# Clinical Services Intake

Name: _____ Date: _____

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

Primary Phone: _____ Secondary Phone: _____

Birthdate: _____ Email: _____

Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Children: ☐ Yes ☐ No How Many: _____

Are you considered a minor? ☐ Yes ☐ No If Yes, who is the responsible payer?

Occupation: _____ Employer: _____

Family Doctor: ☐ Yes ☐ No Name of Doctor: _____ Phone: _____

Emergency Contact: _____ Phone: _____

How did you hear about our facility? _____

**Past Medical History**

For the conditions below, place a check in the "past" column if you have had the condition in the past.

If you presently have any condition listed below, please place a check in the present column.

| Condition | Past | Present |
|---|---|---|
| Headaches | ☐ | ☐ |
| Neck Pain | ☐ | ☐ |
| Upper Back Pain | ☐ | ☐ |
| Mid Back Pain | ☐ | ☐ |
| Low Back Pain | ☐ | ☐ |
| Shoulder Pain | ☐ | ☐ |
| Elbow/Arm Pain | ☐ | ☐ |
| Wrist Pain | ☐ | ☐ |
| Hand Pain | ☐ | ☐ |
| Hip Pain | ☐ | ☐ |
| Upper Leg Pain | ☐ | ☐ |
| Knee Pain | ☐ | ☐ |
| Ankle/Foot Pain | ☐ | ☐ |
| Jaw Pain | ☐ | ☐ |
| Joint Pain/ Stiffness | ☐ | ☐ |
| Arthritis | ☐ | ☐ |
| Rheumatoid Arthritis | ☐ | ☐ |
| Cancer | ☐ | ☐ |
| Tumor | ☐ | ☐ |

| Condition | Past | Present |
|---|---|---|
| Asthma | ☐ | ☐ |
| Chronic Sinusitis | ☐ | ☐ |
| High Blood Pressure | ☐ | ☐ |
| High Cholesterol | ☐ | ☐ |
| Heart Attack | ☐ | ☐ |
| Stroke | ☐ | ☐ |
| Angina | ☐ | ☐ |
| Kidney Stones | ☐ | ☐ |
| Kidney Disorders | ☐ | ☐ |
| Bladder Infection | ☐ | ☐ |
| Loss of Bladder Ctrl | ☐ | ☐ |
| Prostate Problems | ☐ | ☐ |
| Abnormal Wt Loss/Gain | ☐ | ☐ |
| Loss of Appetite | ☐ | ☐ |
| Abdominal Pain | ☐ | ☐ |
| Ulcer | ☐ | ☐ |
| Hepatitis | ☐ | ☐ |
| Liver Disorder | ☐ | ☐ |
| Gall Bladder Disorder | ☐ | ☐ |

| Condition | Past | Present |
|---|---|---|
| General Fatigue | ☐ | ☐ |
| Thyroid Disorder | ☐ | ☐ |
| Muscular Incoordination | ☐ | ☐ |
| Visual Disturbances | ☐ | ☐ |
| Dizziness | ☐ | ☐ |
| Diabetes | ☐ | ☐ |
| Excessive Thirst | ☐ | ☐ |
| Frequent Urination | ☐ | ☐ |
| Addiction Drug/Alcohol | ☐ | ☐ |
| Allergies | ☐ | ☐ |
| Depression | ☐ | ☐ |
| Systemic Lupus | ☐ | ☐ |
| Fibromyalgia | ☐ | ☐ |
| Epilepsy | ☐ | ☐ |
| Skin Conditions | ☐ | ☐ |
| HIV/AIDS | ☐ | ☐ |
| For Women: | ☐ | ☐ |
| Birth Control | ☐ | ☐ |
| Hormone Replacement | ☐ | ☐ |

List ALL Medications you are **Currently** Taking: _____

_____

List any Allergies: (including food) _____

List any Surgeries: _____

Have you had any adverse reaction to massage creams, or massage oils? ☐ Yes ☐ No

Do you have any contraindication to the use of Electrical Stimulation Rehab equipment? ☐ Yes ☐ No

**Family Medical History**

Please indicate if you have any immediate family members with the following conditions:

| | | | | | |
|---|---|---|---|---|---|
| Rheumatoid Arthritis | ☐ | Diabetes | ☐ | Lupus/Fibromyalgia | ☐ |
| Heart Problems | ☐ | Cancer | ☐ | Mulitple Sclerosis | ☐ |

Other Pertinent Family Medical history: _____

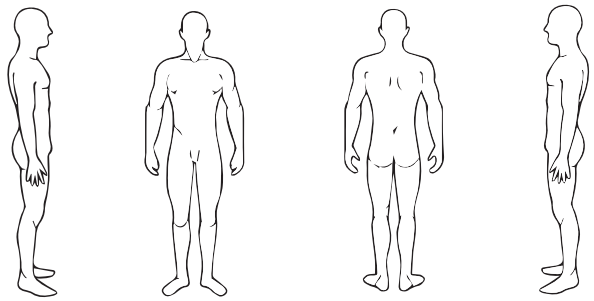
**Social History**

Do you smoke: ☐ Yes ☐ No How Much: _____ Drink Alcohol: ☐ Yes ☐ No How much: _____

For Women Only: Pregnant? ☐ Yes ☐ No How Long: _____ Nursing? ☐ Yes ☐ No

# Clinical Services Intake

Please indicate on the drawings where you are experiencing your symptoms



1) Where is your problem: _____ When Did It Start: _____

Pain Level (0= No Pain/10=Highest Pain) ○0 ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10

How often does it occur: ☐ Occasionally (0-25% of the time) ☐ Intermittently (26-50% of the time) ☐ Frequently (51-75% of the time) ☐ Constantly (76-100% of the time)

Please describe your pain: ☐ Aching ☐ Burning ☐ Dull ☐ Pulling ☐ Sharp ☐ Shooting ☐ Stabbing ☐ Stinging ☐ Throbbing ☐ Tight

What aggravates your symptoms: _____

Notes: _____

_____

_____

2) Where is your problem: _____ When Did It Start: _____

Pain Level (0= No Pain/10=Highest Pain) ○0 ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10

How often does it occur: ☐ Occasionally (0-25% of the time) ☐ Intermittently (26-50% of the time) ☐ Frequently (51-75% of the time) ☐ Constantly (76-100% of the time)

Please describe your pain: ☐ Aching ☐ Burning ☐ Dull ☐ Pulling ☐ Sharp ☐ Shooting ☐ Stabbing ☐ Stinging ☐ Throbbing ☐ Tight

What aggravates your symptoms: _____

Notes: _____

_____

_____

3) Where is your problem: _____ When Did It Start: _____

Pain Level (0= No Pain/10=Highest Pain) ○0 ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10

How often does it occur: ☐ Occasionally (0-25% of the time) ☐ Intermittently (26-50% of the time) ☐ Frequently (51-75% of the time) ☐ Constantly (76-100% of the time)

Please describe your pain: ☐ Aching ☐ Burning ☐ Dull ☐ Pulling ☐ Sharp ☐ Shooting ☐ Stabbing ☐ Stinging ☐ Throbbing ☐ Tight

What aggravates your symptoms: _____

Notes: _____

_____

_____

**Current Treatment of Symptoms**

Have you seen anyone else for these symptoms: ☐ Yes ☐ No Who: _____

List any treatment given for these symptoms: _____

List any medications given for these symptoms: _____

Patient Signature: _____ Date: _____

# Activity Release of Liability

**PLEASE READ CAREFULLY, THIS AFFECTS YOUR LEGAL RIGHTS.**

**In exchange for participation in the activity of any exercise and/or rehabilitation organized by Orlando Body and Movement Therapy, of 7345 West Sand Lake Rd., Orlando, FL 32819 and/or use of the property, facilities and services of Orlando Body and Movement Therapy, I agree for myself and (if applicable) for the members of my family, to the following:**

1. **I agree to observe and obey all posted rules and warnings, and further agree to follow any oral instructions or directions given by Orlando Body and Movement Therapy, or the employees, representatives or agents of Orlando Body and Movement Therapy.**
2. **I recognize that there are certain inherent risks associated with the above described activity and I assume full responsibility for personal injury to myself and (if applicable) my family members, and further release and discharge Orlando Body and Movement Therapy, whether caused by the fault of myself, my family, Orlando Body and Movement Therapy, or other third parties.**
3. **I agree to indemnify and defend Orlando Body and Movement Therapy against all claims, causes of action, damages, judgments, costs or expenses, including attorney fees and other litigation costs, which may in any way arise from my or my family's use of or presence upon the facilities or Orlando Body and Movement Therapy.**
4. **I agree to pay for all damages to the facilities of Orlando Body and Movement Therapy caused by my or my family's negligent, reckless, or willful actions.**
5. **Any legal or equitable claim that may arise from participation in the above shall be resolved under Florida law.**

**I HAVE READ THIS DOCUMENT AND UNDERSTAND IT. I FURTHER UNDERSTAND THAT BY SIGNING THIS RELEASE, I VOLUNTARILY SURRENDER CERTAIN LEGAL RIGHTS.**

_____ _____

**Signature** **Date**

_____ _____

**(Print) Name** **Date of Birth**

_____

**Address** **City** **State** **Zip Code**

_____ _____

**Primary Phone** **Work/Secondary Phone**

_____ _____

**In case of emergency (Relationship)** **Emergency contact phone**

# INFORMED CONSENT OF MANIPULATION WITHOUT DIAGNOSTIC IMAGING

Orlando Body & Movement Therapy does not maintain an X-Ray unit at this facility. X-Ray and other diagnostic imaging studies (MRI, CT, etc.) are not absolutely necessary for spinal and/or joint manipulation to be performed, but can be helpful to better visualize a particular area. It is our policy that all clinic patients be examined to determine if X-Rays are necessary prior to any spinal and/or joint manipulation. If any further diagnostic studies (X-Ray, MRI, CT scan, etc.) are deemed necessary by the physician we will direct you to Sand Lake Imaging Center or another appropriate imaging center of your choosing.

If you have any reservations regarding having X-Rays taken or any other imaging procedure please discuss this with the doctor on staff. Alternatively if you have any reservations regarding receiving spinal and/or joint manipulation without first having taken X-Rays of the area of concern please discuss this with the doctor on staff before signing this form.

By signing this form below you are acknowledging that you have been informed of our policies regarding utilizing diagnostic imaging studies in this facility and your rights to accept or refuse any diagnostic imaging study as well as any spinal and/or joint manipulation. Furthermore you acknowledge that you accept any risks involved in having spinal and/or joint manipulation without having prior diagnostic imaging. You have the right to refuse individual procedures without the risk of hindering any further treatment.

| | | |
|---|---|---|
| Patient Signature | Patient Printed Name | Date |

# Informed Consent

Orlando Body & Movement Therapy is dedicated to helping you regain and maintain control of your health through a holistic approach combining fitness with sports therapy modalities. We will provide you with superior care without the use of drugs or surgery. Our methods are 100% percent natural and based on years of training and experience. We utilize several therapeutic modalities to achieve outstanding clinical outcomes and results. The therapeutic modalities used in your treatment may include one of more of the following; manual therapy techniques, Micro current Point Stimulation, Chiropractic manipulation, electrical stimulation, ultrasound, nutritional supplementation, and exercise therapy.

Where conventional or "allopathic" medicine focuses on treating illness symptoms through surgery and pharmaceutical drugs, the goal of our facility's treatment is to optimize health with a non-invasive approach that does not use drugs or surgery. The primary avenue of care is manual therapy techniques and chiropractic manipulation of the spine to improve the framework of the body. In addition to adjustments, other treatments used by this facility include physical therapy (ice, heat, electrical stimulation, ultrasound,), nutritional recommendations and rehabilitative procedures.

As is the case with all health care interventions, the benefits of care must be weighed against the inherent risks and limitations of receiving treatment. Due to reservations some patients may have regarding chiropractic treatment we feel the need to provide the following information. Chiropractic treatments are one of the safest interventions available to the public as evidenced by malpractice statistics. While there are risks involved with treatment, these are seldom great enough to contraindicate care. Nonetheless, they must be considered when making the decision on whether or not to receive chiropractic care. Listed below are summaries of some key research articles that have addressed both common and rare side effects/complications associated with chiropractic care.

One research study indicated that with the first 2 months of care approximately half of patients report some "reaction" to chiropractic treatment. Of those who reported a reaction, the following were the most commonly reported reactions to initial chiropractic care:

~Local discomfort (53%) ~Tiredness (11%)
~Headache (12%) ~Radiating discomfort (10%)

Most reactions appeared within 4 hours of treatment and resolved within 24 hours.

Other rare, yet possible side effect/complications:
~ Rib fracture (when osteoporosis is apparent)
~Cauda Equina Syndrome ( 1 case per million adjustments)
~Compromise of the vertebrobasilar artery ( 1 case per approx.. 1 million cervical spine adjustments)

References:
Senstad O, et al. Frequency and characteristics of side effects of spinal manipulative therapy. Spine 1997; 22: 435-41
Shekelle PG, et al. Spinal manipulation for low back pain. Ann Intern Med 1992: 117(7):590-8
Haldeman S, etal. Risk factors and precipitating neck movements causing vertebrobasilary artery dissection after cervical trauma and spinal manipulation. Spine 1999; (24): 785-94
Haldeman S, et al. Guidelines for chiropractic quality assurance and practice parameter. Aspen Publishers, 1997
In addition to national guidelines, our clinic has set criteria for how we manage our patients. Through questioning and examination, we will do our best to determine what risk, if any, chiropractic care may pose to you and advise you of those risks as well as the possible need for medical referral. We may also suggest alternate medical approaches if we detect absolute or relative contraindication to the standard therapeutic treatment.
I have read the previous information regarding risks of chiropractic care and my doctor has explained my risks (if any) to me and suggested alternatives when those risks exist. I understand the purpose of my care and have been given an explanation of the treatment, the frequency of care, and alternatives to this care. All of my questions have been answered to my satisfaction. I agree to this plan of care understanding any perceived risk(s) and alternatives to this care.

| | | |
|---|---|---|
| Patient Signature | Patient Printed Name | Date |
| Parent/Guardian Signature | Parent/Guardian Printed Name | Date |