CONNECT FAMILY CHIROPRACTIC INTAKE FORM

Today's Date: _____ HR#: _____

PATIENT DEMOGRAPHICS

Name: _____ DOB: _____-_____-_____ Age: _____ ☐ Male ☐Female

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

Home Phone: _____ Mobile Phone: _____ E-mail Address: _____

Employer: _____ Occupation: _____

Social Security #: _____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Spouse's Name _____

Number of children and ages: _____

Name & Number of Emergency Contact: _____Relationship: _____

Who may we thank for referring you? _____

HISTORY OF COMPLAINT

Health Concerns (List according to severity)	Rate of Severity (0= no pain, 10=unbearable)	When did this problem begin?	Have you had the problem before? When?	Are symptoms constant (C) or intermittent (I)?
1. _____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____

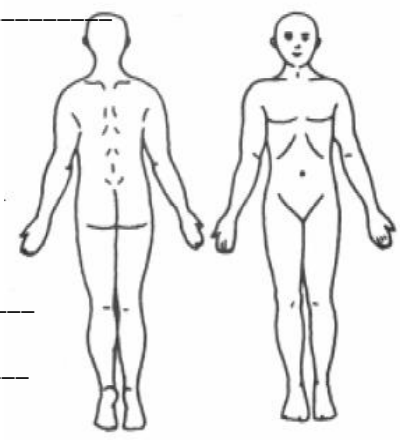
Have you seen other doctors for these conditions? YES / NO

Chiropractor? _____ Medical Doctor? _____ Other _____

Results of treatment? _____

PLEASE MARK the areas on the body diagram with the following **letters** to describe your symptoms:

R = Radiating **B = B**urning **D = D**ull **A =** Aching **N = N**umbness **S = S**harp/**S**tabbing **T = T**ingling



What relieves your symptoms? _____

What makes your symptoms feel worse? _____

Is your problem the result of ANY type of accident? □ Yes □ No If Yes explain:_____

Identify any other injury(s) to your spine, minor or major, that the doctor should know about:

_____

_____

PAST HISTORY

If you have ever been diagnosed with any of the following conditions, please indicate with:

P for in the ***Past*** **C** for ***Currently*** have

___ Broken Bone ___ Dislocations ___ Tumors ___ Rheumatoid Arthritis ___ Fracture ___ Disability ___ Cancer

___ Heart Attack ___ Osteo Arthritis ___ Diabetes ___ Cerebral Vascular

___ Other serious conditions: _____ **If nothing applies here then please write N/A**: _____

PLEASE IDENTIFY ALL PAST and any **CURRENT** conditions you feel may be contributing to your present problem:

Injuries/Type of Treatment/How long ago?_____

Surgeries/Type of Treatment/How long ago? _____

Childhood Diseases/Traumas? _____

Adult Diseases/ Traumas? _____

List Prescription drugs & Supplements you take. If none, please write N/A

_____

_____

FAMILY HISTORY

1. Does anyone in your family suffer with the same condition(s)? □ No □ Yes **If yes,** whom?

□ grandmother □ grandfather □ mother □ father □ sister(s) □ brother(s) □ son(s) □ daughter(s)

2. Any other hereditary conditions the doctor should be aware of? □ No □ Yes:

_____

SOCIAL HISTORY

1. Smoking: □ cigars □ pipe □ cigarettes **How often?**	□ Daily	□ Weekends	□ Occasionally	□ Never
2. Alcoholic Beverage: consumption occurs	□ Daily	□ Weekends	□ Occasionally	□ Never
3. Recreational Drug use:	□ Daily	□ Weekends	□ Occasionally	□ Never
4.Exercise: □ Light □ Moderate □ Heavy	□ Daily	□ Weekends	□ Occasionally	□ Never

ACTIVITIES OF DAILY LIVING

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

ACTIVITIES:	**EFFECT:**			
Carry Children/Groceries	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Lift Children/Groceries	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Climb Stairs	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Walking	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Extended Computer Use	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Sit to Stand	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Read/Concentrate	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Getting Dressed	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Shaving	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Sexual Activities	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Sleep	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Static Sitting	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Static Standing	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Yard work	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Pet Care	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Bathing	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Sweeping/Vacuuming	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Dishes	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Laundry	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Garbage	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Driving	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Other: _____	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform

List your two main health goals that you would like to achieve while under care at this office:

1. _____

2. _____

_____ _____ - _____ - _____

Patient or Authorized Person's Signature **Date Completed**

_____ _____ - _____ - _____

Doctor's Signature **Date Form Review**

REVIEW OF SYSTEMS

Please mark: P for in the Past C for Currently have N for Never

___ Headaches
___ Migraines
___ Jaw/TMJ Pain
___ Neck Pain
___ Shoulder Pain
___ Arm Pain
___ Upper Back Pain
___ Mid Back Pain
___ Lower Back Pain
___ Hip/Leg Pain
___ Knee Pain
___ Foot Pain
___ Ear Infections
___ Hearing Loss
___ Ringing in the Ears
___ Dizziness

___ Loss of Energy
___ Nervousness
___ Double/Blurry Vision
___ Anxiety
___ ADD/ADHD
___ Loss of Balance
___ Depression
___ Allergies
___ Sinus Issues
___ Frequent Colds
___ Thyroid Issues
___ Asthma
___ Chest Pain
___ Heart Problems
___ Nausea
___ Ulcers

___ Digestive Issues
___ Diarrhea
___ Constipation
___ Bed Wetting
___ Kidney Problems
___ Bladder Problems
___ Menstrual Problems
___ Prostate Problems
___ Infertility
___ Fibromyalgia
___ Epilepsy/Convulsions
___ Tremors
___ Disc Problems
___ Muscle Spasms
___ Poor Posture
___ Skin Problems

___ Sexual Dysfunction
___ Sleep Problems
___ Tight/Sore Muscles
___ Sports Injury
___ Sciatica
___ Scoliosis
___ Arthritis/Joint Pain
___ GERD/Gastric Reflux
___ Numbness/Tingling in Arms/Hands
___ Numbness/Tingling in Legs/Feet
___ Stomach Problems
___ High/Low Blood Pressure
___ Difficulty Breathing

_____ _____ - _____ - _____
Patient or Authorized Person's Signature **Date Completed**

_____ _____ - _____ - _____
Doctor's Signature **Date Form Review**

INFORMED CONSENT: Chiropractic Adjustments, Modalities, and Therapeutic Procedures

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risks are most often minimal, complications such sprains/strains injuries, irritation of a disc condition, dislocations of joints, and although very rare, fractures, and possible stroke (estimated to be related in one in one million to one in two million cervical adjustments), have been associated with chiropractic adjustments.
Treatment objectives, as well as the risks associated with chiropractic adjustments and all other procedures provided at Connect Family Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____ _____ ____/____/____
Patient Name (print) **Patient Signature** **Date**

_____ _____ ____/____/____
Parent/Authorized Person Name (print) **Parent/Authorized Person Signature** **Date**

_____ _____ ____/____/____
Witness Name (print) **Witness Signature** **Date**

If not signed by the patient, please indicate relationship: _____

Connect Family Chiropractic **Dr. Allan Venegas, DC**
3677 W. Waters Ave, Tampa, FL 813-252-1225
Cfctampa.com info@cfctampa.com

NOTICE OF PRIVACY PRACTICE AGREEMENT

This office is required, by law, to maintain the privacy and security of your Protected Health Information. We must provide you with written notice concerning your rights to your health information, and the potential circumstances under which, by law, or as dictated by our office policy, we are permitted to use and disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. Please review carefully, sign receipt of acknowledgement, and return to our front desk staff. Keep this page for your records.

PERMITTED DISCLOSURES:

1. Treatment purposes: discussion with other healthcare providers in your care.
2. Inadvertent disclosure: open treating area means open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes: to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes: to process a claim or aid in investigation.
5. Emergency: in the event of a medical emergency, we may notify a family member.
6. For public health and safety: in order to prevent or lessen a serious or imminent threat to the health or safety of a person.
7. To Government agencies or Law Enforcement: to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefit purposes.
9. Deceased persons: discussion with coroner and medical examiners in the event of a patient's death.
10. Telephone calls or email and appointment reminders: we may call your home and leave messages regarding a missed appointment or apprize you of changes in practice hours or upcoming events.
11. Change of ownership: in the event this practice is sold, the new owners would have access to your Personal Health Information.

YOUR RIGHTS:

1. To receive an accounting of disclosures.
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice.
3. To request mailings to an address different from residence.
4. To request restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance.
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain one copy of your records at no charge, when timely notice is provided (72 hours). X-rays are original records, and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call Dr. Allan Venegas. If the doctor is unavailable, you may make an appointment with our receptionist to see a doctor within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights, 200 Independence Ave. SW, Room 509F HHH Building, Washington DC 20201

Effective Date:_____

NOTICE REGARDING YOUR RIGHT TO PRIVACY continued …

Please complete the following where indicated and return to our front desk staff.

Patient initials: _____ - acknowledgement of privacy rights

I hereby acknowledge I have read and received a copy of Connect Family Chiropractic Privacy Practices Notice.

I understand my rights as well as the practice's duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Notice of Privacy Practices" at any time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware the practice will not use or share my information other than as described here unless I have provided written authorization stating otherwise. I understand I may change my mind at any time by providing written notification to the practice.

I am aware an extended detailed version of this "Notice" is available to me upon request.

At this time, I do not have any questions regarding my rights or any of the information I have received.

Print Name : _____ **Date:** _____

Signature : _____ **DOB:** _____

Witness _____ **Date** _____

If not signed by the patient, please indicate relationship:_____

We love to have pictures in our office!

If you would allow us to have your picture in the office, please sign below

For valuable consideration, I hereby irrevocably consent to and authorize the use and reproduction by Connect Family Chiropractic, or anyone authorized by Connect Family Chiropractic, of any and all photographs/videos which were taken of myself and/or my child, for the purposes of promotional TV, website, social media, and/or print ad whatsoever, without further compensation to me. All negatives and positives, together with the prints, shall constitute the property of Connect Family Chiropractic, solely and completely. Any information voluntarily provided by a patient shall also be used in conjunction with the above listed information for purposes previously mentioned. Confidentiality, in regard to any reported conditions, is also waived to the extent of information pertinent to the promotion material only. I authorize Connect Family Chiropractic to share this information via their website and their social media platforms including but not limited to Facebook and Instagram, and for use in the office. All other unrelated patient information shall remain private and protected (according to Health Information and Privacy Act laws).

Signature: _____ Date: _____

POLICIES AND FEES SCHEDULE

Consultation- includes practice member history (this service is complimentary)
Assessment (new or established practice member)- includes one or more of the following: thermography, Surface Electromyography, range of motion, posture assessment, motion/ static palpation, Ortho/ Neuro testing leg check ($60-$120)
Chiropractic Adjustment- The actual re-alignment of the vertebra done by hand or instrument. Often a sound will be heard, but if there is no auditory result, it does not mean that the adjustment has not taken place ($35-$70)
X-Rays- Specific X-ray views taken of your spine to determine a misalignment/subluxation of your vertebrae. These can also be used to indicate progress after period of care. Cost is subject to insurance rate, otherwise $30 per view (per cervical, thoracic, lumbar).

Release of Authorization/Assignment of Benefits: I authorize and request payment of insurance benefits directly to Allan Venegas, DC. I agree that this authorization will cover all services rendered until I revoke the authorization. I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the patient. It is customary to pay for services when rendered unless other arrangements have been made in advance.
I understand that I am financially responsible for charges not covered by insurance.

Signature_____Date_____

X-RAYS AUTHORIZATION

As your healthcare provider, we are legally responsible for your chiropractic records. We must maintain a record of your x-rays in our files. At your request, we will provide you with a copy of your X-ray in our files. **The fee for copying your X-rays on a disc is $15.00. This fee must be paid in advance.** Digital X-rays on CD will be available within 72 hours of prepayment on any regular practice hours day.
Please note: X-rays are utilized in this office to help locate and analyze **vertebral subluxations.** These X-rays are not used to investigate for medical pathology. The doctors of Connect Family Chiropractic do not diagnose or treat medical conditions; however, if any abnormalities are found, we will bring it to your attention so that you can seek proper medical advice.

By my signature below, I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration, I therefore do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

By signing below, you are agreeing to the above terms and conditions

_____	_____	____/____/____
Patient Name (print)	**Patient Signature**	**Date**
_____	_____	____/____/____
Parent/Authorized Person Name (print)	**Parent/Authorized Person Signature**	**Date**

FEMALES ONLY: To the best of my knowledge, I believe I am not pregnant at the time X-rays are taken at Connect Family Chiropractic.
Signature_____ Date_____

For Office Use Only

☐ Lat Cervical Cm:_____	☐Flex/Ext Cm:_____	☐APOM Cm:_____	☐Lower Cervical Cm:_____	☐Lateral Thoracic Cm:_____	☐A-P Thoracic Cm:_____
☐ Lateral Lumbar Cm:_____	☐A-P Lumbar Cm:_____	☐ Other: Cm:_____			

HIPAA Personal Health Information Release

I, _____, hereby authorize Connect Family Chiropractic to discuss with and/or release information to the following people concerning my appointments, insurance, billing, and health treatment rendered.

- ☐ Spouse Name: _____
- ☐ Significant Other Name: _____
- ☐ Parent/Legal Guardian Name: _____
- ☐ Child(ren) Name(s): _____
- ☐ Any Specified Person Name: _____
- ☐ Information is not to be discussed with or released to anyone.

Restrictions:

- ☐ No Restrictions
- ☐ Only discuss my appointment time with the above-named individual(s).
- ☐ Only discuss issues concerning my account, including insurance and/or billing with the above-named individual(s).
- ☐ Only discuss the health treatment rendered to me with the above-named individual(s).

Messages:

Please call ☐ my home ☐ my work ☐ my cell phone

Phone Number: _____ - _____ - _____

If unable to reach me:

- ☐ you may leave a detailed message
- ☐ please leave a message asking me to return your call
- ☐ _____

I understand I may terminate this consent at any time by giving written notice to Connect Family Chiropractic. Any changes to this form will require a new consent form to be completed, signed, and dated.

Signature: _____ Date: _____