HEARTLAND CHIROPRACTIC, PLLC
770 SCENIC HWY N. SUITE 7
BABSON PARK, FL 33827
PHONE: (863) 638-4000
FAX: (863) 884-1525

PATIENT INFORMATION

Name:	Date of Birth:	Date of Accident:	
Address:	City:	ST:	Zip:
Cell Phone:	Home Phone:	SSN:	
Email:			

Primary Doctor:	Phone:
Did you go to the hospital or urgent care? ☐ Yes ☐ No	If yes, which hospital/urgent care center?

INSURANCE INFORMATION

Do you have AUTO insurance? ☐ Yes ☐ No	If yes, which insurance company?
Policy Number:	Claim Number:
Policy Holder's Name:	Policy Holder Relationship to Patient:

Do you have HEALTH insurance? ☐ Yes ☐ No	If yes, which HEALTH insurance company?
Member ID:	Group Number:

General Information:

1. What is your occupation? ________________
2. How tall are you and how much do you weigh? ________________
3. What term(s) describes your discomfort best? ________________
____
4. How often do you feel this discomfort?
☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent
5. How has this complaint changed since the onset?
☐ Worsened ☐ Remained the same ☐ Improved
6. What activity is most significantly affected by this discomfort? ________________
____
7. What treatment, if any, have you received since the injury? ________________
____

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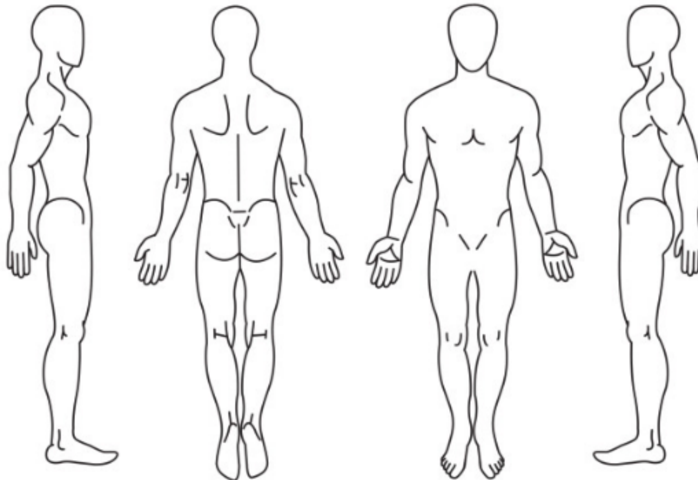
8. On the body diagrams below, please indicate your areas of symptoms marking the appropriate areas.



On a scale of 1 to 10, with 10 being the most severe, how do you rate your discomfort?

None ______________________________ *Unbearable*

0 1 2 3 4 5 6 7 8 9 10

Current Health:

1. Other than the information already provided, do you have additional health concerns involving any of the following:
   a. ☐ Muscles ☐ Bones ☐ Joints
   ☐ No ☐ Yes – Please explain: ____________________
   b. ☐ Nerves ☐ Headaches ☐ Dizziness ☐ Emotional
   ☐ No ☐ Yes – Please explain: ____________________
   c. ☐ Head ☐ Eyes ☐ Ears ☐ Nose ☐ Throat
   ☐ No ☐ Yes – Please explain: ____________________
   d. ☐ Heart ☐ Blood Pressure ☐ Circulation
   ☐ No ☐ Yes – Please explain: ____________________
   e. ☐ Shortness of Breath ☐ Coughing ☐ Asthma ☐ Lung Condition
   ☐ No ☐ Yes – Please explain: ____________________
   f. ☐ Stomach ☐ Bowels ☐ Digestive Conditions
   ☐ No ☐ Yes – Please explain: ____________________
   g. ☐ Genital ☐ Bladder ☐ Urinary Conditions
   ☐ No ☐ Yes – Please explain: ____________________
   h. ☐ Diabetes ☐ Thyroid ☐ Glandular Conditions
   ☐ No ☐ Yes – Please explain: ____________________
   i. ☐ Skin ☐ Bleeding Conditions
   ☐ No ☐ Yes – Please explain: ____________________
2. Do you have any medication allergies?
   ☐ No ☐ Yes – Please explain: ____________________

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Personal and Family History:

1. Have you had any surgical procedures?
   ☐ No ☐ Yes – Please explain: ______
2. Are there any past illnesses or conditions we should be aware of?
   ☐ No ☐ Yes – Please explain: ______
3. Do you have a past history of accidents or trauma?
   ☐ No ☐ Yes – Please explain: ______
4. Are there any past illnesses or conditions we should be aware of?
   ☐ No ☐ Yes – Please explain: ______
5. Are you presently taking any medication?
   ☐ No ☐ Yes – Please explain: ______
6. Do you have a past family illness history, such as diabetes, cancer, hypertension, and progressive neurological diseases that we should be aware of?
   ☐ No ☐ Yes – Please explain: ______
7. Current work habits: (Choose all that apply.)
   ☐ Permanently fully disabled
   ☐ Permanently partially disabled
   ☐ Part-time (1 to 20 hours per week)
   ☐ Full-time (21 to 40 or more hours per week)
   ☐ Cannot work due to current condition
   ☐ Retired Student Homemaker
   ☐ Unemployed
8. Personal social habits: (Choose all that apply.)
   ☐ Smoke or use tobacco products
   ☐ Drink alcohol
   ☐ Drink caffeine
   ☐ Use recreational drugs
   ☐ Other, to be discussed with doctor: ______
9. Present exercise habits: (Choose all that apply.)
   ☐ No current exercises
   ☐ Exercises daily
   ☐ Exercises 3+ times per week
   ☐ Cannot exercise due to current condition
10. Diet and nutrition habits: (Choose all that apply.)
    ☐ Vegan or vegetarian
    ☐ Daily supplements
    ☐ **Other:**______

REFERRAL SOURCE

How did you hear about us?

☐ Doctor: ______
(Name)

☐ Friend: ______
(Name)

☐ Attorney: ______
(Name)

☐ Other: ______
(Name)

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INFORMED CONSENT

I have been informed that it is not uncommon for patients to have increased discomfort after an adjustment. If that happens, I will rest and apply ice to the area. If I am concerned about this discomfort or develop any new symptoms, I can call the office for attention.

If I am out of town or unable to contact the provided phone number, I can present myself to the emergency room.

If any test were performed outside this office (laboratory or other diagnostic procedures), I understand that the doctor will notify me of the results at my next scheduled appointment or when the reports are made available.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various methods of physical therapy and cold laser therapy; and if necessary, diagnostic x-ray on me by the Doctor of Chiropractic in this office or anyone working in this clinic authorized by the doctor of chiropractic. (Note: Patients who receive cold laser therapy must wear a protective eyewear or may run the risk of eye damage. Pregnant patients are not to received cold laser therapy.)

I further understand and have been informed that, as in all health and chiropractic medicine, there are some very slight risks to treatment, including, but not limited to, muscle strains and sprains, disc injuries and strokes. I do not expect the doctor to be able to anticipate and explain all the risks and complications. I will rely on the doctor to exercise judgment during the course of the procedure, which the doctor feels is in my best interest at the time based on the known facts.

OUR OFFICE POLICY

We believe that a clear definition of our office policies will allow you, our Patient, and our office to concentrate on the main issue – *REGAINING AND MAINTAINING YOUR HEALTH*.

If you are unable to keep an appointment for any reason, it is required that you call this clinic as soon as you are aware of the conflict in order to re-schedule your visit. If you miss an appointment, it must be rescheduled within the week it is missed. This permits you to stay on the treatment plan that the doctor has prescribed for the best results possible. Staff in not authorized to change or alter you prescription; only the doctor can do so.

I have read the above Informed Consent, and by signing, agree to the aforementioned procedures. I intend for this Consent to cover the entire course of treatment for my present condition and for any future condition for which I seek treatment.

______________________________ ______________
Patient or Guardian Date

______________________________ ______________
Witness Date

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HIPAA COMPLIANCE PATIENT CONSENT FORM

Our Notice of Privacy Practice provides information about how we may use or disclose protected health information. The notice contains a patient's right section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of this notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) law allows for the use of the information for treatment, payment or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time, and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email or send you a text message to confirm appointments? ☐ Yes ☐ No

May we leave a message on your answering machine at home or your cell phone? ☐ Yes ☐ No

May we discuss your medical condition with other members of your family? ☐ Yes ☐ No

If yes, please list the approved family members:

____

____

Patient's Printed Name: ______________________________

Patient's Signature: ______________________________ Date: ____________________

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AUTHORIZATION TO RELEASE INFORMATION

Patient Name:	DOB:	Phone Number:
Address:		
City:	State:	Zip:

I understand that I may revoke this consent in writing at any time except to the extent that action has been already taken. Mental health, alcohol, drug, HIV and/or AIDS information is confidentially protected by Federal and State law, which prohibits disclosure without specific written authorization of the undersigned or as otherwise permitted by such regulations.

- ☐ Entire Records
- ☐ X-Rays
- ☐ MRI
- ☐ Specific Information:____

I authorize ______________________________ to release medical records to ___________________________________ for insurance-related reasons.

I authorize ______________________________ to release medical records to HEARTLAND CHIROPRACTIC, PLLC.

Patient Signature:	Date:
Witness Signature:	Date:

This authorization will expire one (1) year from the date signed.

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DISCLOSURE OF PHYSICIAN OWNERSHIP NOTICE TO PATIENTS

Please review the information contained in this notice carefully.

If you have any questions concerning this notice, please feel free to ask your physician or any representative of Heartland Chiropractic PLLC. By reading this Disclosure of Physician Ownership, you acknowledge that you have read and understand the foregoing notice and hereby understand that your physician has an ownership interest in Heartland Chiropractic, PLLC.

1. Carrie Anderson-Weeks, D.C., is the owner of Heartland Chiropractic PLLC, 770 Scenic Hwy N Suite 7, Babson Park, FL 33827.
2. You have the right to choose the provider of your health care services. Therefore, you have the option to use a health care facility other than Heartland Chiropractic PLLC.
3. You will not be treated differently by your physician if you choose to obtain healthcare services at a facility other than Heartland Chiropractic, PLLC.

Patient Name (*print*):	Patient Signature:	Date:

Youth Patient:

Youth Patient Name (*print*):	Date:
Name of Parent/Guardian (*print*):	Signature of Parent/Guardian:

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NOTICE OF PRIVACY POLICY ACKNOWLEDGEMENT

By signing this form, you acknowledge receipt of the Notice of Privacy Policy from Heartland Chiropractic, PLLC. The Notice of Privacy Policy provides information about how we may use and disclose your protected health information. We encourage you to review the document carefully. The Notice of Privacy Policy is subject to change. If the Notice is changed, you may obtain a revised copy by requesting one from our staff.

I acknowledge receipt of the Notice of Privacy Policy from Heartland Chiropractic, PLLC.

____
Printed Name of Patient or Guardian

____ ____________________
Signature of Patient or Guardian Date