Manatee Wellness & Chiropractic Centers

8788 East SR 70, Suite 101, Bradenton, FL 34202
Phone (941) 756-4362 Fax (941) 755-4652

Today's Date:_____

PATIENT INFORMATION:

Patient's Full Name:_____ Birthdate:_____ Age:____ Sex: M/F
Address:_____ City:_____ State:____ Zip Code:_____
Home Phone:_____ Cell Phone:_____ Social Security #:_____
Email:_____ Height:_____ Weight:_____
Emergency Contact:_____ Relationship:_____ Emergency Contact #:_____
How did you hear about us (Circle): Website Phone Book Google Maps Office Sign
Referring Friend:_____

EMPLOYMENT INFORMATION:

Employment Status (circle): Retired Employed PT Student FT Student Other_____
Employer:_____ Occupation:_____
Employer Address:_____ City:_____ State:____ Zip Code:_____
Work Phone:_____ Hours Worked Per Week:_____

SPOUSE INFORMATION:

Name:_____ Birthdate:_____ Age:_____
Employer:_____ Occupation:_____
Work Phone:_____ Cell Phone: _____

SOCIAL HISTORY:

Do You Smoke? Y/N # of Cigarettes/Day?____ Do You Drink Alcohol? Y/N # of Drinks/Day?_____
Do You Exercise: Y/N How Often?_____

HEALTH HISTORY:

Has any member of your immediate family had any of the following (X)?

Disease	Father	Mother	Brother	Sister	Grandmother	Grandfather
Alcoholism						
Diabetes						
Cancer (Name Type)						
Heart Disease						
High Blood Pressure						
Stroke						
Arthritis						
Depression						
Thyroid Disease						
Osteoporosis						

Do you have a history of the following (circle):

Arthritis	Y/N	Kidney Stones	Y/N	Frequent Urination	Y/N
High Blood Pressure	Y/N	Nausea	Y/N	Blurred Vision	Y/N
Poor Circulation	Y/N	Hernia	Y/N	Heart Burn	Y/N
Loss of Bladder Control	Y/N	Weight Loss/Gain	Y/N	Dizziness	Y/N
Shortness of Breath	Y/N	Osteoporosis	Y/N	Hearing Loss	Y/N
Difficulty Walking	Y/N	Headaches	Y/N	Ringing in Ears	Y/N
Insomnia	Y/N	Fatigue	Y/N	Diarrhea	Y/N

List any hospitalizations and dates:_____
List any injuries/accidents and dates:_____
List any major surgeries and dates:_____
Taking medications? Y/N If so, please list:_____
Taking over the counter medication? Y/N If so, please list:_____

Patient Health Questionnaire - PHQ

Patient Name _____ *Date* _____

1. Describe your symptoms _____

_____

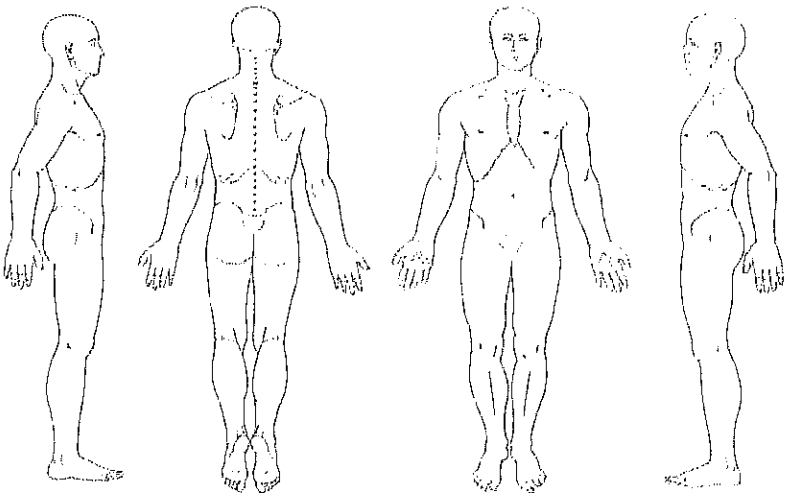
a. When did your symptoms start? _____

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* _____

Neck Index

Patient's Name:_____ Date:_____
Patient's Signature:_____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
③ The pain is fairly severe at the moment.
④ The pain is very severe at the moment.
⑤ The pain is the worst imaginable at the moment.

Sleeping

⓪ I have no trouble sleeping.
① My sleep is slightly disturbed (less than 1 hour sleepless).
② My sleep is mildly disturbed (1-2 hours sleepless).
③ My sleep is moderately disturbed (2-3 hours sleepless).
④ My sleep is greatly disturbed (3-5 hours sleepless).
⑤ My sleep is completely disturbed (5-7 hours sleepless).

Reading

⓪ I can read as much as I want with no neck pain.
① I can read as much as I want with slight neck pain.
② I can read as much as I want with moderate neck pain.
③ I cannot read as much as I want because of moderate neck pain.
④ I can hardly read at all because of severe neck pain.
⑤ I cannot read at all because of neck pain.

Concentration

⓪ I can concentrate fully when I want with no difficulty.
① I can concentrate fully when I want with slight difficulty.
② I have a fair degree of difficulty concentrating when I want.
③ I have a lot of difficulty concentrating when I want.
④ I have a great deal of difficulty concentrating when I want.
⑤ I cannot concentrate at all.

Work

⓪ I can do as much work as I want.
① I can only do my usual work but no more
② I can only do most of my usual work but no more.
③ I cannot do my usual work
④ I can hardly do any work at all
⑤ I cannot do any work at all

Personal Care

⓪ I can look after myself normally without causing extra pain.
① I can look after myself normally but it causes extra pain.
② It is painful to look after myself and I am slow and careful.
③ I need some help but I manage most of my personal care.
④ I need help every day in most aspects of self care.
⑤ I do not get dressed, I wash with difficulty and stay in bed.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
④ I can only lift very light weights.
⑤ I cannot lift or carry anything at all.

Driving

⓪ I can drive my car without any neck pain
① I can drive my car as long as I want with slight neck pain.
② I can drive my care as long as I want with moderate neck pain.
③ I cannot drive my car as long as I want because of moderate neck pain.
④ I can hardly drive at all because of severe neck pain.
⑤ I cannot drive my car at all because of neck pain.

Recreation

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

Headaches

⓪ I have no headaches at all.
① I have slight headaches which come infrequently.
② I have moderate headaches which come infrequently.
③ I have moderate headaches which come frequently.
④ I have severe headaches which come frequently
⑤ I have headaches almost all the time

Neck Index Score ____

Back Index

Patient's Name:_____ Date:_____
Patient's Signature:_____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain is very severe and does not vary much.

Sleeping

⓪ I get no pain in bed.
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

Sitting

⓪ I can sit in any chair as long as I like.
① I can only sit in my favorite chair as long as I like.
② Pain prevents me from sitting more than 1 hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

Standing

⓪ I can stand as long as I want without pain.
① I have some pain while standing but it does not increase with time.
② I cannot stand for longer than 1 hour without increasing pain.
③ I cannot stand for longer than 1/2 hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

Walking

⓪ I have no pain while walking.
① I have some pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

Personal Care

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing and dressing without help.
⑤ Because of the pain I am unable to do any washing and dressing without help.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

Traveling

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

Social Life

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
③ Pain has restricted my social life and I do not go out very often.
④ Pain has restricted my social life to my home.
⑤ I have hardly any social life because of the pain.

Changing degree of pain

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow
③ My pain is neither getting better or worse.
④ My pain is gradually worsening
⑤ My pain is rapidly worsening.

Back Index Score ☐

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INFORMED CONSENT

I, _____, hereby request and consent to the performance of procedures, which may include, but is not limited to, spinal and extremity manipulation, massage, electrical muscular stimulation, ultrasound, and/or therapeutic modalities by either Dr. Amanda Mitchell D.C., Dr. Justin Mitchell D.C., and/or other licensed therapists who, now or in the future, treat me while employed by or associated with Manatee Wellness & Chiropractic Centers. I have had an opportunity to discuss with the doctor and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and/or other procedures.

I understand and am informed that in the practice of chiropractic there are some risks to treatments including, but not limited to, fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I have read or have had read to me, the above consent. I have also had the opportunity to ask questions about its content, and by signing below I agree to the above-named procedure. 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.

Patient Name:_____ Date:_____

Signature of Patient:_____

Signature of Representative (if minor):_____

Relationship to Patient:_____

Manatee Wellness & Chiropractic Centers

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ASSIGNMENT OF BENEFITS

I, _____, hereby authorize _____
(name of insured) (name of insurance company)
to pay to and mail directly to Manatee Wellness & Chiropractic Centers the medical benefits otherwise payable to me for their services, but not to exceed the charges of those services. 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. I hereby irrevocably assign to Manatee Wellness & Chiropractic Centers the benefits under any policy of insurance, indemnity agreement, or any other collateral source as defined in Florida Statutes for any services and charges provided by Manatee Wellness & Chiropractic Centers.

Patient Name:_____ Date:_____

Signature of Patient:_____

Signature of Representative (if minor):_____

Relationship to Patient:_____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, acknowledge that I was provided a copy of Manatee Wellness & Chiropractic Centers Notice of Privacy Practices, for which I have read, understood, and agree to the terms of the Privacy Practices.

Patient Name:_____ Date:_____

Signature of Patient:_____

Signature of Representative (if minor):_____

Relationship to Patient:_____

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AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name:
Social Security Number:
Birthdate:

I hereby authorize the Person/Organization providing the information to release medical information about me to Manatee Wellness & Chiropractic Centers.

Dates Of Service Needed: From:_____ To: _____

Person/Organization Providing The Information	**Person/Organization Receiving The Information**
Name:	**Name:** Manatee Wellness & Chiropractic Centers
Address:	**Address:** 8788 East State Road 70, Suite 101 Bradenton, FL 34202-3705
Phone:	**Phone:** 941-756-4362
Fax:	**Fax:** 941-755-4652

Specific Description of Information Needed:

___X-Ray Reports ___MRI Reports ___CT Reports
___EMG Reports ___Progress Notes ___All Records

- I am aware that such records may contain information related to mental health, substance abuse (both alcohol and drug), and sexually transmissible diseases (including test results related to HIV/AIDS), and I specifically authorize the release of such information pursuant to this authorization.
- I understand that I may revoke the authorization at any time in writing. I further understand that any such revocation will not apply to any information already released under this Authorization. I understand that I am under no obligation to sign this Authorization, and that my ability to obtain treatment from Manatee Wellness & Chiropractic Centers will not depend in any way on whether I sign this authorization.
- I understand that I have a right to request a copy of this Authorization.

By signing below, I authorize the release of my medical information as described above.

Patient Signature:_____ Date:_____

Representative Signature (if minor):_____ Date:_____

Relationship to Patient:_____