ACTIVE FAMILY CHIROPRACTIC, P.A.

Application for Care

Dr. Jenny Mejia Spicer, Chiropractic Physician
11232 W Hillsborough Ave.
Tampa, FL 33635

Today's Date: _____

PATIENT DEMOGRAPHICS

Name: _____ Birth Date: _____ Age: _____ Sex: M/F

Address: _____

City: _____ State: _____ Zip: _____

E-mail Address: _____ Social Security #: _____

Mobile Phone: _____ Alternate Phone: _____

Do you have Insurance? Yes/ No If Yes, Name of Insurance Company _____

Employer: _____ Occupation: _____

Marital Status: Single/ Married

Spouse's Name _____ Spouse's Employer_____

Number of Children and Ages: _____

Name & Number of Emergency Contact: _____Relationship: _____

HISTORY OF COMPLAINT

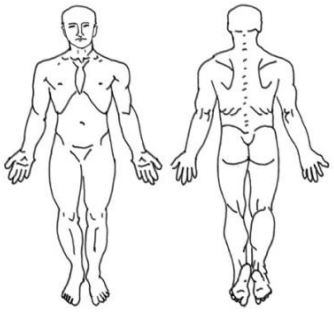
Please identify the condition(s) that brought you to this office and on a scale of 1 to 10 with 10 being the worst pain and one being no pain, rate your above complaints by circling the number:

Primary or chief complaint is_____:0-1-2-3- 4-5-6-7-8-9-10

Second complaint is _____:0-1-2-3- 4-5-6-7-8-9-10

Third complaint is _____:0-1-2-3- 4-5-6-7-8-9-10

Fourth complaint is _____:0-1-2-3- 4-5-6-7-8-9-10



*PLEASE MARK the areas on the Diagram with the following letters to describe your symptoms:
R =Radiating
B =Burning
D =Dull
A= Aching
N =Numbness
S =Sharp/ Stabbing
T= Tingling

When did the problem(s) begin? _____

When is the pain at its worst? AM / PM / Mid-Day / Late PM

How long does it last? Constant / On and off during the day / Comes and goes throughout the week

What aggravates your pain? Sit/Stand/Walking/Bending/Lift/Twist/Push/Pull/Driving/Movements
Other: _____

What relieves your pain? Recumbence/Medication/ Movement/ Rest/ Adjustment/ Massage
Other: _____

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

_____

Do you get headaches? Yes/ No If yes, how often? _____

Condition(s) ever been treated by anyone in the past? No/Yes

If yes, when: _____ by whom? _____

How long were you under care? _____ Name of Previous Chiropractor: _____

LIST RESTRICTED ACTIVITY: CURRENT ACTIVITY LEVEL: USUAL ACTIVITY LEVEL:

_____

_____

Is your problem the result of ANY type of accident? Yes / No If yes, date of accident: _____

How did the injury happen? _____

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PAST HISTORY

Have you suffered with any of these or a similar problem in the past? No / Yes If yes, how many times/episodes? _____
When was the last? _____ Other forms of treatment tried: No / Yes
If yes: Type of Treatment: _____ Who provided it? _____
How long ago? _____ What were the results? Favorable/ Unfavorable. Please explain: _____
_____

Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body:

_____

_____

If you have ever been diagnosed with any of the following conditions, please indicate with a P for in the Past, C for Currently have and N for Never have had:

_Broken Bone _Dislocations /Heart Attack _Osteoarthritis _Tumors _Rheumatoid Arthritis _Diabetes
_Stroke _Fracture _Disability _Cancer Other serious conditions: _____

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

INJURIES	SURGERIES	CHILDHOOD DISEASES	ADULTHOOD DISEASES

SOCIAL HISTORY

1. Smoking: cigars/ pipe / cigarettes Daily/ Weekends/ Occasionally / Never
2. Alcoholic Beverage: consumption occurs Daily/ Weekends/ Occasionally / Never
3. Recreational Drug use: How often? Daily/ Weekends/ Occasionally / Never
4. How does your present problem affect the following: Hobbies -Recreational Activities- Exercise Regime:
   _____

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)
   Have they ever been treated for their condition? No / Yes /I don't know
2. Any other hereditary conditions the doctor should be aware of No / Yes If yes, please explain:
   _____

I hereby authorize payment to be made directly to Active Family Chiropractic, for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Active Family Chiropractic for any and all services I receive at this office.

_____ _____
Patient or Authorized Guardian's Signature Date Form Completed

_____ _____
Doctor's Signature Date Form Reviewed

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ACTIVITIES OF DAILY LIVING

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

ACTIVITIES:	EFFECT:			
Carrying Groceries	No Effect	Painful(can do)	Painful(limits)	Unable to Perform
Sit to Stand	No Effect	Painful(can do)	Painful(limits)	Unable to Perform
Climbing Stairs	No Effect	Painful(can do)	Painful(limits)	Unable to Perform
Pet Care	No Effect	Painful(can do)	Painful(limits)	Unable to Perform
Driving	No Effect	Painful(can do)	Painful(limits)	Unable to Perform
Extended Computer Use	No Effect	Painful(can do)	Painful(limits)	Unable to Perform
Household Chores	No Effect	Painful(can do)	Painful(limits)	Unable to Perform
Lifting	No Effect	Painful(can do)	Painful(limits)	Unable to Perform
Reading/Concentration	No Effect	Painful(can do)	Painful(limits)	Unable to Perform
Dressing	No Effect	Painful(can do)	Painful(limits)	Unable to Perform
Shaving	No Effect	Painful(can do)	Painful(limits)	Unable to Perform
Sleep	No Effect	Painful(can do)	Painful(limits)	Unable to Perform
Extended Sitting	No Effect	Painful(can do)	Painful(limits)	Unable to Perform
Extended Standing	No Effect	Painful(can do)	Painful(limits)	Unable to Perform
Walking	No Effect	Painful(can do)	Painful(limits)	Unable to Perform
Washing/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
Yardwork	No Effect	Painful(can do)	Painful(limits)	Unable to Perform
Exercise	No Effect	Painful(can do)	Painful(limits)	Unable to Perform
Sexual Activity	No Effect	Painful(can do)	Painful(limits)	Unable to Perform

Patient Signature: _____ Date: _____

Additional Information:

_____

_____

_____

_____

_____

_____

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LIST PRESCRIPTION & NON-PRESCRIPTION MEDICATIONS YOU TAKE:

_Pain Killers _ Muscle Relaxers _Blood Pressure Medication _Insulin _Aspirin

_Acetaminophen/ Ibuprofen _Other: _____

_____

_____

_____

X-RAYS/IMAGING STUDIES

FEMALES ONLY please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.

Are you pregnant? _____ Are you nursing? _____

The first day of my last menstrual cycle was on _____ (date)

By my signature below I am acknowledging that the above information is correct. I understand 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.

Patient Signature: _____ Today's Date: _____

Witness Signature: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand and have been provided with a notice of information practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent.
- The right to object to the use of my health information for directory purposes.
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.
- Our office offers open adjusting areas, by signing below I am agreeing to be taken care of in this manner.
- If I choose not to sign below, I will be given a private room.

Patient Signature: _____

Today's Date: _____

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AUTHORIZATION AND ASSIGNMENT

In consideration of your undertaking to treat me, I agree to the following:

Authorization to Release Information
You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered by you, and I hereby release you of any consequence thereof.

Authorization to Pay Directly to Doctor
I authorize the direct payment to you of any sum I now or hereafter owe you by my attorney out of the proceeds of any settlement of my case, and/or by any insurance company obligated to reimburse me for the charges for your services or otherwise obligated to make payment to me or you based in whole or in part upon the charges made for your services.

Authorization of Cause of Action
In the event any insurance company is obligated by contractual agreement to make payment to me or to you for the demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is believed to be correctly set forth under pertinent data below) and authorize you to prosecute said action either in my name or in your name as you see fit and further authorize you to compromise, settle or otherwise resolve said claim as you see fit. However, it is understood that until all reasonable efforts have been made to collect the sums due from the insurance company (or companies) contractually obligated, you will refrain from attempts and efforts to collect the amounts owed directly from me.

Date _____

Patient Name (Printed): _____

Patient Signature: _____

Witness Signature: _____

PERTINENT DATA
Date of Injury _____

Name of my Insurance Company:

_____

_____

_____

Insurance Company Name of Person Responsible for Injuries:

_____

_____

_____

Attorney Name, Telephone and Address:

_____

_____

_____

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HEALTH CARE AUTHORIZATION FORM

Patient Name: _____ Patient's Date of Birth: _____

The patient identified above authorizes Active Family Chiropractic, P.A. to use and or disclose protected health information in accordance with the following:

SPECIFIC AUTHORIZATIONS

- I give permission to Active Family Chiropractic, P.A. to use my address, phone number, e-mail address, and clinical records to contact me with birthday/holiday cards, information about treatment or other health related information.
- If Active Family Chiropractic, P.A. contacts me by phone, I give them permission to contact me via text message and/or to leave a phone message on my answering machine or voicemail.
- I give Active Family Chiropractic, P.A. permission to treat me in a semi-private room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. *Should I need to speak with the doctor at any time in private, the doctor will provide a private room for these conversations.*
- By signing this form, I give Active Family Chiropractic, P.A. the permission to use and disclose my protected health information in accordance with the directives listed above.
- The authorization shall expire on the following date: _____

RIGHT TO REVOKE AUTHORIZATION

You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization.

You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the AFC. The written notice must contain the following information: Your name, social security number, date of birth, a clear statement of your intent to revoke this AUTHORIZATION, the date of your request, and your signature. The revocation is not effective until the Privacy Official receives it.

Active Family Chiropractic, P.A. requests this AUTHORIZATION for its own use/disclosure of Active Family Chiropractic, P.A. (Minimum necessary standards apply) You have the right to refuse to sign this AUTHORIZATION; Active Family Chiropractic, P.A. will not refuse to provide treatment. You have the right to inspect or copy the AFC to be used/disclosed.

A COPY OF THE SIGNED AUTHORIZATION WILL BE PROVIDED TO YOU

Patient Signature: _____

Today's Date: _____

Signature of Personal Representative: _____

Description of Representative's Authority to Act for Patient: _____