

Chiropractic Registration & History

Welcome to our office! Please complete the following information and return your forms to the receptionist.
All information will remain confidential.

General Patient Information

Name _____ Date of birth _____ Sex M F
Address _____ City _____ State _____ Zip _____
*Social Security Number _____ Cell/HomePhone _____
Occupation _____ Employer _____
Job Requirements _____
Work Phone _____ Email _____
Marital Status S M D W Spouse's Name _____
Do you have children? Yes No Names & Ages _____
Emergency Contact Name & Phone _____
Whom may we thank for referring you to our office? _____

*Your Social Security number is used exclusively for billing purposes. Insurance companies require your number to quote policy benefits.

Chief Complaint

What is your major complaint? _____
How long have you had this condition? _____
Have you had this or similar conditions in the past? _____
What do you think caused this condition? _____
Have you seen a Chiropractor at any time in the past for this or any other condition? Yes No
If yes, please list name and location of your previous Chiropractor _____

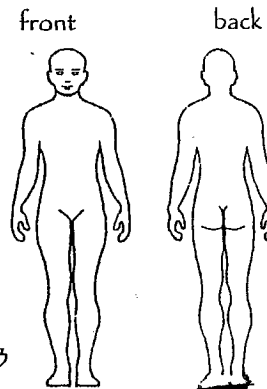
Other Doctors/Therapists who have treated this condition _____

Please mark the areas of your symptoms on the figures below. Use the following symbols:

XXXXX Aches

nnnnn Numbness

///// Pins & Needles



Fox Chiropractic, B.S., D.C. ♦ Dr. Tamara Fox
1224 East Concord Street ♦ Orlando, FL 32803
Phone: 407.228.1140 ♦ Fax: 407.228.1141

Reviewing Physicians Signature _____ Date _____

Patient Health History

Patient Name _____

Have you ever been in an auto accident or had any other personal injury? Yes No

If yes, please give dates and describe _____

Do you have a family physician? Name & Phone _____

Are you currently taking any medications? Yes No (If yes, please list below. Please include all over the counter medications and herbs.)

Medication Name	Dosage	Frequency	Condition	Prescribed by

Have you ever had surgery? Yes No (If yes, please list date and type of surgery)

Have you ever been hospitalized for any reason? Yes No (If yes, please list date and condition)

Do you have any allergies? Yes No If yes, please list: _____

Current Weight _____ Have you recently lost or gained weight? Yes No
If yes, how much? _____ Is there any chance that you are pregnant? Yes No

Mental Work	<input type="checkbox"/> Heavy	<input type="checkbox"/> Moderate	<input type="checkbox"/> Light	Hours per day _____
Physical Work	<input type="checkbox"/> Heavy	<input type="checkbox"/> Moderate	<input type="checkbox"/> Light	Hours per day _____
Exercise	<input type="checkbox"/> Heavy	<input type="checkbox"/> Moderate	<input type="checkbox"/> Light	Hours per week _____ Type _____
Smoking	<input type="checkbox"/> Current	<input type="checkbox"/> Previous	Amount _____	Number of years _____
Alcohol	Beers/week _____	Wine/week _____	Liquor/week _____	Number of years _____
Caffeine	Cups/day _____	Number of years _____		

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Please check only the symptoms you have now or have had in the past.

General Now Past

- Weakness
- Fatigue
- Fever
- Chills
- Night Sweats
- Fainting

Skin Now Past

- Color Changes
- Nail Changes
- Hair Changes
- Mole Changes
- Rashes
- Sores

Head Now Past

- Headaches
- Injuries
- Bumps
- Last eye exam _____
- Glasses
- Contacts
- Cataracts

Ears Now Past

- Hard of hearing
- Deafness
- Ringing
- Discharge
- Earache
- Itching
- Dizziness
- Room spins

Throat Now Past

- Soreness
- Bad Tonsils
- Hoarseness
- Pain
- Trouble _____
- Swallowing

Recurrent _____

- Infections

Neck Now Past

- Gland swelling
- Stiff neck
- Masses

Breasts Now Past

- Discharge
- Lumps
- Pain
- Bleeding
- Nipple changes
- Skin changes
- Bloating

Lungs Now Past

- Dry Cough
- Productive _____
- Cough
- Phlegm
- Short of breath
- Wheezing
- Pain
- Congestion
- Inhalant _____
- Exposure

Gastrointestinal Now Past

- Abdominal Pain
- Nausea
- Bloating
- Gas
- Heartburn
- Indigestion
- Irregular Bowels
- Constipation
- Diarrhea
- Hemorrhoids
- Poor appetite
- Food intolerance
- Discolored stools

Genitourinary Now Past

- Urgency
- Incontinence
- Straining
- Kidney pain
- Frequent voiding
- Stones
- Burning
- Bed wetting
- Discharge
- Impotence
- Dribbling
- Cloudy urine
- Painful intercourse
- Itching

Females Now Past

- Menstrual cramps
- Spotting
- Irregular periods
- Hot flashes
- Last pap smear _____
- Last mammogram _____

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<u>Nose</u>		
Bleeding	Now	Past
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain	<input type="checkbox"/>	<input type="checkbox"/>
Discharge	<input type="checkbox"/>	<input type="checkbox"/>
Obstruction	<input type="checkbox"/>	<input type="checkbox"/>
Post Nasal Drip	<input type="checkbox"/>	<input type="checkbox"/>
Runny nose	<input type="checkbox"/>	<input type="checkbox"/>
<u>Sinus</u>		
Congestion	<input type="checkbox"/>	<input type="checkbox"/>
<u>Mouth</u>		
Bleeding gums	Now	Past
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sores	<input type="checkbox"/>	<input type="checkbox"/>
Dental problems	<input type="checkbox"/>	<input type="checkbox"/>
Bad breath	<input type="checkbox"/>	<input type="checkbox"/>
Loss of taste	<input type="checkbox"/>	<input type="checkbox"/>
Dry mouth	<input type="checkbox"/>	<input type="checkbox"/>
Blisters	<input type="checkbox"/>	<input type="checkbox"/>
<u>Psychiatric</u>		
Depression	Now	Past
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bi-polar	<input type="checkbox"/>	<input type="checkbox"/>
Suicidal	<input type="checkbox"/>	<input type="checkbox"/>
Thoughts	<input type="checkbox"/>	<input type="checkbox"/>
Schizophrenia	<input type="checkbox"/>	<input type="checkbox"/>
Troubled sleep	<input type="checkbox"/>	<input type="checkbox"/>
Hallucinations	<input type="checkbox"/>	<input type="checkbox"/>
Irritability	<input type="checkbox"/>	<input type="checkbox"/>
Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>
Addiction	<input type="checkbox"/>	<input type="checkbox"/>
<u>Other</u>		
Diabetes	Now	Past
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
STD's	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Tumor	<input type="checkbox"/>	<input type="checkbox"/>
Blood disease	<input type="checkbox"/>	<input type="checkbox"/>

<u>Heart</u>		
Murmur	Now	Past
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Palpitations	<input type="checkbox"/>	<input type="checkbox"/>
Swollen	<input type="checkbox"/>	<input type="checkbox"/>
extremities	<input type="checkbox"/>	<input type="checkbox"/>
Cold extremities	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>
Varicose veins	<input type="checkbox"/>	<input type="checkbox"/>
Blood clots	<input type="checkbox"/>	<input type="checkbox"/>
Blue extremities	<input type="checkbox"/>	<input type="checkbox"/>
<u>Blood</u>		
Anemia	Now	Past
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Easy bruising	<input type="checkbox"/>	<input type="checkbox"/>
Easy bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Swollen nodes	<input type="checkbox"/>	<input type="checkbox"/>
Painful nodes	<input type="checkbox"/>	<input type="checkbox"/>
Blood transfusion	<input type="checkbox"/>	<input type="checkbox"/>
Blood type	_____	_____
<u>Immunizations</u>		
DPT	<input type="checkbox"/>	<input type="checkbox"/>
Mumps	<input type="checkbox"/>	<input type="checkbox"/>
Small pox	<input type="checkbox"/>	<input type="checkbox"/>
Tetanus	<input type="checkbox"/>	<input type="checkbox"/>
Measles	<input type="checkbox"/>	<input type="checkbox"/>
Rubella	<input type="checkbox"/>	<input type="checkbox"/>
Polio	<input type="checkbox"/>	<input type="checkbox"/>
Pneumococcal	<input type="checkbox"/>	<input type="checkbox"/>
<u>Other</u>		
Gout	Now	Past
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Gallstones	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Leukemia	<input type="checkbox"/>	<input type="checkbox"/>

<u>Endocrine</u>		
Weight loss	Now	Past
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weight gain	<input type="checkbox"/>	<input type="checkbox"/>
Underweight	<input type="checkbox"/>	<input type="checkbox"/>
Heat intolerance	<input type="checkbox"/>	<input type="checkbox"/>
Cold intolerance	<input type="checkbox"/>	<input type="checkbox"/>
<u>Neurological</u>		
Seizures	Now	Past
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vertigo	<input type="checkbox"/>	<input type="checkbox"/>
Hand trembling	<input type="checkbox"/>	<input type="checkbox"/>
Loss of sensation	<input type="checkbox"/>	<input type="checkbox"/>
Lack of coordination	<input type="checkbox"/>	<input type="checkbox"/>
Loss of facial muscles	<input type="checkbox"/>	<input type="checkbox"/>
Weak grip	<input type="checkbox"/>	<input type="checkbox"/>
Paralysis	<input type="checkbox"/>	<input type="checkbox"/>
Speech difficulty	<input type="checkbox"/>	<input type="checkbox"/>
Tingling	<input type="checkbox"/>	<input type="checkbox"/>
Memory loss	<input type="checkbox"/>	<input type="checkbox"/>
<u>Musculo-skeletal</u>		
Muscle pain	Now	Past
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle weakness	<input type="checkbox"/>	<input type="checkbox"/>
Muscle cramps	<input type="checkbox"/>	<input type="checkbox"/>
Joint stiffness	<input type="checkbox"/>	<input type="checkbox"/>
Joint pain	<input type="checkbox"/>	<input type="checkbox"/>
<u>Other</u>		
Liver Problems	Now	Past
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Angina	<input type="checkbox"/>	<input type="checkbox"/>
Jaundice	<input type="checkbox"/>	<input type="checkbox"/>
Parasites	<input type="checkbox"/>	<input type="checkbox"/>
Polio	<input type="checkbox"/>	<input type="checkbox"/>
Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>

I certify that the above information is correct to the best of my knowledge.

Patient Signature

Date

Witness

Date

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1224 East Concord Street ♦ Orlando, FL 32803
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Reviewing Physicians Signature

Date

Please list any diseases/conditions that run in your family _____

Please complete the following information regarding your family of origin:

Relative	Age if living	Age at death	Cause of death or	State of health	Illnesses
Father:					
Mother:					
Brother(s):					
Sister(s):					
Maternal Grandfather:					
Maternal Grandmother:					
Paternal Grandfather:					
Paternal Grandmother:					

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ASSIGNMENT OF BENEFITS

I, _____, assign all of the rights and benefits of any applicable personal injury protection, medical payments, or other coverage provided by any insurance policy issued pursuant to Florida Statutes §627.730 - §627.7405, to Fox Chiropractic Services, Inc., for services and supplies provided to me related to personal injuries I suffered in an automobile accident which occurred on or about _____.

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

This assignment includes, but is not limited to:

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

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

all rights to recover attorney fees, legal assistant fees, costs, and any interest on fees and costs, for any legal or other action taken by Fox Chiropractic Services, Inc. as my assignee.

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 Fox Chiropractic Services, Inc. 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 that I may have for personal injuries.

I have been given a copy of this assignment to retain for my records; 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, as authorized representative of Fox Chiropractic Services, Inc. accepts the assignment of benefits as set forth above.

Fox Chiropractic Services, Inc.

Date

Fox Chiropractic

Patient Consent for Treatment

Consent for Treatment:

I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of my physician. I also understand that all risks involved with treatment will be explained to me upon request.

Consent for Active Rehabilitation:

I voluntarily consent to participation in active rehabilitation at Fox Chiropractic. I understand that my participation in this program is voluntary and that I can stop the rehab program at any times. Since the process of strengthening and conditioning are a form of "controlled strain," there is a chance of aggravation to my injury that I observe during my rehabilitation process. I understand that all exercises and equipment will be fully explained to me before use.

I have read the above and understand the risks and benefits of the rehabilitation program. I agree to participate and have my rehabilitation information released to me doctor, insurance company, or attorney, if required.

Patient Signature

Printed Name

Date

Fox Chiropractic
Dr. Tamara Fox, B.S., D.C.
1224 E. Concord St., Orlando, FL 32803
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PART X HIPAA MEDICAL AUTHORIZATION

Applicant A

This is a HIPAA-compliant authorization.

"HIPAA" stands for The Health Insurance Portability and Accountability Act of 1996, as amended.

Agreement: I understand and agree that:

- a) If I do not sign this authorization, John Hancock may decline my application; decline to pay my claim for benefits; and decline to provide health information about me to my doctor(s) or the individual(s) / entity(ies) named below.
- b) My authorization may be revoked by sending a written request to John Hancock at the address shown on the application. However, I may not revoke an authorization that was obtained as a condition of obtaining insurance, or that was relied and acted upon.
- c) My health information may be re-disclosed and no longer protected by HIPAA if the person receiving this information is not required to comply with HIPAA. HIPAA only regulates certain types of entities, such as insurers and health care providers. However, John Hancock does require its agents and service providers to protect the confidentiality of health information.
- d) A copy of this authorization is as valid as the original.
- e) This authorization expires within 24 months from the date I sign it.

Authorization: I authorize:

- a) The use and disclosure of my medical records and medical history and other information that relates to: (a) the diagnosis of any physical or mental condition, and (b) the treatment or prognosis of any physical or mental condition, whether this information is in electronic or paper form. This includes, but is not limited to, information related to psychiatric or psychological conditions; prescription drugs; alcohol or drug abuse; and communicable or infectious conditions such as Human Immunodeficiency Virus (HIV); Acquired Immune Deficiency Syndrome (AIDS); or sexually transmitted diseases. However, I understand that the John Hancock may not furnish specific test results for exposure to the HIV infection to an insurer industry data bank such as the Medical Information Bureau, Inc. (MIB) if a review of the information would identify me and the specific test results.
- b) The following persons or entities are authorized to disclose health information about me: a doctor; medical practitioner; hospital; clinic; medical or medically-related facility; pharmacy or pharmacy benefit manager; or any insurance or reinsurance company (including John Hancock Life Insurance Company (John Hancock)); any consumer reporting agency such as the MIB; or any other organization, institution, or person having personal health information about me.
- c) The disclosure of my health information to John Hancock and its affiliates, service providers, reinsurers, agents and representatives, and to any consumer reporting agency.
- d) The use and disclosure of my health information in connection with this application, to determine the premium for my long term care insurance, to service my long term care insurance coverage, and to evaluate my claim for long term care insurance benefits. I understand that there may be additional uses or disclosures of my health information that are specifically permitted by law without my authorization. For example, John Hancock may be obligated to disclose health information to government, regulatory and law enforcement entities.
- e) The disclosure of my health information to my doctor(s) or other individual(s) as named below.

Doctor/Individual Name (First, M.I., Last)	Doctor/Individual Name (First, M.I., Last)
Address:	Address:
City State Zip	City State Zip
Tel. #:	Tel. #:

If this authorization is signed by a personal representative of the applicant, a description of the representative's authority to act on behalf of the applicant must be included:

X

Print Name of Applicant A

Signature of Applicant A

Date