AMERICAN FAMILY & SPORTS CHIROPRACTIC CENTER, INC.

Dr. Elizabeth J. Hennighan

PATIENT REGISTRATION

PATIENT #:_____

NAME: _____DATE: _____E-Mail_____

ADDRESS: _____CITY/STATE/ZIP:_____

Residence and mailing

HOME TELEPHONE ( ) _____CELL ( ) _____NO. OF CHILDREN___AGES _____

BIRTHDATE_____ AGE__MALE__FEMALE__SOCIAL SECURITY #_____MARITAL STATUS_____

OCCUPATION_____EMPLOYER_____ WORK ( ) _____

ADDRESS_____ NAME OF SPOUSE/PARENT _____

SPOUSE'S OCCUPATION_____SPOUSE EMPLOYER_____

RESPONSIBLE PARTY: (IF PARENT PLEASE FILL OUT ABOVE LINES)_____

REFERRED BY: YELLOWPAGES___SIGNBOY___INTERNET___OTHER_____

REASON FOR CONSULTING OUR OFFICE_____

YOUR HEALTH PROFILE

WHY THIS FORM IS IMPORTANT

As a **full** spectrum Chiropractic office, we focus on your ability to be healthy. Our goals are, first, to address the issues that brought you to this office, and second, to offer you the opportunity of improved health potential and wellness services in the future. On a daily basis we experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential. Most the times the effects are gradual; not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your health potential.

THE BEGINNING YEARS (To Age 17)

Research is showing that many of the health challenges that occur later in life have their origins during the developmental years, some starting at birth. Please answer the following questions to the best of your ability.

YOUR CHILDHOOD YEARS	YES	NO	UNSURE
Did you have any childhood illnesses?	○	○	○
Did you have any serious falls?	○	○	○
Did you play youth sports?	○	○	○
Did you take/use any drugs?	○	○	○
Did you have any surgery?	○	○	○
Have you fallen/jumped from a height over three feet? (i.e. crib, bunk bed, trees)?	○	○	○
Were you involved in any accidents? (i.e. automobile, sports, bikes)?	○	○	○

	YES	NO	UNSURE
Was there any prolonged use of medicine such as antibiotics or an inhaler?	○	○	○
Did you suffer any other traumas (physical or emotional)	○	○	○
Were you vaccinated?	○	○	○
As a child, were you under regular Chiropractic care?	○	○	○

COMMENTS:

_____

If you are accepted as a patient you are expected to pay at the end of each visit unless prior arrangements are approved. Returned checks will be subject to service fees in accordance with the Laws of the State of Florida, with a minimum charge of $25.00. There is a $25.00 fee for missed appointments without 24 hours notice of cancellation. This office will gladly prepare medical claim forms, but we cannot render services on the assumption that our charges will be paid by an insurance company. You are responsible for payment whether or not paid by insurance. Responsible Party agrees to pay for all attorney fees and collection costs necessary to collect fees and expenses.

_____ _____

Signature **Date**

Addressing the Issues That Brought You to the Office

Please check (√) here ____ If you have no symptoms or complaints, and are here for continuous wellness services, then skip to Family Health Profile.

Others need to briefly describe the chief area of complaint, including the effect it has had on your life.

_____

_____

If you are experiencing pain, is it….. ( ) Sharp ( ) Dull ( ) Comes and goes ( ) Travels ( ) Constant

Since the problem started, it is…. ( ) About the same ( ) Getting better ( ) Getting worse

What makes it worse: _____

Yes, it interferes with: ( ) Work ( ) Sleep ( ) Walking ( ) Sitting ( ) Hobbies ( ) Leisure

( ) Other _____

Other Doctors: Primary: _____ Other Chiropractor _____ Orthopedic: _____

Was it regarding the problem brought to us today: ____ List any Surgeries you have had: _____

List any X-rays or MRI's taken in the past year including where _____

_____

(√) all symptoms you have ever had, even if they do not seem related to your current problem.

( ) Headaches	( ) Pins and needles in legs	( ) Fainting	( ) Neck Pain
( ) Pins and Needles in arms	( ) Buzzing in ears	( ) Back Pain	( ) Loss of Balance
( ) Dizziness	( ) Ringing in ears	( ) Nervousness	( ) Lights bother eyes
( ) Numbness in fingers	( ) Numbness in toes	( ) Loss of taste	( ) Tension
( ) Fatigue	( ) Depression	( ) Cold Hands	( ) Cold Feet
( ) Sleeping problems	( ) Stiff Neck	( ) Menstrual Irregularity	( ) Mood Swings
( ) Menstrual Pain			

What alleviates the pain:

_____

Family Health Profile:

At our office we are not only interested in your health and well-being, but also the health and Well-being of your family. Please mention below any health conditions or concerns you may have about your:

Children _____ **Spouse** _____

Mother _____ **Father** _____

Other _____

If you are accepted as a patient you are expected to pay at the end of each visit unless prior arrangements are approved. Returned checks will be subject to service fees in accordance with the Laws of the State minimum charge of $25.00. THIS OFFICE WILL GLADLY PREPARE MEDICAL CLAIM FORMS, BUT WE CANNOT RENDER SERVICES ON THE ASSUMPTION THAT OUR CHARGES WILL BE PAID BY AN INSURANCE COMPANY. YOU ARE RESPONSIBLE FOR PAYMENT WHETHER OR NOT PAID BY INSURANCE. Responsible party agrees to pay for all attorney fees, collection fees and expenses.

I authorize the release of any medical information necessary to process the claim and request payment of insurance benefits either to myself or the party who accepts assignment below.

Signed_____ Date_____

CONSENT TO TREATMENT OF MINOR

I hereby authorize Elizabeth Hennighan, D.C. and whomever she may designate as her assistants to administer treatment(s) as she so deems necessary till said person is 18yrs of age. Minors Name:_____, Relationship:_____.

Dated at Port Orange, FL., on this _____day of _____, 20_____.

Signed_____

MEDICARE WAIVER

Manual manipulation of the spine (98940-98942) is the only covered chiropractic service allowed by law to be reimbursed by Medicare. All other services rendered to the beneficiary are their financial responsibility. If Medicare determined that a particular service, although it would be otherwise covered, is not "reasonable and necessary" under Medicare program standards (12-24 manipulations per year), Medicare will deny payment for that service. Manual spinal manipulations are only covered under the Medicare program for certain conditions that Medicare deems medically reasonable and necessary.

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation:

_____ _____

Signature **Date**

Am Chiro
Review of Systems

Patient Name: _____ Today's Date: _____

Please check the signs and/or symptoms related to the following body systems you now have or have experienced in the past.

CONSTITUTIONAL
- ☐ Deny All
- ☐ Chills
- ☐ Drowsiness
- ☐ Fainting
- ☐ Fatigue
- ☐ Fever
- ☐ Night Sweats
- ☐ Weakness
- ☐ Weight Gain
- ☐ Weight Loss

EYES
- ☐ Deny All
- ☐ Blindness
- ☐ Blurred Vision
- ☐ Cataracts
- ☐ Change in Vision
- ☐ Double Vision
- ☐ Dry Eyes
- ☐ Eye Pain
- ☐ Field Cuts
- ☐ Glaucoma
- ☐ Sensitivity to Light
- ☐ Tearing
- ☐ Wears Glasses

CARDIOVASCULAR
- ☐ Deny All
- ☐ Angina
- ☐ Chest Pain
- ☐ Claudication
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Orthopnea
- ☐ Palpitations
- ☐ Shortness of Breath
- ☐ Swelling of Legs
- ☐ Varicose Veins

RESPIRATORY
- ☐ Deny All
- ☐ Asthma
- ☐ Bronchitis
- ☐ Dry Cough
- ☐ Productive Cough
- ☐ Coughing up Blood
- ☐ Difficulty Breathing
- ☐ Difficulty Sleeping
- ☐ Hemoptysis
- ☐ Pneumonia
- ☐ Sputum Production
- ☐ Wheezing

MUSCULOSKELETAL
- ☐ Deny All
- ☐ Arthritis
- ☐ Neck Pain
- ☐ Decreased Motion
- ☐ Gout
- ☐ Injuries
- ☐ Joint Pain
- ☐ Joint Stiffness
- ☐ Locking Joints
- ☐ Back Pain
- ☐ Muscle Cramps
- ☐ Muscle Pain
- ☐ Muscle Twitching
- ☐ Muscle Weakness
- ☐ Swelling

INTEGUMENTARY
- ☐ Deny All
- ☐ Breast Lumps / Pain
- ☐ Change in Nail Texture
- ☐ Change in Skin Color
- ☐ Eczema
- ☐ Hair Growth
- ☐ Hair Loss
- ☐ History of Skin Disorders
- ☐ Hives
- ☐ Itching
- ☐ Paresthesia
- ☐ Rash
- ☐ Skin Lesions

GASTROINTESTINAL
- ☐ Deny All
- ☐ Abdominal Pain
- ☐ Belching
- ☐ Black, Tarry Stools
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Jaundice
- ☐ Nausea
- ☐ Rectal Bleeding
- ☐ Abnormal Stool Caliber
- ☐ Abnormal Stool Color
- ☐ Abnormal Stool Consistency
- ☐ Vomiting
- ☐ Vomiting Blood

GENITOURINARY
- ☐ Deny All
- ☐ Birth Control Therapy
- ☐ Burning Urination
- ☐ Cramps
- ☐ Erectile Dysfunction
- ☐ Frequent Urination
- ☐ Hesitancy / Dribbling
- ☐ Hormone Therapy
- ☐ Irregular Menstruation
- ☐ Lack of Bladder Control
- ☐ Prostate Problems
- ☐ Urine Retention
- ☐ Vaginal Bleeding
- ☐ Vaginal Discharge

ENMT
- ☐ Deny All
- ☐ Bad Breath
- ☐ Dentures
- ☐ Deviated Septum
- ☐ Difficulty Swallowing
- ☐ Discharge
- ☐ Dry Mouth
- ☐ Ear Drainage
- ☐ Ear Pain
- ☐ Frequent Sore Throats
- ☐ Head Injury
- ☐ Hearing Loss
- ☐ Hoarseness
- ☐ Loss of Smell
- ☐ Loss of Taste
- ☐ Nasal Congestion
- ☐ Nose Bleeds
- ☐ Post Nasal Drip
- ☐ Sinus Infections
- ☐ Runny Nose
- ☐ Snoring
- ☐ Sore Throat
- ☐ Ringing in Ears
- ☐ TMJ Problems
- ☐ Ulcers

NEUROLOGICAL
- ☐ Deny All
- ☐ Change in Concentration
- ☐ Change in Memory
- ☐ Dizziness
- ☐ Headache
- ☐ Imbalance
- ☐ Loss of Consciousness
- ☐ Loss of Memory
- ☐ Numbness
- ☐ Seizures
- ☐ Sleep Disturbance
- ☐ Slurred Speech
- ☐ Stress
- ☐ Strokes
- ☐ Tremors

PSYCHIATRIC
- ☐ Deny All
- ☐ Agitation
- ☐ Anxiety
- ☐ Appetite Changes
- ☐ Behavioral Changes
- ☐ Bipolar Disorder
- ☐ Confusion
- ☐ Convulsions
- ☐ Depression
- ☐ Homicidal Indication
- ☐ Insomnia
- ☐ Location Disorientation
- ☐ Memory Loss
- ☐ Substance Abuse
- ☐ Suicidal Indication
- ☐ Time Disorientation

ENDOCRINE
- ☐ Deny All
- ☐ Cold Intolerance
- ☐ Diabetes
- ☐ Excessive Appetite
- ☐ Excessive Hunger
- ☐ Excessive Thirst
- ☐ Goiter
- ☐ Hair Loss
- ☐ Heat Intolerance
- ☐ Unusual Hair Growth
- ☐ Voice Changes

HEMATOLOGIC / LYMPHATIC
- ☐ Deny All
- ☐ Anemia
- ☐ Bleeding
- ☐ Blood Clotting
- ☐ Blood Transfusions
- ☐ Bruise Easily
- ☐ Lymph Node Swelling

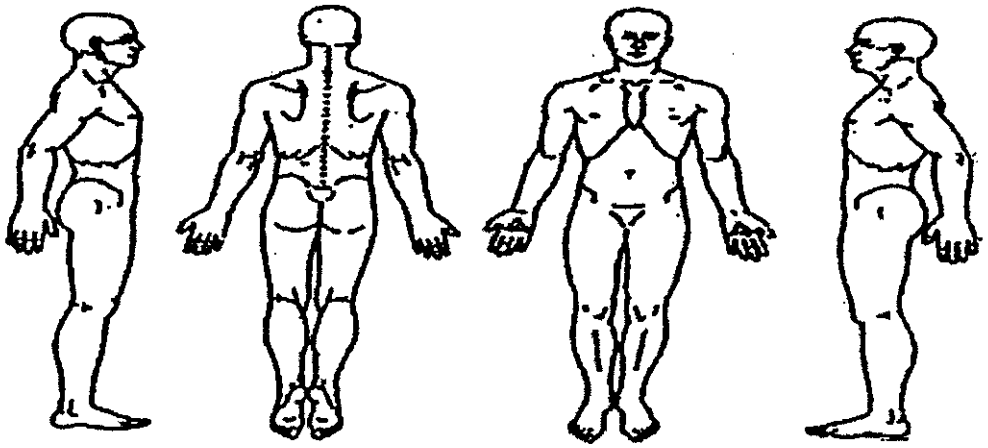
ALLERGIC / IMMUNOLOGIC
- ☐ Deny All
- ☐ History of Anaphylaxis
- ☐ Itchy Eyes
- ☐ Sneezing
- ☐ Specific Food Intolerance

PATIENT INTAKE FORM

Patient Name: _____ Date: _____

1. Is today's problem caused by: ◻ Auto Accident ◻ Workman's Compensation

2. Indicate on the drawings below where you have pain/symptoms



3. How often do you experience your symptoms?

◻ Constantly (76-100% of the time) ◻ Occasionally (26-50% of the time)
◻ Frequently (51-75% of the time) ◻ Intermittently (1-25% of the time)

4. How would you describe the type of pain?

◻ Sharp ◻ Numb
◻ Dull ◻ Tingly
◻ Diffuse ◻ Sharp with motion
◻ Achy ◻ Shooting with motion
◻ Burning ◻ Stabbing with motion
◻ Shooting ◻ Electric like with motion
◻ Stiff ◻ Other:_____

5. How are your symptoms changing with time?

◻ Getting Worse ◻ Staying the Same ◻ Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (*Please circle*)

7. How much has the problem interfered with your work?

◻ Not at all ◻ A little bit ◻ Moderately ◻ Quite a bit ◻ Extremely

8. How much has the problem interfered with your social activities?

◻ Not at all ◻ A little bit ◻ Moderately Quite a bit ◻ Extremely

9. Who else have you seen for your problem?

◻ Chiropractor ◻ Neurologist ◻ Primary Care Physician
◻ ER physician ◻ Orthopedist ◻ Other:_____
◻ Massage Therapist ◻ Physical Therapist ◻ No one

10. How long have you had this problem? _____

11. How do you think your problem began?

_____

12. Do you consider this problem to be severe?

◻ Yes ◻ Yes, at times ◻ No

13. What AGGRAVATES, and what ALLEVIATES your problem._____

_____

14. What concerns you the most about your problem; what does it prevent you from doing?

_____

American Family & Sports Chiropractic Center, Inc.

4649 S. Clyde Morris Blvd. Suite 609
Port Orange, Florida 32129
Elizabeth J. Hennighan, D.C.

Patient Authorization regarding chiropractic care being provided in an "Open-Door" adjusting environment

An "Open-Door" approach involves the doctor moving from patient care area to patient care are and leaving the doors between patient care areas open. As a result patients are occasionally within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and is NOT the environment used for taking patient histories, performing examinations, or presenting reports of findings. These procedures are completed in a private and confidential setting.

We are requesting this authorization of you due to various interpretations under federal law with respect to what is known as an "incidental disclosures" of health information. It is our view that the kinds of matters related in an "open-door" environment are incidental matters, in the event you or someone else would not agree with us we are providing this disclosure and requesting your authorization.

The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care. If you choose not to be adjusted in an "open-door" environment other arrangements will be made for you. Your decision will have no adverse effect on your care from American Chiropractic Center or on your relationship with our staff.

Your signature indicates your authorization of this activity.

Print Name: _____

Signature: _____ Date: _____

General Release Form

This authorization may be revoked by you at anytime. Revocation may be accomplished by advising us in writing of you desire to withdraw your authorization. Please allow a reasonable processing time for the change in our procedures to be completed.

I authorize the release of any medical information necessary to process the claim and request payment of insurance benefits either to myself or the party who accepts assignment.

I assign, transfer and convey to Elizabeth Hennighan, D.C. medical insurance benefits to which I may be entitled according to my policy or insurance from services rendered.

I authorize American Family Chiropractic Center to photocopy this release to expedite insurance billing for a period of up to two years from the date of this release.

Your signature indicates your authorization of this activity.

Print Name: _____

Signature: _____ Date: _____

American Family & Sports Chiropractic Center, Inc.

Elizabeth J. Hennighan, D.C.
4649 S. Clyde Morris Blvd. Suite 609
Port Orange, Florida 32129
Phone (386)760-6150 Fax (386)788-1998
www.americanchirocenter.com

INFORMED CONSENT FOR CHIROPRACTIC TREATMENT

American Family & Sports Chiropractic Center, Inc.

I hereby request and consent to the performance of chiropractic treatments (also known as chiropractic adjustments or chiropractic manipulative treatments) and any other associated procedures: physical examination, tests, diagnostic x-rays, physio therapy, physical medicine, physical therapy procedures, etc. on me by the doctor of chiropractic named above and/or other assistants and/or licensed practitioners.

I understand, as with any health care procedures, that there are certain complications, which may arise during chiropractic treatments. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, Homers' syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to complications including stroke.

I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, that are in my best interest.

I have had an opportunity to discuss the nature, purpose and risks of chiropractic treatments and other recommended procedures. I have had my questions answered to my satisfaction. I also understand that specific results are not guaranteed.

If there is any dispute about my care, I agree to a resolution by binding arbitration according to the American Arbitration Association guidelines.

I have read (or have had read to me) the above explanation of the chiropractic treatments. I state that I have been informed and weighed the risks involved in chiropractic treatment at this health care office. I have decided that it is in my best interest to receive chiropractic treatment. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition(s) and for any future conditions(s) for which I seek treatment.

Sign only after you understand and agree to the above.

_____
Printed name of Patient

x_____ _____
Signature of Patient Date

x_____ _____
Signature of Representative Date
(If patient is a minor or is handicapped)

x_____ _____
Witness to Patient's Signature Date

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Terms of Acceptance

When a patient seeks chiropractic health care, and when a chiropractor accepts a patient for such care, it is essential for both to be working towards the same objective.
Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. In this way there will be no confusion, misunderstanding, or disappointment.

Vertebral Sublaxation is a misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses resulting in a lessening of the body's innate ability to express its maximum health potential.

Adjustment is the specific application of forces to facilitate the body's correction of vertebral sublaxation. Our chiropractic method of correction is by specific adjustment of the spine.

Health is a state of optimal physical, emotional, and spiritual well-being, not merely the absence of disease or infirmity.

We do not offer to diagnose or treat any disease or condition other that vertebral sublaxation. However, if during the course of chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of the disease the chiropractor is not offering to heal, treat, or cure it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral sublaxation.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction.

I have read the above, understand it fully, and accept chiropractic care on this basis.

_____ _____

Patient or Guardian Signature **Date**

American Family & Sports Chiropractic Center, Inc.
Elizabeth J. Hennighan, D.C.
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Port Orange, FL 32129
PH: (386) 760-6150
FAX: (386) 788-1998

NOTICE OF PRIVACY PRACTICES

Protecting the privacy of your personal health information is important to us. This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment, or practice operations will be made only after obtaining your consent. You may request restrictions on disclosures.

Disclosures of protected health information are limited to the minimum necessary for the purpose of the disclosure. This provision does not apply to the transfer of medical records for treatment.

You may inspect and receive copies of your records within 30 days of a written request. There may be a reasonable cost-based fee for photocopying, postage and preparation.

You may request changes to your records. Our practice has the right to accept or deny your request.

We maintain a history of protected health information disclosures that is accessible to you.

In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff.

Our practice is required to abide by this notice. We have the right to change this notice in the future. Any revisions will be prominently displayed in a clearly visible location in our office.

Print Name: _____

Signature: _____ Date: _____

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

Patient Authorization

It is our desire for our staff to use your name for the purpose of testimonials, thank you board, appointment reminders, scheduling related matters, and contact by phone or mail regarding chiropractic care, related health services and/or related health products. Your signature indicates your authorization of this activity.

_____ _____

Patient Name (please print) Signature

_____ _____

Parent, Guardian or Patient's legal representative Date

The use of this information is intended to make your experience with our office more efficient and productive. If you choose not to authorize this information your decision will have no adverse effect on your care from American Family & Sports Chiropractic Center or on your relationship with our staff. This authorization may be revoked by you at anytime. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for change in our system.

Thank you

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.

American Family & Sports Chiropractic Center, Inc.
4649 Clyde Morris Blvd. Unit 609
Port Orange, FL 32129
PH: (386) 760-6150
FAX: (386) 788-1998

RELEASE OF PATIENT RECORDS AUTHORIZATION

I hereby authorize _____ to release a copy of my patient records or x-rays containing protected health information to American Family & Sports Chiropractic Center, Inc. This authorization is given pursuant to Florida Statute 456.057 and HIPAA regulations. I understand that Florida Statute 456.057 (10) 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 Name (Print)

_____
Patient or Legal Representative's Signature

_____
Patient's SSN

_____
Patient's Date of Birth

_____
Date Signed

Specific description of information to be disclosed:

_____
_____
_____
_____
_____
_____
_____
_____