



5811 Memorial Hwy. Suite 106, Tampa, FL 33615
PH: 813-330-0232 | FAX: 813-345-4075 | Expresslife@essentialspinalcare.com

PATIENT INFORMATION

DATE: _____

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 _____

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

NAME:

What health concerns brings you into our office?

Is this the first time you've experienced this? _____ 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 If yes, Where to? _____

Numbness/Tingling? (Circle) Yes or No If yes, Where? _____

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

Drop attacks (passing out) Numbness of one side of face or body Dizziness Vertigo Speech Difficulty

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? _____



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Medical Information

Name: _____

Allergies: 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	German Measles	High Cholesterol
Stroke	TB/Lung Disease	Kidney Stone(s)	Rheumatic Fever	Prostate Enlargement
Seizures/Epilepsy	Pleurisy	Diabetes or PreDiabetes	Chicken Pox	Migraines
Heart Attack or Angina	Jaundice or Liver Disease	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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Name: _____

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 ____ On Birth control? Yes or No **What kind?** _____

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 recurring 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



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Name: _____

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 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 _____

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 stabilize 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 brief increase in existing symptoms after an adjustment. In regards to manual Chiropractic adjustments and or Physical Therapy manipulations, there has been a .0025% association to VBA (Vertebral Basilar Artery) Dissections (stroke) occurring 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 ____ (initial) Reject ____ (initial)

I ACKNOWLEDGE 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 guardian, please print and sign your name below.

Representative or Guardian (print)

Representative or Guardian'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



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Essence of Life Spinal Care, Inc. Financial Policy

1. **Patients without Insurance:** Patients without insurance coverage must pay in full at each visit for services rendered. Payment plans are offered on all Chiropractic services. This payment plan does not apply to nutritional supplements, DME, or any other merchandise sold.
2. **Health Insurance:** Your insurance is an agreement between you and your insurance company, not between your insurance company and our office. Therefore, you are ultimately financially responsible. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding coverage.

We are **NON participating** providers with all insurance plans, including Medicare. If you are insured by a private insurance plan we will provide you with a super bill for each treatment, you then can submit these forms to your own insurance company. We are not responsible for any non-payment from your health insurance. Payment is due in full at each visit. It is to be agreed and understood that any services rendered are charged to you directly and you are personally responsible for any co-pays, deductibles, co-insurance, and non-covered services.

3. **Co-payments, Deductibles, Coinsurance:** All co-payments, deductibles, and coinsurance, must be paid in full at time of service. This arrangement is part of your contract with your insurance company, and is a legal requirement for us to collect in full at each visit.
4. **Non-covered Services:** Please be aware that some-and perhaps all-of the services you may receive are non-covered or not considered necessary by Medicare or other insurers. These are your responsibility and must be paid in full at time of service.



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5. **Medicare:** The doctor in this office is a non-participating Medicare provider. We DO NOT submit any claims to Medicare or secondary plans. You are responsible for payment in full at time of service. These would include X-rays, examinations, therapies, nutritional supplements, supports, DME, and any other merchandise sold at the office.

6. **“On the Job” Injury (Worker’s Compensation):** If you are injured on the job, your care should be paid for under your employer’s Worker’s Compensation insurance. You will need to inform your employer of the accident and obtain the name and address of the carrier of your insurance. **You must pay in full at time services are rendered. We will provide you with a super bill so that you may request compensation from the company yourself.**

7. **Personal Injury or Automobile Accidents:** Please present your photo ID, auto insurance card, health insurance card and accident report also any claim numbers or adjustor information, and tell us if you have retained an attorney. **We MUST have a copy of YOUR automobile insurance before treatment begins to confirm whether or not you have Med Pay coverage. Regardless of who is at fault, if you have Med Pay we will use that for billing purposes. Your insurance will NOT go up if this is used.** If you **DO NOT** have Med Pay coverage, there are three options available to the PI Patient:
 - a. Pay up front for all services rendered and we will submit reports whenever necessary.
 - b. We will bill your auto insurance ONLY if we receive a Letter of Protection or Doctor’s Lien signed from an attorney or your car insurance company. (We will provide you with a copy to have signed)
 - c. We will bill your auto insurance plan and you will be responsible for all Co-pays, deductibles, or coinsurance at the time services are rendered.



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8. **Non-Payment:** If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if balance remains unpaid, we may refer you to a collection agency where you will be responsible for ALL fees associated and you and your immediate family members may be discharged from this practice.
9. **Appointment Cancellation Policy:** We want to thank you for choosing us as your chiropractic health provider. We strive to render excellent care to you and the rest of our patients. Your care and treatment is a priority to us. We also ask that you respect our chiropractor's time and expertise. **Therefore, Essence of Life Spinal Care, Inc. requires a 24hr cancellation notice. This will enable us to offer your cancelled time to other patients that desire to get their treatment completed. We will keep a credit card, debit card or checking account for auto debit form on file at all times for late fees only. There is a mandatory service charge of \$50 for NO-SHOWS or CANCELLATIONS without proper notice. This charge is NOT covered by your insurance and is billed directly to you. This fee will be collected before we will provide further chiropractic services. Repeat missed appointments may warrant a discontinuance of care.**

I have read and understand the Financial Policy of Essence of Life Spinal Care, Inc. and I agree to be bound by its terms. I further acknowledge that all information given whether oral or written by me, to Essence of Life Spinal Care, Inc. is true.

Patient or Guardian Signature

Date