Essence of Life
Spinal Care

5811 Memorial Hwy. Suite 106, Tampa, Fl 33615

PH: 813-330-0232 | FAX: 813-513-4590 | Expresslife@essentialspinalcare.com

PATIENT INFORMATION

Full Name: _____ **DOB:** _____

Email: _____ **Social #:** _____-_____-_____

Full Home Address: *(No P.O. Box)* _____

_____

Employer _____ **Work #** _____

If none (Circle) Self employed Not employed Unemployment Retired Disabled Veteran N/A

Home #: _____ **Cell #:** _____

Best time to reach you: (Circle) Morning before 11am Afternoon 12pm-3pm Evening after 5pm

Marital Status: (Circle) Married Single Divorced Widowed

Children? (Circle) None Yes If yes, How many? _____
Their Gender Boy _____ Girl _____
Do they have any health conditions/symptoms? (Circle) Yes or No If so, what are they:
_____

How did you hear about us? (Circle) Google FaceBook Instagram Email Friend/Co-worker Family
Other _____
If someone, Who?_____

Emergency Contact Info: Full Name _____ Relation _____

Phone number_____

In an attempt to provide a more relaxing atmosphere, as well as a courtesy to all of our patients, please silence your cell phones upon entering the office. We thank you in advance for your cooperation.

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PATIENT CONDITION

What health concerns brings you into our office?

_____

How long have you been dealing with this? _____

Time of day at it's worst: Morning Afternoon Evening Does not Fluctuate it's Constant

Rate the severity of your problem(s)/Concern(s): On a scale of 1 (being least severe) to 10 (being most severe)

At it's worst = _____ At it's best = _____

Radiating pain? (Circle) Yes or No **Numbness/Tingling? (Circle)** Yes or No

If yes, Where to? _____

(Circle any present symptoms) Nausea Difficulty swallowing Double vision Loss of balance

Drop attacks (passing out) Numbness of the face or eyes Dizziness Slurred Speech

If no, circle >>> NONE If yes, Explain: _____

Health Questionnaire

Do you exercise routinely? *(circle)* No Yes If *Yes*, what exercise/how often?

_____

Have you ever smoked? *(circle)* No Yes (Circle) Cigar Pipe Cigarettes Marijuana
If *Yes*: # per day _____
If you have never smoked, skip this: Do you still smoke now? *(circle)* No Yes If *No*, when did you quit? _____

Caffeine: Do you drink *(circle)* caffeinated coffee, teas or sodas regularly? *(circle)* No Yes #/day _____
Tell us a little about your home environment: *(e.g. live alone, with family, single parent, house, apt., etc.)*

_____

Are you under a lot of pressure at work or at home? *(circle)* No Yes, Which? _____

Medical Information

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Allergies: Are you allergic to any drugs? *(circle)* No Yes Please list: _____

Medications *(list all medications you are taking regularly. Include over the counter, herbal or natural remedies.)*

_____

_____

_____

Medical Illnesses or Conditions *(list any chronic conditions which you have been diagnosed to have if not present below)* **Have you ever had or been diagnosed to have:** *(check box by all that apply)*

Cataracts	Heart Disease	Ulcers	Anemia	Depression
Glaucoma	Heart Murmur	Digestive Disorder	Bleeding Disorders	Frequent Infection
Asthma	High Blood Pressure	Hemorrhoids	Bone or Joint Disease	Cancer (type)
Allergies	Pneumonia	Kidney Disease		
Stroke	TB/Lung Disease	Kidney Stone(s)	German Measles	High Cholesterol
Seizures/Epilepsy	Pleurisy	Diabetes or PreDiabetes	Rheumatic Fever	Prostate Enlargement
Heart Attack or Angina	Jaundice or Liver Disease		Chicken Pox	Migraines
		Thyroid Disease	Syphilis	Herniated Disc
Lupus	Fibromyalgia	Erectile Dysfunction	Infertility	

Surgeries: *Please list any past surgery & approximate year* _____

Family Medical History	**Age**	**Health** *(list significant illness)*	**Age at Death**	**If deceased, cause**
Father				
Mother				
Brothers or Sisters				
Spouse				
Children				

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Weight: What is your weight now? _____ One year ago? _____

Females Only: Are you pregnant, planning a pregnancy or nursing a child? *(circle)* *Yes* *No*
*Which?*_____ Date of last menstrual period?_____ Menopausal? since when: _____

Painful orgasms Yes _____ No _____

Recent accident or Injury (Last 6 months)? (Circle) YES or NO **If Yes, when & what type:** ___

Past History of all accidents, traumas & injuries: Minor or Major. (Circle) Yes No
If yes, Explain:_____

Systems Review

Please indicate those items that have been a recurrent or a recent significant change. Write Yes, No or Circle below

Constitutional/Endocrine Symptoms Good health lately Recent significant weight change Unusual fatigue or weakness Frequent headaches Glandular or hormone problem Heat or cold intolerance Excessive skin dryness Excessive thirst or urination Change in hand or glove size

Eyes Change in vision Blurred or double vision Eye disease or injury Wear glasses/contact lenses?

Ears/Nose/Mouth/Throat/Neck Do you wear hearing aids? Hearing loss or ringing in ears? Earaches or drainage? Chronic sinus problems or runny nose Nose bleeds Mouth sores Bleeding gums Sore throat/hoarseness or voice change Lumps or swollen glands in neck Difficulty swallowing

Cardiovascular Chest pain Abdomen pain Palpitations Shortness of breath with walking or lying flat Swelling feet, ankles or hands Waking at night with shortness of breath High blood pressure

Gastrointestinal Loss of appetite Change in bowel movements Nausea or vomiting Painful

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bowel movements constipation Frequent diarrhea Abdominal pains Acid Reflux

Genitourinary Change in force or strain when urinating Incontinence or dribbling of urine Sexual difficulties Men: Testicular pain Women: Painful periods or Irregular periods Recurrent vaginal discharge Number of pregnancies (including miscarriages): # Deliveries _____ #Miscarriages _____ Method of birth control (if applicable): _____

Musculoskeletal Joint pain(s) Joint stiffness/swelling or warmth Weakness of muscles or joints Muscle pain or recurrent cramps Low Back pain Cold hands or feet Hip pain Shoulder pain Mid-back pain Neck pain

Neurological Frequent, recurring or increasing headaches Light-headedness or dizziness Convulsions seizures or spasms Numbness or tingling sensations Tremors Paralysis Stroke Head injury

Mental Health Have you had bouts of depression and or anxiety? *No* *Yes* _____

Have you been diagnosed to have bipolar disorder, obsessive compulsive disorder, or other psychiatric condition? Yes No

Comments:_____

Patient signature:_____

Print Name:_____ Date: _____

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Informed Consent

Patients usually seek treatment to alleviate whatever ailments or conditions that are bothering them. However worthy such a goal may be, treating and or curing diseases is not the goal of a Chiropractor. It therefore, is important that the patient understands that goal and the means that will be used for its attainment.

Chiropractic is based on the premise that living things have an inborn intelligence striving to maintain their own health. It recognizes that the greatest doctor is the doctor within. When the body is unable to maintain its own health and express abundant life, it is frequently due to some form of interference. A major form of interference, occurs when we have a "vertebral subluxation."
A subluxation is when one or more bones have misaligned and are now causing irritation/pressure to the nervous system. A subluxation interferes with the normal generation, transmission and expression of nerve impulses between the brain, organs and tissue cells of the body, thereby causing dis-ease.

The Chiropractor's one goal is to periodically examine the patient's spine and should a vertebral subluxation be detected, correct it by means of a Chiropractic adjustment. This adjustment re-establishes a more normal nerve function. In this office the adjustments do not consist of any manual, rotating or pulling adjustments.The adjustments are done using a hand held instrument called the Laney instrument. This instrument is designed to precisely and specifically adjust the vertebrae, Using a mechanical impulse.

During your first visit we go over your current and past health history, do a complete and thorough spinal exam and refer for X-rays if necessary. X-rays give us a blue print of what is going on in your spine. We will schedule a follow up appointment within the next 3 days. During the second visit we review the x-rays with you and explain what we find, what it means, what can be done to help, and then an adjustment, if needed will be performed to restore normal function to the body. For the third visit we will see how your body is responding and on the fourth visit we will have a report on what it''ll take for you to reach ideal functional wellness and maintain progress for the future.

The whole process is usually painless and may or may not provide instant relief after the 1st adjustment. Our goal is to stablize subluxations for continued future function. In addition to the benefits of adjustments for the removal of subluxations, one should also be aware of what you may experience after the first few corrections. Such as, soreness, lightheadedness or dizziness, mild nausea and or breif increase in existing symptoms after an adjustment. In regards to mannual Chiropractic adjustments and or Physical Therapy, there has been a .0025% correlation to VBA (Vertebral Basilar Artery) Dissections (stroke) occuring after therapy or a manual adjustment, according to an article published in 1995 in the JMPT journal. Rib fractures may also be an adverse event after high velocity adjustments. However, due to the light force and non-rotatory adjustments we provide, the likelihood of these reactions are significantly decreased even further and usually patients notice a positive difference after their first correction.

The chiropractic examination and adjustment are not substitutes for other types of health care, just as no other type of health care can substitute for chiropractic care. Though one could not be healthy while Subluxated, health is more than the absence of subluxation. Each patient is encouraged to seek the services of other health care providers for health concerns other than the correction of vertebral subluxation.

Sign_____ Print _____ Date:_____

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NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT OF RECEIPT

DATE: _____

Special Privacy Protection: Since we are a non-participating provider with all insurances,we will not disclose information to your commercial health plan concerning health care items, records or services for which you paid for in full out-of-pocket. Only at your written request or unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.
Accept ____ Reject ____ (initial)

I ACKNOWLEDE THAT I WAS PROVIDED WITH A COPY OF THE NOTICE OF PRIVACY PRACTICES.

_____ _____
PATIENT NAME PATIENT SIGNATURE

If completed by a patient's personal representative and or gaurdian, please print and sign your name below.

_____ _____
Representative or Gaurdian (print) Representative or Gaurdian's Signature

_____
Relationship

List who you give permission & access to your private health information: (*If none put N/A)*

Full Name(s) _____ _____ _____

Doctor's Use Only

Complete this section if this form is not signed and dated by the patient or patient's representative.

I have made a good faith effort to obtain a written acknowledgement of receipt of Notice of Privacy Practices but was unable to for the following reason:

____ Patient refused to sign ____ Patient unable to sign ____ Other:_____

_____
Employee Name Date