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#/Member ID#_____

Group #_____

Claim# **(AUTO OR WORK COMP ONLY)**_____

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 or Legal Guardian Signature: _____ Date: _____

FOR OFFICE USE ONLY: HT_____ WT_____ BP ____/____ PULSE _____ TEMPERATURE _____

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Reason For Visit:

Primary/Main Complaint: _____

What caused this complaint? _____

*Is this related to a **recent automobile accident or work injury**? □Yes □No*

If yes, date of accident: ___/___/___ - (PLEASE INFORM THE FRONT DESK STAFF IF YOU HAVE NOT ALREADY)

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:

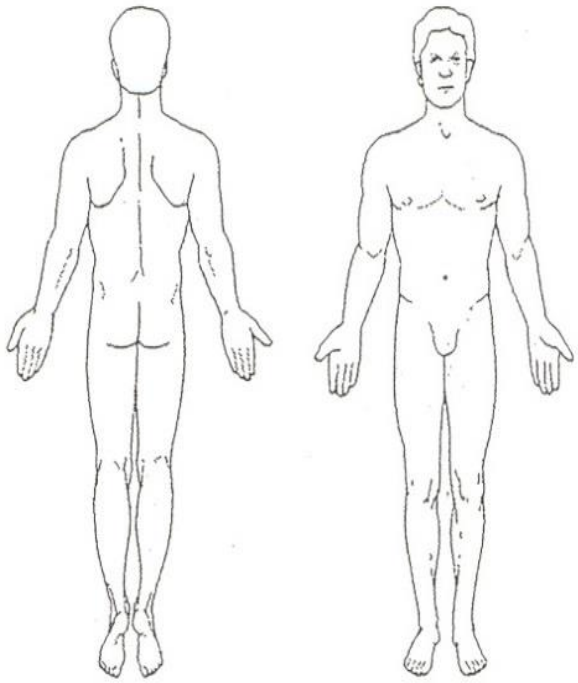
No Pain (0)				*Moderate Pain (5)*					*Worst Possible Pain (10)*	
0	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*

Have you seen anyone else for this complaint? □ Yes □ No If "Yes", who? _____

Have you ever been under chiropractic care? □ Yes □ No If "Yes", please describe _____

□ Primary Care Physician □ Orthopedic Specialist □ Neurologist □ Other: _____

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: _____			

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

_____

_____

SURGERIES and/or HOSPITALIZATIONS (List and Date):

_____

HAVE YOU HAD A HISTORY OF SPINAL SURGERY? □ Yes □ No **IF YES PLEASE LIST BELOW**

_____

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

Please list which facility you had these images completed at: _____

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FEMALES ONLY: Is there any chance that you are pregnant?

□ Yes □ No If yes, how many weeks? _____

Pregnancy due date: __/__/_____

FEMALES ONLY : FUTURE ACKNOWLEDGEMENT -

I understand that in the future if I do become pregnant I will inform the front desk staff or the treating physician PRIOR to treatment. * Patient Signature: _____ Date: _____

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

If there are NO current medications, check here □

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

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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AUTHORIZATON TO RELEASE MEDICAL RECORD INFORMATION

Tenpenny Chiropractic associates is authorized to release any medical records pertinent to the health care of the above named patient, but not inclusive of, any insurance carrier, adjuster, attorney, care provider, or immediate family member, upon receipt of the signature of myself or the signature of the patient's legal guardian. This authorization is given with full knowledge that such disclosure may contain information of a confidential nature and may result in denial of insurance coverage (in the event that claims are submitted to an insurance company on your behalf) for services rendered by Tenpenny Chiropractic Associates.

FINANCIAL RESPONSIBILITY AND POLICY

As a courtesy to you, Tenpenny Chiropractic Associates will attempt to pre-verify your insurance coverage for your Chiropractic Care. Coverage information is obtained from your insurance company using the information provided by you prior to your initial visit. We emphasize that your insurance policy is a relationship between you and your insurance carrier. Please be advised that the information provided by your insurance company is not a guarantee of payment, only an estimate of what might be covered under your policy at the time of inquiry.

By signing below you confirm you understand that:

- It is your responsibility to inform us of any changes to your insurance policy so that coverage can be re-verified prior to treatment.
- Not all services are a covered benefit with all insurance plans.
- It is your responsibility to be aware of what services are being provided to you and if it is a covered benefit under your insurance.
- You are responsible for any non-covered charges not payable by your insurance policy.
- We will send required claim forms and documentation to ensure your claims are processed in a timely manner.
- Final determination of benefits available is determined when the claim is sent to your insurance company and receive and explanation of benefits.
- After all co-pays, contracted plan reductions, and insurance payment credits are applied to your account, any remaining portion will be your responsibility.

By signing below, you have read and understand the above financial policy and agree to meet financial obligations.

Patient Printed Name: _____

Patient Signature: _____ Date: _____