CONFIDENTIAL PATIENT INFORMATION

Patient ID #: ________________

First Name:__________________________Middle Initial: _____ Last Name: _________________________________

Address:____

City:_______________________________State: _________ Zip Code: ____________

Date of Birth:______________________ Age:_____ Number of Children: _____

SS number: _____________________

Marital Status: ☐ Married ☐ Single Spouse's Name: _________________
(if applicable)

☐ Widow ☐ Divorced

Occupation:___________________________________ Dominant Hand: ☐ Right ☐ Left ☐ Both

Email:________________________@________________.________________

Home#: (___)______-___________Work#: ( ) ____ -_____ ___________Cell#: (___) _______-_________

May we email you? Y / N May we text you? Y / N May we leave a voicemail? Y / N

Emergency Contact:____Contact #: (____)_________-_________

Medications: ____

Health Conditions: ____

Auto Insurance Company:______________________________ Date of Injury _____________________

Auto Insurance Address: ____

Policy Holder (If different than patient): ____

Claim Number/Policy ID: ____

Did you receive treatment anywhere? If so, where? ____

Attorney:____

Attorney Contact#: (_____) _______-________ Contact person: _______________________________

DESCRIPTION OF SYMPTOMS

(INDICATE YOUR SYMPTOMS IN THE SECTIONS BELOW)

Area of Pain:	Which Side?			Type of Pain: *You are welcome to choose from the list of descriptors below*
Headaches ☐ Front of head ☐ Top of head ☐ Back of head	☐ Left	☐ Right	☐ Both Sides	
Jaw	☐ Left	☐ Right	☐ Both Sides	
Eye	☐ Left	☐ Right	☐ Both Sides	
Neck	☐ Left	☐ Right	☐ Both Sides	
Upper Back	☐ Left	☐ Right	☐ Both Sides	
Mid Back	☐ Left	☐ Right	☐ Both Sides	
Low Back	☐ Left	☐ Right	☐ Both Sides	
Chest	☐ Left	☐ Right	☐ Both Sides	
Abdomen	☐ Left	☐ Right	☐ Both Sides	
Ribs	☐ Left	☐ Right	☐ Both Sides	
Buttocks	☐ Left	☐ Right	☐ Both Sides	
Shoulder	☐ Left	☐ Right	☐ Both Sides	
Upper Arm	☐ Left	☐ Right	☐ Both Sides	
Forearm	☐ Left	☐ Right	☐ Both Sides	
Hand	☐ Left	☐ Right	☐ Both Sides	
Knee	☐ Left	☐ Right	☐ Both Sides	
Hip	☐ Left	☐ Right	☐ Both Sides	
Leg	☐ Left	☐ Right	☐ Both Sides	
Foot	☐ Left	☐ Right	☐ Both Sides	

Common Descriptors of Pain:

Dull	Sharp	Aching	Cutting	Shocking
Throbbing	Burning	Numbing	Tingling	Cramping
Spasm	Stinging	Shooting	Pounding	Constricting

Patient Name:____________________________ ID#____________ Date:_________________

PATIENT'S STATEMENT OF PRIVACY RIGHTS

Patient Name:__________________________ Date: __________

As a patient of this practice, you have the right to privacy of your Personal Health Information, and to know that such information shall be properly and securely maintained by this practice, in accordance with our own policy and in compliance with the Health Information Accountability and Portability Act of 1996 (HIPAA). HIPPA was enacted to give you, the patient of a health care provider and covered under a health insurance claim, more control over your health information, to set boundaries on the use and release of health records, establish appropriate safeguards that health care providers and others must achieve to protect the privacy of Personal Health Information, and to hold violators accountable, with appropriate penalties for violation of a patient's right to privacy.

This notice takes effect on_____________________and remains in effect until we replace it.

AS A PATIENT OF THIS PRACTICE:

1. You are entitled to an individually delivered, written notification of your Privacy Rights at the time of your first visit to this practice's facility. The document you are reading is this notice. PLEASE REVIEW TO CAREFULLY.
2. You are entitled to see your medical records.
3. You are entitled to receive a copy of your medical records. (Forms are available upon request.) As per allowance by HIPAA the charge will be $0.10 per page.
4. You are entitled to make an amendment to your patient health information within those records. (Forms are available upon request.)
5. While the doctor has a right to deny inclusion of amendments into a patient file, you gave the right to disagree with the doctor's refusal of such inclusion of amendment to those records. (Forms are available upon request.) If the doctor disagrees, he shall supply you with written notification of such disagreement.
6. The doctor has a right to a rebuttal to the patient's disagreement. But any time a file is sent out of the office, a copy of that rebuttal must be included in the file.
7. You have the right to specify how access to your health information is restricted and from whom.
8. You have the right to indicate the method and/or phone numbers and/or addresses to which telephonic and written communications to you shall be forwarded.
9. All covered entities under HIPAA, such as this practice or other health care providers, or business associated such as billing companies or claims administrators, as are designated by the HIPAA Privacy Rule, and with whom this practice must work on your behalf from the standpoint of effective treatment or billing of medical services and administration of such services, shall be part of a "chain of trust" under applicable with those parties. This means that those parties are bound to maintain the same privacy and security of your health information, as are we.
10. No personal health information shall be released to any person without a signed consent from patient.
11. You are entitled to this practice's best efforts to maintain the security of Personal Health Information on your behalf within and outside this office.
12. The practice shall provide Personal Health Information to require parties on the basis of the minimum necessary standard of release (releasing only that information necessary for those parties to provide treatment, reimbursement, or administrative services on your behalf) and so as to maintain the intent of HIPAA in establishing that standard.
13. You have the right to inquire of this office and gain correct and appropriate answers to any questions regarding your privacy rights at any time, consistent with those rights as covered by HIPAA.
14. You have the right to contact the Depart of Health and Human Services, Office of Civil Rights, which administrates HIPAA, with questions or to file a complaint at Toll Free: 1-877-696-6775 or Email: www.hhs.gov/ocr.

PATIENT'S AFFIRMATION OR RECEIPT OF PATIENT'S STATEMENT OF PRIVACY RIGHTS

ACKNOWLEDGEMENT FORM

I have received this office's Statement of Privacy Rights, provided on my behalf and in accordance with law, and have read and understand my rights to privacy and security of Personal Health Information, as a patient of this practice.

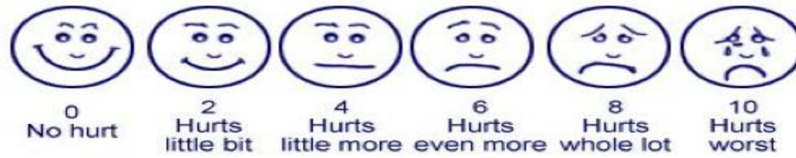
Affirmed,

Print Name:______________________________

Birth Date:______________________________

Signature:______________________________

PLEASE SPECIFY IN CIRCLED AREAS PAIN



Front **Back**

Be **VERY** specific when describing radiating pain, numbness, or tingling.

RIGHT **LEFT** **LEFT** **RIGHT**

Name:______________________________________ Date: ____________

CAPABILITY INDEX

ACTIVITIES OF DAILY LIVING	DO YOU NEED ASSISTANCE TO:	
Dressing	Put on a shirt? Yes ☐ ☐ No	
	Put on pants? Yes ☐ ☐ No	
Grooming	Shower/wash hair? Yes ☐ ☐ No	
	Shave face or body? Yes ☐ ☐ No	
Walking	Affected? Yes ☐ ☐ No	
	Help needed? Yes ☐ ☐ No	
How long can you walk without pain?	________ min(s)	
Sitting	Affected? Yes ☐ ☐ No	
	Help needed? Yes ☐ ☐ No	
How long can you walk without pain?	________ min(s)	
Standing	Affected? Yes ☐ ☐ No	
	Help needed? Yes ☐ ☐ No	
How long can you walk without pain?	________ min(s)	
Sitting to Standing	Affected? Yes ☐ ☐ No	
	Help needed? Yes ☐ ☐ No	
Painful In/out of bed	Affected? Yes ☐ ☐ No	
	Help Needed? Yes ☐ ☐ No	
Lifting	Affected? Yes ☐ ☐ No	
	Help needed? Yes ☐ ☐ No	
Maximum lifted weight	________	
Driving	Affected? Yes ☐ ☐ No	
	Help needed? Yes ☐ ☐ No	
How long can you drive without pain?	________ min(s) / hr(s) (Please circle one)	
Child Care: Activities *(if applicable)*	Affected? Yes ☐ ☐ No	
	Help needed? Yes ☐ ☐ No	
Duration	________ min(s) / hr(s) (Please circle one)	

Name: ____________________

DOB: ________________

Housework

Any issues...

Sweeping?

____

____

Does it require more time to complete? Yes ☐ ☐ No

Washing dishes?

____

____

Does it require more time to complete? Yes ☐ ☐ No

Doing laundry?

____

____

Does it require more time to complete? Yes ☐ ☐ No

Sleeping

Affected? Yes ☐ ☐ No

How long do you sleep at night?

____

Where do you sleep?

____

How long do you sleep without waking up in pain?

____

Interruptions? Yes ☐ ☐ No

____

CAPABILITY INDEX

Exercise

Affected? Yes ☐ ☐ No

Help needed? Yes ☐ ☐ No

Duration without pain:________________min(s)
(Please circle one)
hr(s)

Types of Exercise:

☐ Swimming ☐ Running ☐ Bicycling

☐ Dancing ☐ Golf ☐ Bowling

☐ Walking ☐ Hiking ☐ Yoga

☐ Martial arts ☐ Lifting weights

Additional Exercise:

____

____

____

Job Description

Occupation:________________________________

Duration:________________________________hr(s)

Frequency:________________________________day(s)

Typical Activities:

☐ Driving a car

☐ Driving a truck

Transmission type:
(if applicable)

☐ Manual

☐ Automatic

☐ Typing ☐ Lifting

☐ Twisting ☐ Standing

Additional Activities :

____

____

____

By signing below, I certify all information is true and correct to the best of my knowledge.
I understand that it is my responsibility to inform the doctor if there are any changes in my health.
I hereby authorize North Florida Rehab and Chiropractic LLC to utilize this information provided to perform the necessary services.

____ ______________________

Patient's Signature (or Guardian's Signature) **Date**

____

Print Patient's Name (or Print Guardian's Signature)

AUTOMOBILE ACCIDENT DESCRIPTION

Please answer the questions below.
If you do not know the answer to any of the questions, do not answer the question.

Your Vehicle Type

☐ Car ☐ Station Wagon
☐ Van ☐ Pickup Truck
☐ Large Truck Bus
☐ Other: ____________

Your Position in Vehicle

☐ Driver ☐ Front Passenger
☐ Left Rear Passenger
☐ Right Rear Passenger
Other: ____________

What was your vehicle doing at the time of the accident?

☐ Stopped at intersection ☐ Slowing Down
☐ Stopped in traffic ☐ Proceeding Along
☐ Stopped at Light ☐ Parking
☐ Making Right Turn ☐ Accelerating
☐ Making Left Turn
Other: ____________

Time of Accident: ____________

Your vehicle's speed: ____________ MPH

Their vehicle's speed: ____________ MPH

Damage to your vehicle

☐ Mild ☐ Moderate
☐ Totaled

Visibility at time of accident

☐ Poor ☐ Fair ☐ Good

Who hit who / what?

☐ You hit other vehicle
☐ Other vehicle hit you

You hit... (object)

____

____

Road Conditions at time of accident

☐ Icy ☐ Wet ☐ Sandy ☐ Dark ☐ Clean and dry

Point of impact

☐ Head-On ☐ Left Front ☐ Right Front
☐ Rear-End ☐ Left Rear ☐ Right Rear

	Yes	No
Did you see the accident coming?	Yes ☐	☐ No
Were you braced for the impact?	Yes ☐	☐ No
Did you have a seat belt on?	Yes ☐	☐ No
Did you have a shoulder harness on?	Yes ☐	☐ No
Does your vehicle have headrests?	Yes ☐	☐ No

What was the position of your headrest at the time of impact?

☐ Even with top of head ☐ Even with bottom of head ☐ Middle of neck

What was the direction of your head at the time of impact?

☐ Facing straight forward ☐ Turned to the right ☐ Turned to the left

Did driver side air bags deploy? Yes ☐ ☐ No Did passenger side air bags deploy? Yes ☐ ☐ No Did side air bags deploy? Yes ☐ ☐ No

8. Accident Description:

____

____

9. Have you ever been in an auto accident before? ____________ If yes, when, and where did you treat? ____________

____

10. What were your injuries? ____________

____

11. Any previous surgeries or fractures? What? When? ____________

____

Patient Signature: ____________ Date: ____________