TENPENNY
Chiropractic Associates
Wellness awaits you...

100 Burnsed Place Suite# 1020
Oviedo, Florida 32765
(407)-971-3898

WELCOME BACK! CONFIDENTIAL EXISTING PATIENT HEALTH HISTORY

Personal Information: *please fill in below if any of your existing information has changed*

Last Name: _____ First Name: _____ Middle Initial: _____

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

Home Phone:_____ Cell Phone:_____ Work Phone:_____

E-Mail Address: _____ Social Security #: _____

Date of Birth:_____ Age:_____ Sex: Male / Female Marital Status: Married / Single / DIV / WID

Employer: _____ Employer Address: _____

Employed: Full Time / Part Time / Retired Student: Full Time / Part Time / Not Applicable

Spouse Name:_____ Spouse Date of Birth: _____

Spouses Employer:_____ Referred By: _____

Insurance Information: *please fill in below if any of your existing information has changed*

Type of Insurance: □ Private Ins. □ Medicare □ Auto Ins. □ Worker's Comp
□Other_____
Primary Insurance Carrier:_____
Phone:_____

Policy#_____

Group #_____

Claim#_____

Name of Policy Holder:_____

Relationship to Patient:_____

Policy Holder's Birthdate :_____/_____/_____ Policy Holder's SSN: _____/____/_____
Employer:_____

Is patient covered by another insurance? □ Yes □ No

Secondary Insurance Carrier:_____Policy #:_____

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand if I suspend or terminate my care/treatment, any fees or professional services rendered to me will be immediately due and payable.

Patient, Patient, or Legal Guardian Signature: _____ Date: _____

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Reason For Visit:

Is this a complaint you have been treated for here before? □Yes □No

Primary/Main Complaint:_____ What caused this complaint?_____
Is this related to an automobile accident or work injury? □Yes □No If yes, date of accident: ___/___/___

When did this complaint begin (most recent flare up)**?** ___/___/___ **Is it getting worse?** □Yes □No

My Complaint is: □Constant □Comes and goes **My complain is worse:** □ End of day □ Beginning of day

Have you had this or similar complaint in the past? □ Yes □ No If "Yes", when?_____

What does your complaint (s) feel like? **Circle all** that apply*: Sharp/ Dull/ Sore / Stiff / Tight / Aching / Spasms / Throbbing / Stabbing / Shooting / Burning / Cramping / Nagging / Tingling / Numbness / Other*_____

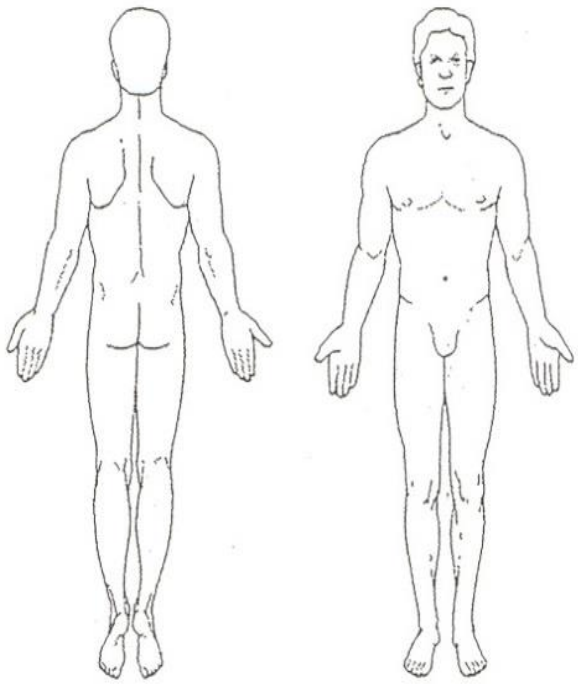
On the scale below, please circle the severity of your main complaint right now:

No Pain (0)				*Moderate Pain (5)*					*Worst Possible Pain (10)*
0	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*

Have you seen anyone else for this complaint since your last visit? □ Yes □ No If "Yes", who & describe treatment?

_____

Please mark with an "X" on the diagram to the right the location where you are experiencing pain or other symptoms.



Does your pain radiate/travel?

□ Yes □ No If "Yes", please describe _____

_____

What aggravates your symptoms? _____

_____

What relieves your symptoms? _____

_____

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How often do you experience these symptoms

throughout the day? □100% □75% □50% □25% □10% □Only with activity _____

What activity makes your complaint worse? *Sitting/Standing/Walking/Sleeping/Exercising/Lifting/Bending*

Medical History:

Please check **ALL** of the health conditions below that apply to **you** currently or in the past.				**Family History** Mark **ALL** conditions that run in your family		Relationship: (Father,Mother,Sister,Brother)
□	Osteoarthritis/Degenerative Joint Disease	□	Whiplash Injury *Date of injury:*	□	Cancer *Type:*	
□	Asthma	□	Headaches	□	Anemia	
□	Diabetes □ Type I □ Type II	□	Kidney Infection or Kidney Stones	□	Diabetes (check one) □Type I □ Type II	
□	Anemia	□	Migraines	□	Heart Problems / Stroke	
□	Cancer/Tumor Type: _____	□	Osteoporosis /Osteopenia	□	High Blood Pressure	
□	Rheumatoid Arthritis	□	Epilepsy / Seizures	□	Genetic Disorders	
□	Depression/ Anxiety	□	Fibromyalgia / Chronic Fatigue	□	Rheumatoid Arthritis	
□	Disc Herniation Location: _____	□	Genetic Disorders	□	Other (List):	
□	High Blood Pressure /Hypertension	□	Pacemaker/Defibrillator/Electric Device			
□	Heart Disease / Stroke		Please list any other medical conditions: _____			

RECENT FRACTURES (Broken Bones, Sprains, Strains, Major Trauma/Injury (List and Date:)

_____

_____

RECENT SURGERIES and/or HOSPITALIZATIONS (List and Date):

_____

_____

Have you had any recent X-ray or CT scan or MRI? □ Yes □ No If "yes", please describe (list body region & date)? _____

FEMALES: Is there a chance that you are pregnant? □ Yes □ No

List current prescription medications, including frequency and dosage if known.

If there are NO current medications, check here □

Name of prescription medication	*Dosage*	4.	*Dosage*
1.		5.	
2.		6.	
3.		7.	

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Social History:

Do you exercise? □ Yes □No How often? _____

Do you smoke? □ Yes □ No If yes, how many packs per day?_____ How long? _____
Do you drink alcohol? □ Yes □ No How often? _____

Do you drink coffee? □Yes □No If yes, how many cups per day? _____

Do you drink soda? □Yes □No If yes, how many per 12 oz. servings per day? _____
Do you drink water? □Yes □No If yes, how much per day?_____

Do you eat vegetables and fruits? □Yes □No

Do you take any supplements (i.e. vitamins, minerals, herbs)? □Yes □No If yes, list the supplements you are taking: _____

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Informed Consent to Treatment:

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy, and if necessary, diagnostic x-rays on me (or the patient, for whom I am legally responsible for) by the chiropractic physician and/or anyone working in this office authorized by the chiropractic physician.

I further understand that such chiropractic services may be performed by Tenpenny Chiropractic Associates Clinic and/or other licensed Physicians of Chiropractic who may treat me now or in the future at this office. I have had an opportunity to discuss with the physician or other office personnel the nature and purpose of the chiropractic adjustment and other procedures.

I understand and am informed that, as in the practice of medicine and all healthcare, the practice of chiropractic carries some risks to treatment; including, but not limited to: fractures, disc injuries, strokes (CVA), dislocation, and sprains. Further, I wish to rely on the physician to exercise judgement during the course of the procedure which the physician feels are in my best interests at the time, based upon the facts that are known.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommended by my physician. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment.

_____

Print Patient's Name/Parent or Legal Guardian

_____

Signature of Patient/Parent or Legal Guardian

___/____/____

Date of Signature

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ATTENTION MEDICARE PATIENTS ONLY:

Medicare covers spinal manipulation only. Examinations and therapeutic modalities such as electrical muscle stimulation, intersegmental traction, and ultrasound are **non-covered charges**. If the doctor feels that one of these are necessary for treatment these are an "out of pocket expense" and are the responsibility of the patient. Please discuss this with the doctor prior to treatment if you have any further questions.

I understand that I am responsible for any examinations or fees not covered by Medicare.

_____ ___/____/____

Patient Signature Date

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Discounted Massage Therapy:

Cigna, Blue Cross Blue Shield, Aetna, Wellcare, and AVMed which is part of the American Specialty Network offers a 25% discount on massage therapy. You would be responsible for $27.50 for a half hour and $55 for a one hour massage. This service is not billed to the insurance company. Just show your insurance card and you will receive the discount. If you would like to know if your insurance company offers this program or are interested in obtaining more information please notify the front test.

X_____

Yes, I am interested in massage therapy.

X_____

No, I am not interested in massage therapy.