Confidential Patient Case History

Dear Patient: Please complete this questionnaire. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. THANK YOU.

CELL PHONE _____

NAME _____ DATE _____ HOME PHONE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____ WORK PHONE _____

DATE OF BIRTH _____ AGE _____ M ____ F ____ MARITAL STATUS _____ NO. CHILDREN _____

OCCUPATION _____ SS # _____ SPOUSE _____

E-MAIL ADDRESS: _____ REFERRED BY _____

Please check the appropriate box for any of the following symptoms which you now have or have had previously. We want all the facts about your health before we accept your case. THIS IS A CONFIDENTIAL HEALTH REPORT.

O - OCCASIONAL
F - FREQUENT
C - CONSTANT

O	F	C	
			GENERAL
☐	☐	☐	Allergy
☐	☐	☐	Chills
☐	☐	☐	Convulsions
☐	☐	☐	Dizziness
☐	☐	☐	Fainting
☐	☐	☐	Fatigue
☐	☐	☐	Fever
☐	☐	☐	Headache
☐	☐	☐	Loss of sleep
☐	☐	☐	Loss of weight
☐	☐	☐	Nervousness/depression
☐	☐	☐	Neuralgia
☐	☐	☐	Numbness
☐	☐	☐	Sweats
☐	☐	☐	Tremors
			MUSCLE & JOINT
☐	☐	☐	Arthritis
☐	☐	☐	Bursitis
☐	☐	☐	Foot trouble
☐	☐	☐	Hernia
☐	☐	☐	Low back pain
☐	☐	☐	Lumbago
☐	☐	☐	Neck pain or stiffness
☐	☐	☐	Pain between shoulders
			Pain or numbness in:
☐	☐	☐	Shoulders
☐	☐	☐	Arms
☐	☐	☐	Elbows
☐	☐	☐	Hands
☐	☐	☐	Hips
☐	☐	☐	Legs
☐	☐	☐	Knees
☐	☐	☐	Feet
☐	☐	☐	Painful tail bone
☐	☐	☐	Poor posture
☐	☐	☐	Sciatica
☐	☐	☐	Spinal curvature
☐	☐	☐	Swollen joints

O	F	C	
			GASTRO-INTESTINAL
☐	☐	☐	Belching or gas
☐	☐	☐	Colitis
☐	☐	☐	Colon trouble
☐	☐	☐	Constipation
☐	☐	☐	Diarrhea
☐	☐	☐	Difficult digestion
☐	☐	☐	Distension of abdomen
☐	☐	☐	Excessive hunger
☐	☐	☐	Gall bladder trouble
☐	☐	☐	Hemorrhoids
☐	☐	☐	Intestinal worms
☐	☐	☐	Jaundice
☐	☐	☐	Liver trouble
☐	☐	☐	Nausea
☐	☐	☐	Pain over stomach
☐	☐	☐	Poor appetite
☐	☐	☐	Vomiting
☐	☐	☐	Vomiting of blood
			EYES, EARS, NOSE & THROAT
☐	☐	☐	Asthma
☐	☐	☐	Colds
☐	☐	☐	Crossed eyes
☐	☐	☐	Deafness
☐	☐	☐	Dental decay
☐	☐	☐	Earache
☐	☐	☐	Ear discharge
☐	☐	☐	Ear noises
☐	☐	☐	Enlarged glands
☐	☐	☐	Enlarged thyroid
☐	☐	☐	Eye pain
☐	☐	☐	Failing vision
☐	☐	☐	Far sightedness
☐	☐	☐	Gum trouble
☐	☐	☐	Hay fever
☐	☐	☐	Hoarseness
☐	☐	☐	Nasal obstruction
☐	☐	☐	Near sightedness
☐	☐	☐	Nosebleeds
☐	☐	☐	Sinus infection
☐	☐	☐	Sore throat
☐	☐	☐	Tonsillitis

O	F	C	
			CARDIO-VASCULAR
☐	☐	☐	Hardening of arteries
☐	☐	☐	High blood pressure
☐	☐	☐	Low blood pressure
☐	☐	☐	Pain over heart
☐	☐	☐	Poor circulation
☐	☐	☐	Rapid heart beat
☐	☐	☐	Slow heart beat
☐	☐	☐	Swelling of ankles
			RESPIRATORY
☐	☐	☐	Chest pain
☐	☐	☐	Chronic cough
☐	☐	☐	Difficult breathing
☐	☐	☐	Spitting up blood
☐	☐	☐	Spitting up phlegm
☐	☐	☐	Wheezing
			SKIN
☐	☐	☐	Boils
☐	☐	☐	Bruise easily
☐	☐	☐	Dryness
☐	☐	☐	Hives or allergy
☐	☐	☐	Itching
☐	☐	☐	Skin eruptions (rash)
☐	☐	☐	Varicose veins
			GENITO-URINARY
☐	☐	☐	Bed-wetting
☐	☐	☐	Blood in urine
☐	☐	☐	Frequent urination
☐	☐	☐	Inability to control kidneys
☐	☐	☐	Kidney infection or stones
☐	☐	☐	Painful urination
☐	☐	☐	Prostate trouble
☐	☐	☐	Pus in urine
			FOR WOMEN ONLY
☐	☐	☐	Congested breasts
☐	☐	☐	Cramps or backache
☐	☐	☐	Excessive menstrual flow
☐	☐	☐	Hot flashes
☐	☐	☐	Irregular cycle
☐	☐	☐	Menopausal symptoms
☐	☐	☐	Painful menstruation
☐	☐	☐	Vaginal discharge

☐ Yes ☐ No Are you pregnant?

CHECK THE FOLLOWING CONDITIONS YOU HAVE HAD:

☐ Alcoholism	☐ Cold sores	☐ Goiter	☐ Miscarriage	☐ Scarlet fever
☐ Anemia	☐ Diabetes	☐ Gout	☐ Multiple sclerosis	☐ Stroke
☐ Appendicitis	☐ Diphtheria	☐ Heart disease	☐ Mumps	☐ Tuberculosis
☐ Arteriosclerosis	☐ Eczema	☐ Influenza	☐ Pleurisy	☐ Typhoid fever
☐ Arthritis	☐ Emphysema	☐ Lumbago	☐ Pneumonia	☐ Ulcers
☐ Cancer	☐ Epilepsy	☐ Malaria	☐ Polio	☐ Venereal Disease
☐ Chorea	☐ Fever blisters	☐ Measles	☐ Rheumatic fever	☐ Whooping cough

Have you ever had previous chiropractic care? _____ If yes, date of last care _____

Do you have Health and Accident Insurance? _____ If yes, with what company? _____

Is this an Industrial Accident Case? ☐ Yes ☐ No

To Order: Call 1-800-950-8044

#1300120

AMERICAN CHIROPRACTIC CENTRE

Patient Name _____

PLEASE PRINT

What is your major complaint? _____

_____

Other complaints _____

How long have you had this condition? _____ Have you had this or similar conditions in the past? _____

What activities aggravate your condition? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Constant ☐ Comes and goes

Is this condition interfering with your: ☐ Work ☐ Sleep ☐ Daily routine Other _____

How long has it been since you really felt good? _____

List previous diagnoses and treatments you have received for present condition _____

_____

What do you believe is wrong with you? _____

List surgical operations and years: _____

_____

Drugs you now take: ☐ Nerve pills ☐ Pain killers ☐ Muscle relaxers ☐ "Pep" pills ☐ Tranquilizers ☐ Birth control pills

Others _____

Dental visits: ☐ Every six months ☐ Yearly ☐ Toothache or emergency only ☐ Complete dentures

Age of mattress _____ ☐ Comfortable ☐ Uncomfortable Do you use a bed board: _____

Are you wearing: ☐ Heel lifts ☐ Sole lifts ☐ Inner soles ☐ Arch supports

Have you been in an auto accident: ☐ Past year ☐ Past five years ☐ Over five years ☐ Never

Describe _____

Have you ever had any mental or emotional disorders? ☐ Yes ☐ No When? _____

Have others in your family had such disorders? ☐ Yes ☐ No When? _____

FAMILY HEALTH INFORMATION (Many health problems are the result of hereditary spinal weaknesses; thus information about your family members will give us a better picture of your total health picture.)

NAME	RELATION	PAST AND PRESENT HEALTH PROBLEMS

HAVE YOU EVER:	YES	NO	DESCRIBE BRIEFLY
Been knocked unconscious?	☐	☐	
Used a cane, crutch, or other support?	☐	☐	
Been treated for a spine or nerve disorder?	☐	☐	
Had a fractured bone?	☐	☐	
Been hospitalized for other than surgery?	☐	☐	
DO YOU:			
Now take vitamins or minerals?	☐	☐	
Think you may need vitamins or minerals?	☐	☐	
Have an allergy to any drug?	☐	☐	

DATE OF LAST:	Less than 6 months	6-18 months	Over 18 months	Never
Spinal examination	☐	☐	☐	☐
Physical examination	☐	☐	☐	☐
Blood test	☐	☐	☐	☐
Chest X-ray	☐	☐	☐	☐
Spinal X-ray	☐	☐	☐	☐
Dental X-ray	☐	☐	☐	☐
Urine test	☐	☐	☐	☐

HABITS	Heavy	Moderate	Light	None
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐

LIST BELOW ALL CONDITIONS FOR WHICH YOU HAVE BEEN TREATED IN THE PAST 10 YEARS.

_____

_____

_____

_____

_____

_____

IN CASE OF EMERGENCY: (Name of relative or close friend not living in your home):

NAME _____

ADDRESS _____ PHONE _____

PCP Name: _____ **Phone #:** _____

American Chiropractic and Acupuncture Center
Marcia C. Sasso, D.C., P.A.
Debra Rabideau, D.C., P.A.
5663 Coral Gate Blvd
Margate, FL 33063
Ph:(954) 974-3456 Fax:(954) 974-3568

INFORMED CONSENT / HIPAA CONSENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by Dr. Marcia C. Sasso, D.C., Dr. Debra A. Rabideau, D.C., and/or their precept and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with, or serving as back-up for Dr. Marcia C. Sasso, D.C.,P.A., Dr. Debra Rabideau, D.C. or including those working for her office.

I have had an opportunity to discuss with the Dr. Sasso, Dr. Rabideau and/or with other office personnel the nature and purpose of chiropractic adjustments and other procedures. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. It is not reasonable to expect the doctor to be able to anticipate and explain all risks and complications of a given procedure on any particular visit, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

Chiropractic treatment involves the science, philosophy and art of locating and correcting spinal misalignments and as such, is oriented toward improvement of spinal function relative to range of motion, muscular and neurological aspects. There has been no promise, implied or otherwise, of a cure for any symptom, disease or condition as a result of treatment in this clinic. I understand that the chiropractor will use her hands or a mechanical device upon my body to adjust a joint, which may cause an audible "pop" or "click." It is my intention to rely on the doctor to exercise professional judgment during the course of any procedures, which she feels at the time to be in my best interest. Neither the practice of chiropractic or medicine is an exact science, but relies upon information related by the patient, information gathered during examination, and the doctor's interpretation thereof, as well as the doctor's judgment and expertise in working with like cases.

HIPAA Consent
I understand that as part of my healthcare, this Practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as a basis for planning my care and treatment; a means of communication among other health professionals who may contribute to my care; a source of information for applying my diagnosis and treatment information to my bill; and a means by which a third-party payer can verify that services billed were actually provided.

I understand and have been provided with a Notice of Privacy Practices and that I have read or declined the opportunity to read and understand the Notice of Privacy Practices. I understand that the Practice reserves the right to change their notice and practices and that I will be informed of such changes upon them doing so. I understand that I have the right to object to my health care information being shared or disclosed with any entity not associated with this Practice. And that prior to this Practice disclosing my health care information a request will be made by me in writing.

I have read, or have had read to me, the Informed Consent to Chiropractic Adjustments and Care. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment at this office.

_____ _____
Name (Printed) Date Signed

_____ _____
Signature of Patient or Legal Representative Witness Signature

American Chiropractic and Acupuncture Center
Marcia C. Sasso, D.C., P.A.
Debra Rabideau, D.C., P.A.
5663 Coral Gate Blvd
Margate, FL 33063
Ph:(954) 974-3456 Fax:(954) 974-3568

Assignment of Benefits Form / Financial Responsibility

Financial Responsibility

I have requested medical services from Marcia C. Sasso, D.C, P.A. and/or her associates on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I understand that fees are due and payable on the date that services are rendered and I agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

I further understand that should my account not be paid, I assume all costs of collection, including but not limited to court costs, interest and legal fees.

Assignment of Benefits

I hereby assign all medical/chiropractic benefits to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to **MARCIA C. SASSO, D.C., P.A.** for services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize Marcia C. Sasso, D.C., P.A. to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

Medical Authorization for Release / Disclosure of Protected Health Information

This is to authorize you to release any information regarding my condition and care to Medicare, My Insurance Carrier(s), or Other HealthCare Providers or Referring Physicians directly associated with my care. I "do" authorize Marcia C. Sasso, D.C., P.A. and staff to provide and/or discuss my care and medical needs with my immediate family; spouse, children, parents.

Patient Name (Printed) _____ **Date** _____

Patient/Legal Representative Signature _____ **Witness Signature** _____

American Chiropractic and Acupuncture Center
Marcia C. Sasso, D.C., P.A.
Debra Rabideau, D.C., P.A.
5663 Coral Gate Blvd
Margate, FL 33063
Ph:(954) 974-3456 Fax:(954) 974-3568

Patient Name (Please Print) _____ Date of Birth _____

AUTHORIZATION FOR MEDICAL INFORMATION

I hereby authorize _____ to release a copy of my patient records, x-rays, or insurance information containing protected health information to the office of Marcia C. Sasso, D.C., P.A. This authorization is given pursuant to Florida Statute 456.057 and HIPAA regulations. I understand that Florida Statute 456.057(12) makes clear that any third party to whom records are disclosed is prohibited from further disclosing any information in the medical record without the expressed written consent of the patient or the patient's legal representatives.

Patient / Legal Representative Signature _____ Today's Date _____

RELEASE OF PATIENT RECORDS AUTHORIZATION

I hereby authorize the office of Marcia C. Sasso, D.C., P.A. to release a copy of my patient records or x-rays containing protected health information to:

_____.

This authorization is given pursuant to Florida Statute 456.057 and HIPAA regulations. I understand that Florida Statute 456.057(12) makes clear that any third party to whom records are disclosed is prohibited from further disclosing any information in the medical record without the expressed written consent of the patient or the patient's legal representatives.

Patient / Legal Representative Signature _____ Date Signed _____

Specific description of information to be disclosed: _____

American Chiropractic and Acupuncture Center
Marcia C. Sasso, D.C., P.A.
Debra Rabideau, D.C., P.A.
5663 Coral Gate Blvd
Margate, FL 33063
Ph:(954) 974-3456 Fax:(954) 974-3568

No Show Policy:
Massage Therapy & Consultations

Dear Patient,

We understand that sometimes emergency situations arise and that you may need to cancel or reschedule your appointment. In the event that you are unable to keep your appointment, or if you are running late, we ask you to please show consideration by calling well in advance. Due to limited time and space, we do not "double-book" appointments and would like to have the option to offer that appointment to another patient who is in need of care.

Please be advised that we require a minimum of 12 hours notice when cancelling and or rescheduling an appointment. If you fail to give a minimum of 12 hours notice of cancellation you will be charged a fee of $25.00 for 1/2 hour massage, $50.00 for 1 hour massage, and $50.00 for each ½ hour consultation scheduled with the Doctor. Please be aware that YOU, not your insurance carrier, will be responsible for the cancellation fee.

_____
Print Patient Name

_____ _____
Patient's/Legal Representative's Signature Date Signed

_____ _____
Witness Signature Date Signed