provide us with your request to make changes in writing. If you wish to include a statement in your file, please provide it to us in writing. We may or may not make the changes that you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will neither move nor alter earlier documents, but will add new information.

Y0U HAVE THE RIGHT TO RECEIVE A COPY OF THIS NOTICE AT ANYTIME UPON REQUEST

If we change any details of this notice we will notify you in writing.

You may file a complaint with the Department of Health and Human Services, 200 Independence Ave SW, Room 509F, Washington, DC 20201. Before filing a complaint however, please contact our Privacy Officer at 813-891-1600. This notice went into effect on October 1, 2007.

ACKNOWLEGEMENT: I have read, understand, and agree with the above Notice of Privacy Prac.

Signature_____

Date_____

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Assignment of Benefits Form

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completes to file for insurance carrier payments. I understand that I am responsible for turning over payments and EOBs from my insurance carrier for medical services rendered by this office within seven days of receipt or be subject to finance charges and the cost of the collection process.

Assignment of Benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Dr. Garrett Bode for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance. I furthermore understand that I am waving any anti-assignment clauses that are written in to my health care contract. I have requested that the office of Bode Chiropractic be my agent in the filing, processing and appealing of claims related specifically to medical treatment rendered by this office. I understand that I have chosen voluntarily to have the claims submitted by and paid directly to Bode Chiropractic with accompanying explanation of benefits.

Authorization to Release Information

I hereby authorize Bode Chiropractic to: (1) release any information necessary to insurance carrier regarding my illness and treatments (2) process insurance claims generated in the course of examination or treatment: and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from Dr. Garrett Bode on behalf of myself and/or my dependants and understand that by making this request, I become fully financially responsible for any and all charges incurred during the course of treatment.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full, immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

_____ _____

Patient/Responsible Party Print Name Date

_____

Patient/Responsible Party Signature

BODE CHIROPRACTIC

Accident & Wellness Center

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RECORDS REQUEST

PATIENT'S NAME:_____
DOB:_____
SS:
DATE OF RECORDS AND/OR MRI, CT'S ETC_____

I HEREBY REQUEST THAT YOU RELEASE MY MEDICAL RECORDS, MRI'S, CT'S TO THE ABOVE MENTIONED DR.

PATIENT'S SIGNATURE_____

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HOW DID YOU HEAR ABOUT OUR CLINIC:

PPO-HMO Provider book:_____

Sign/Location:_____

Friend/Relative/Co-worker:_____

Yellow Pages:_____

Attorney:_____

Another Doctor/or Clinic:_____

THANK YOU FOR CHOOSING ***BODE SPINAL CENTER*** FOR YOUR HEALTH CARE NEEDS.