ORLANDO SPORTS CHIROPRACTIC

7513 West Sand Lake Road ♦ Orlando, FL 32819

PHONE 407-345-8686 FAX 407-345-8626

www.orlandosportschiropractic.com

Chiropractic · Massage · Acupuncture · Nutrition · Chinese Medicine · Exercise Therapy

PERSONAL INFORMATION

Full Name _____ Nickname_____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ext._____

Cell Phone _____ Email _____

Height: _____ Weight: _____ Sex ☐ M ☐ F Age _____ Birthday _____/_____/_____

Marital Status ☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Widowed **Children**: #: _____ Ages: _____

Hand Dominance ☐ Right ☐ Left **Race** ☐ Caucasian ☐ African-American ☐ Hispanic ☐ Asian ☐ Other _____

Employer: _____ Occupation:_____ Level of Education: _____
☐ F/T ☐ P/T ☐ Seasonal ☐ F/T student ☐ P/T student

Have you been to a Chiropractic Office before? ☐ Yes ☐ No If yes, how long ago? _____

How did you hear about our office?
☐ Referring Physician: _____ ☐ Another patient: _____ ☐ Online: _____
☐ Health Fair/Sports Event: _____ ☐ Other _____

Emergency Contact Name _____ Phone _____

Has any family member been seen in this office? ☐Yes ☐No Family member name: _____

REASON FOR VISIT

☐ New Injury:
_____
_____

☐ Chronic Condition:
(*Please fill-out next page)*

☐ Wellness Check-up
(Please skip next page and continue with medical history)

GOAL OF TREATMENT

☐ Relief from pain
☐ Get back to normal day-to-day
☐ Be able to work
☐ Get back to exercising
☐ Get back to sport
☐ Improve Posture
☐ Improve Sports Performance
☐ Wellness
☐ Other: _____

ACCOUNT INFORMATION

PERSON RESPONSIBLE FOR THIS ACCOUNT

Name: _____ Relationship: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

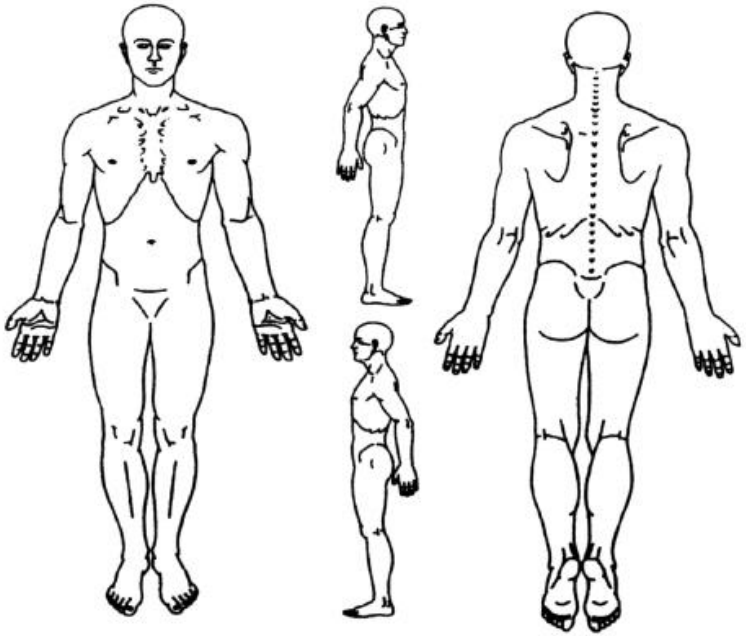
Payment Method: ☐ Cash ☐ Check ☐ Credit Card ☐ Care Credit

FEES ARE PAYABLE WHEN SERVICES ARE RENDERED UNLESS OTHER ARRANGEMENTS ARE MADE. WE ARE REQUIRED TO MAINTAIN ORIGINAL X-RAYS AND RECORDS AS PROPERTY OF THIS CLINIC. X-RAY COPIES ARE AVAILABLE ($25 per disc).

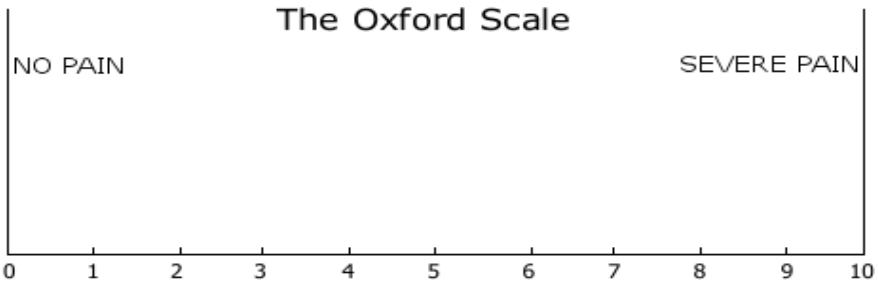
Patient Name: _____ Date: _____

What is your main complaint(s)? _____
When did it begin? _____ Have you had this same or similar pain before? □Yes □No
Is it □getting worse □staying the same □getting better?
Briefly explain what happened: _____
_____

On the diagram below, please show where you are experiencing all of your present complaints using the following letters:
A: ache B: burning C: cramping D: dull R: throbbing N: numbness T: tingling S: stiffness



Please mark on this scale, the severity of your pain:



What treatment have you already received for your current condition?
□ None □ Medications □ Surgery □ Physical Therapy □ Chiropractic □ Acupuncture □ Injections
□ Massage □ Other: _____ Please explain briefly: _____

What makes it better? _____ What makes it feel worse? _____

I understand the above information and guarantee this form was completed to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature: _____ Date: _____

CURRENT SYMPTOM LIST

Name:_____ Date: _____

HEAD:
_____Headaches
_____a. migraine in nature
_____b. back of Head
_____c. sinus (allergy)
_____d. temples
_____e. entire head
Frequency _____ x's per _____
_____ Head feels heavy
_____ Lightheadedness
_____ Fainting
_____ Loss of memory
_____ Eye Strain
_____ Light bothers eyes
_____ Blurred vision
_____ Double vision
_____ Loss of vision
_____ Loss of balance
_____ Dizziness
_____ Loss of hearing
_____ Pain in the ears
_____ Ringing/buzzing in the ear/s
_____ Loss of taste
_____ Loss of smell
_____ Sinus trouble
_____ Jaw pain

NECK:
_____ Neck pain and stiffness
_____ Neck pain
_____ Neck stiffness
_____ Neck pain with movement
____ forward
____ backward
____ turning to the left
____ turning to the right
____ bending to the left
____ bending to the right
_____ Muscle spasms in neck
_____ Grinding sounds in the neck
_____ Arthritis in the neck

SHOULDERS:
_____ Pain in the joint ☐ L ☐ R
_____ Pain across the shoulders
_____ Pain between shoulder blades
_____ Stiffness in shoulder ☐L ☐ R
_____ Tension in the shoulders
_____ Muscle spasms ☐ L ☐ R
_____ Unable to raise arm over head/over shoulder level

ARMS & HANDS:
_____ Pain in the upper arm ☐ L ☐ R
_____ Pain in the elbow ☐ L ☐ R
_____ Tennis elbow ☐ L ☐ R
_____ Pain in forearm ☐ L ☐ R
_____ Pain in hands ☐ L ☐ R
_____ Pain in fingers ☐ L ☐ R
_____ Sensation of pins and needles in Arms ☐ L ☐ R
_____ Sensation of pins and needles in fingers ☐ L ☐ R
_____ Numbness in arms ☐ L ☐ R
_____ Numbness in hands ☐ L ☐ R
_____ Fingers go to sleep ☐ L ☐ R
_____ Stiffness in fingers ☐ L ☐ R
_____ Hands get cold ☐ L ☐ R
_____ Swollen joints in fingers
_____ Loss of grip strength ☐ L ☐ R

MID-BACK:
_____ Mid-back pain and stiffness
_____ Mid-back pain
_____ Mid-back stiffness
_____ Muscle spasms in mid-back
_____ Pain in kidney area

CHEST:
_____ Chest pain
_____ Shortness of breath
_____ Pain around the ribs
_____ Breast pain
_____ Irregular heartbeat

ABDOMEN:
_____ Nervous stomach
_____ Nausea
_____ Gas
_____ Constipation
_____ Diarrhea
_____ Hemorrhoids

Women Only:
_____ Menstrual pain _____
_____ Menstrual cramping
_____ Irregular periods

Men Only:
_____ Urinary frequency
_____ Difficulty in starting urination
_____ Night urination
_____ Prostate swelling/pain

LOW BACK:
_____ Low back pain and stiffness
_____ Low back pain
_____ Low back stiffness
_____ Muscle spasms in low back

HIPS, LEGS & FEET
_____ Pain in the buttocks ☐ L ☐ R
_____ Pain in the hip joint ☐ L ☐ R
_____ Pain down both leg
_____ Pain down one leg ☐ L ☐ R
_____ Leg cramps ☐ L ☐ R
_____ Knee pain ☐ L ☐ R
_____ inside ☐ L ☐ R
_____ outside ☐ L ☐ R
_____ Pins & needles in legs ☐ L ☐ R
_____ Numbness in legs ☐ L ☐ R
_____ Numbness in feet ☐ L ☐ R
_____ Numbness in toes ☐ L ☐ R
_____ Swollen ankles ☐ L ☐ R
_____ Swollen feet ☐ L ☐ R
_____ Feet feel cold

GENERAL
_____ Anxiety
_____ Nervousness
_____ Irritable
_____ Depression
_____ Fatigue
_____ Generally feel run down
_____ Loss of weight _____lbs
_____ Gain weight _____lbs
_____ Excessive perspiration
_____ Tremors
_____ Other _____

Activities of Daily Living: Check all the activities that you are unable to do or have difficulty with because of this problem.
☐ Sitting ☐ Standing ☐Lifting ☐ Moving Arms ☐ Moving legs ☐ Bending at waist ☐ Carrying ☐ Lying/sleeping ☐ Pulling ☐ Pushing ☐ Kneeling ☐ Twisting or turning back ☐ Twisting or turning neck ☐ Turning over ☐Reaching ☐ Grooming ☐ Dressing ☐Bathing ☐ Going to the bathroom ☐ Recreational activities ☐ Golfing ☐ Sexual relations ☐ Going up/down stairs ☐ Laundry ☐ Household chores/Housework ☐ Cough/ sneeze ☐ Riding in car

Patient Name: _____ Date: _____

Head and Neck

Eyes
- ☐ Burn
- ☐ Itch
- ☐ Watery
- ☐ Dry
- ☐ Blurry
- ☐ Floaters
- ☐ Red Eyes
- ☐ Light Sensitivity
- ☐ Pressure Behind
- ☐ Bags/Dark Circles
- ☐ Swollen
- ☐ Glasses/contacts

Ears
- ☐ Itchy
- ☐ High-pitched Ringing
- ☐ Low-pitched Ringing
- ☐ White Noise
- ☐ Hearing Loss
- ☐ Chronic Ear Infections
- ☐ Drainage
- ☐ Excessive Wax
- ☐ Dizziness/Vertigo

Nose
- ☐ Nasal/Sinus Congestion
- ☐ Sneezing
- ☐ Wheezing
- ☐ Frequent Colds
- ☐ Shortness of Breath
- ☐ Snoring
- ☐ Poor sense of smell
- ☐ Nasal Discharge
  - o Clear
  - o White
  - o Yellow
  - o Green
  - o Blood-tinged
  - o Sticky
  - o Slippery
  - o Watery
  - o Dry
  - o Profuse
  - o Scanty

Mouth/Throat
- ☐ Coughing
  - o Loud/Barking
  - o Weak
- ☐ Gagging (needing to clear throat often)
- ☐ "Lump in Throat"
- ☐ Sore
- ☐ Dry
- ☐ Swollen
  - o Tongue
  - o Gums
  - o Throat
  - o Lips
- ☐ Bleeding Gums
- ☐ Hoarseness
- ☐ Loss of Voice

Integumentary

Hair
- ☐ Normal
- ☐ Dry
- ☐ Falling Out
- ☐ Thinning
- ☐ Premature Greying

Skin
- ☐ Normal
- ☐ Itchy
- ☐ Red
- ☐ Hot
- ☐ Inflamed
- ☐ Dry
- ☐ Acne
- ☐ Hives/Rashes
- ☐ Flushing
- ☐ Excessive Sweating
- ☐ Non-healing wounds
- ☐ Nodules/masses
- ☐ Easy bruising
- ☐ Cancer
- ☐ Scars
- ☐ Skin Condition: _____

Nails
- ☐ Normal
- ☐ Brittle
- ☐ Thickening
- ☐ Yellowing
- ☐ Fungus
- ☐ Ridges
- ☐ Discoloration

CardioVascular System

Heart
- ☐ Irregular/Skipped Heartbeats
- ☐ Rapid/Pounding Heartbeats
- ☐ Chest Pain/Pressure
- ☐ Foot/ankle swelling

Lungs
- ☐ Chest Congestion
- ☐ Asthma
- ☐ Bronchitis
- ☐ Shortness of Breath
- ☐ Difficulty Breathing
- ☐ Frequent Sighing
- ☐ Fatigue

Musculoskeletal
- ☐ Poor Coordination
- ☐ Joint Pains
- ☐ Stiffness
- ☐ Muscle Pains
- ☐ Feeling of weakness
- ☐ Arthritis

Digestive System

Appetite
- ☐ Normal
- ☐ Low
- ☐ Always Hungry
- ☐ Binge eating/drinking
- ☐ Compulsive eating

Thirst
- ☐ Normal
- ☐ No desire
- ☐ Constantly sip
- ☐ Gulp
- ☐ More thirsty at night
- ☐ Dry mouth

Cravings
- ☐ None
- ☐ Sweet
- ☐ Sour
- ☐ Salty
- ☐ Spicy
- ☐ Bitter
- ☐ Crunchy
- ☐ Pica: _____

Symptoms
- ☐ Burping
- ☐ Hiccups
- ☐ Gas
- ☐ Bloating
- ☐ Nausea/Vomiting
- ☐ Acid Reflux
- ☐ Epigastric Pain
- ☐ Indigestion
- ☐ Bad Breath
- ☐ Intestinal/Abdominal Pain
- ☐ Hemorrhoids
- ☐ Ulcers

Bowel & Bladder Function
- ☐ Frequency: _____
- ☐ Consistency
  - o Formed
  - o Loose
  - o Watery
  - o Dry/hard
  - o Soft
  - o Pellet-like
  - o Undigested food in stool
  - o Bloody
  - o Mucous
- ☐ Constipation
- ☐ Diarrhea
- ☐ Alternating constipation/diarrhea
- ☐ Frequent Urination
- ☐ Wake to Urinate
- ☐ Urine Color
  - o Dark yellow
  - o Pale yellow
  - o Clear
  - o Bloody
  - o Cloudy

Metabolism

Sweat
- ☐ Normal
- ☐ Don't sweat
- ☐ Profuse
- ☐ Evening Sweating
- ☐ Night Sweating
- ☐ Easy to sweat

Body Temp
Normal
Constantly Hot
Tend to be cold
Hot in evenings
Chills
Fevers

Energy/Weight
- ☐ Excessive weight
- ☐ Underweight
- ☐ Water Retention
- ☐ Fatique/Sluggish
- ☐ Hyperactivity
- ☐ Restlessness

Energy Level 1-10: _____
Stress Level 1-10: _____
Sources of Stress
- ☐ Work
- ☐ Personal
- ☐ Physical
- ☐ Chemical

Neurological

Mind
- ☐ Poor Memory
- ☐ Confusion
- ☐ Poor Concentration
- ☐ Cloudy Thinking
- ☐ Tremors/Ticks
- ☐ Seizures
- ☐ Fainting
- ☐ Vertigo
- ☐ Stuttering
- ☐ Slurred Speech
- ☐ Difficulty Learning
- ☐ Difficulty making decisions
- ☐ Poor Coordination/balance

Behavioral
- ☐ Teeth/Jaw Clenching
- ☐ Teeth Grinding
- ☐ OCD
- ☐ ADD/ADHD

Emotions
- ☐ Mood Swings
- ☐ Anxiety, Fear, Nervousness
- ☐ Anger, Irritability, Aggressiveness
- ☐ Depression
- ☐ Overthinking
- ☐ Worry
- ☐ Frustration
- ☐ Restlessness

Patient Name: _____ Date: _____

WOMEN ONLY

Medical History

- ☐ Menopausal
- ☐ Endometriosis
- ☐ Infertility
- ☐ Fibrocystic breasts
- ☐ Fibroids/Ovarian cysts
- ☐ Breast Cancer
- ☐ Pelvic Inflammatory Disease
- ☐ Vaginal Infections
- ☐ Bladder Infections
- ☐ Sexually Transmitted Disease
- ☐ D&C
  - o #: _____
- ☐ Hysterectomy
  - o Complete
  - o Partial
- ☐ Uterine Prolapse
- ☐ Incontinence
- ☐ Urgency
- ☐ Difficulty passing urine
- ☐ Pregnancies: _____
- ☐ Births: _____
  - o C-Section: _____
  - o Vaginal: _____
- ☐ Miscarriages _____
- ☐ Abortions: _____
- ☐ Date of last GYN exam: _____
- ☐ Mammogram: Date: _____
- ☐ PAP
- ☐

Menstral Cycle

Age 1st Menses: _____
Cycle: ____ days
Days of Bleeding: ____
Last period: _____

Timing

- ☐ Regular
- ☐ Irregular

Flow

- ☐ Light
- ☐ Moderate
- ☐ Heavy
- ☐ Spotting

Color

- ☐ Pale
- ☐ Bright Red
- ☐ Dark Red
- ☐ Purple
- ☐ Dark Purple
- ☐ Brown

Consistency

- ☐ No clots
- ☐ Small clots
- ☐ Large clots

Pre-Menstral Symptoms

- ☐ Irritability
- ☐ Depression
- ☐ Mood Swings
- ☐ Breast Tenderness
- ☐ Breast Swelling
- ☐ Fatigue
- ☐ Appetite change
- ☐ Bloating

Menstral Pain

Quality

- ☐ Crampy
- ☐ Sharp
- ☐ Dull

Alleviating

- ☐ Heat
- ☐ Massage
- ☐ Passing clot

Location

- ☐ Lower Abdomen
  - o Left
  - o Right
  - o Both
- ☐ Lower Back
  - o Left
  - o Right
  - o Both
- ☐ Hips
  - o Left
  - o Right
  - o Both

Timing/Pattern

- ☐ Fixed/local
- ☐ Moving
- ☐ Constant
- ☐ Intermittent

Pregnant

- ☐ Yes
- ☐ No
- ☐ Not sure

Other _____
_____

Vaginal Discharge

- ☐ Production
  - o Scanty
  - o Moderate
  - o Heavy
- ☐ Consistency
  - o Thin
  - o Thick
- ☐ Color
  - o Clear
  - o White
  - o Yellow

Genital Symptoms

- ☐ Burning
- ☐ Itching
- ☐ Cold
- ☐ Pain
- ☐ Painful intercourse

Birth Control

- ☐ IUD
- ☐ Birth Control Pills
- ☐ Birth Control Shot
- ☐ Birth Control Patch
- ☐ Condoms
- ☐ Abstinence
- ☐ Rhythm Method

Libido

- ☐ Normal
- ☐ Low
- ☐ Excessive

MEN ONLY

Medical History

- ☐ Date of last Prostate exam: _____
- ☐ Stop & Go Urination
- ☐ Difficulty passing urine
- ☐ Incontinence
- ☐ Urgency
- ☐ Prostate Cancer
- ☐ Benign Prostate Hyperplasia
- ☐ Impotence
- ☐ Infertility
- ☐ Genital Pain
- ☐ Genital Swelling
- ☐ Vasectomy
- ☐ Sexually Transmitted Disease

Libido

- ☐ Normal
- ☐ Low
- ☐ Excessive
- ☐ Other

For doctor/therapist use:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Your Medical History

Patient Name: _____ Date: _____

Medical Conditions

- ☐ Arthritis
- ☐ Allergies/Hay Fever
- ☐ Asthma
- ☐ Alcoholism
- ☐ Alzheimer's
- ☐ Autoimmune Disease
- ☐ Blood Pressure Problems
- ☐ Bronchitis
- ☐ Cancer
- ☐ Chronic Fatigue Syndrome
- ☐ Cholesterol Problems
- ☐ Circulatory Problems
- ☐ Colitis
- ☐ Dental Problems
- ☐ Depression
- ☐ Diabetes
- ☐ Diverticular Disease
- ☐ Drug Addiction
- ☐ Eating Disorder
- ☐ Epilepsy
- ☐ Emphysema
- ☐ Eyes, Ears, Nose, Throat Problems
- ☐ Environmental Sensitivities
- ☐ Fibromyalgia
- ☐ Food Intolerance
- ☐ Genetic Disorder
- ☐ Glaucoma
- ☐ Gout
- ☐ Heat Disease
- ☐ Chronic Infection
- ☐ Inflammatory Bowel Disease
- ☐ Irritable Bowel Syndrome
- ☐ Kidney or Bladder Disease
- ☐ Learning Disabilities
- ☐ Liver or Gallbladder Disease (ex. Stones)
- ☐ Mental Illness
- ☐ Mental Retardation
- ☐ Migraine Headaches
- ☐ Neurological Problems (ex. Parkinson's, Paralysis)
- ☐ Sinus Problems
- ☐ Stroke
- ☐ Thyroid Trouble
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Skin Problems
- ☐ Stomach Reflux
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Urinary Tract Infection
- ☐ Varicose Veins
- ☐ Others: _____

Explain: _____

_____

- ☐ No known problems

Traumas

- ☐ Head
- ☐ Neck/Back
- ☐ Organ
- ☐ Dislocations
- ☐ Bone fracture(s)
- ☐ Joint Sprain(s)
- ☐ Muscle Strain(s)
- ☐ Scar(s)
- ☐ Other _____

Explain

_____

_____

- ☐ None

Surgeries/Hospitalizations

- ☐ Appendectomy
- ☐ Tonsillectomy
- ☐ Ear Tubes
- ☐ C-Section
- ☐ Heart
- ☐ Colonoscopy
- ☐ Shoulder
- ☐ Knee
- ☐ Other Joint/Bone: _____
- ☐ None
- ☐ Others: _____

Explain:

_____

_____

Lab & Diagnostics (dates and outcomes)

- ☐ Blood: _____
- ☐ Urine: _____
- ☐ X-RAY: _____
- ☐ MRI: _____

_____

- ☐ CAT Scan: _____

_____

- ☐ Bone Density: _____
- ☐ Colonoscopy/Endoscopy: _____
- ☐ Others: _____

_____

Other Doctors/Providers

- ☐ OB/GYN: _____
- ☐ NEURO: _____
- ☐ ORTHO: _____
- ☐ GP: _____
- ☐ ENDO: _____
- ☐ PT: _____
- ☐ Other: _____
- ☐ No Other Doctors

Allergies

- ☐ Medications
- ☐ Food
- ☐ Latex
- ☐ Environmental
- ☐ Pollen
- ☐ Cats
- ☐ Other _____

_____

- ☐ None (no known allergies)

Family Health History

(Parents & Siblings)

- ☐ Arthritis
- ☐ Asthma
- ☐ Alcoholism
- ☐ Alzheimer's
- ☐ Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Eating Disorder
- ☐ Genetic Disorder
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ Infertility
- ☐ Learning Disabilities
- ☐ Mental Illness
- ☐ Mental Retardation
- ☐ Migraine Headaches
- ☐ Neurological Disorders (ex. Parkinson's, Paralysis)
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Stroke
- ☐ Suicide
- ☐ Other _____

If more room is needed, please feel free to use the back of this form.

Patient Name: _____ Date: _____

Health Habits

Social

- ☐ Tobacco
  - Cigarettes: #/day _____
  - Cigars: amt _____
  - Chew: amt _____
  - Quit: _____
  - None
- ☐ Alcohol
  - Wine: #glasses/d or wk _____
  - Liquor: #oz/d or wk _____
  - Beer: #glasses/d or wk _____
  - None
- ☐ Caffeine
  - Coffee: #6oz cups/d _____
  - Tea: #6oz cups/d _____
  - Soda: #cans/d _____
  - Other Sources: _____
  - None
- ☐ Recreational Drug Use
  - Occasionally
  - Regularly
    Explain: _____
  - None

Exercise

- ☐ 5-7 Days per week
- ☐ 3-4 Days per week
- ☐ 1-2 Days per week
- ☐ 45 Minutes or more duration
- ☐ 30-45 Minutes duration
- ☐ Less than 30 minutes
- ☐ Walk - #days/wk _____
- ☐ Run, Jog, Other Aerobic - #days/wk _____
- ☐ Weight Lift - #days/wk _____
- ☐ Stretch - #days/wk _____

Other _____

- ☐ None

Sports

- ☐ Swimming
- ☐ Cycling
- ☐ Mountain Biking
- ☐ Hiking
- ☐ Baseball/Softball
- ☐ Soccer
- ☐ Football
- ☐ Basketball
- ☐ Golf
- ☐ Tennis
- ☐ Volleyball
- ☐ Lacrosse
- ☐ Gymnastics
- ☐ Skiing
- ☐ Dance/Cheer
- ☐ Marathon/Triathlon
- ☐ Other _____

Nutrition & Diet

- ☐ Mixed Food Diet (Animal and Vegetable)
- ☐ Vegetarian
- ☐ Vegan
- ☐ Salt Restriction
- ☐ Fat Restriction
- ☐ Starch/Carbohydrate Restriction
- ☐ Total Calorie Restriction
- ☐ Specific Diet Plan: _____
  (ex Weight Watchers, Atkins)

Specific food restrictions:

- ☐ Dairy
- ☐ Corn
- ☐ All Gluten
- ☐ Soy
- ☐ Wheat
- ☐ Eggs
- ☐ Other _____

Food Frequency (often, sometimes, or never)

Fruit: _____
Dark Vegetable:_____
Grains: _____
Beans, Peas, Legumes:_____
Dairy, Eggs: _____
Meat, Poultry, Fish:_____
Water: #oz/d _____

Eating Habits

- ☐ Skip Meals - _____(which)
- ☐ One Meal/Day
- ☐ Two Meals/Day
- ☐ Three Meals/Day
- ☐ Graze (Small Frequent Meals)
- ☐ Generally Eat on the Run
- ☐ Eat Constantly Whether Hungry or Not

Current Supplements

- ☐ Multivitamin/Mineral
- ☐ Vitamin C
- ☐ Vitamin D
- ☐ Vitamin E
- ☐ EPA/DHA
- ☐ Calcium, Source _____
- ☐ Magnesium
- ☐ Zinc
- ☐ Minerals; Describe _____
- ☐ Acidophilus
- ☐ Digestive Enzymes
- ☐ Amino Acids
- ☐ CoQ10
- ☐ Antioxidants
- ☐ Herbs
- ☐ Homeopathy
- ☐ Protein Shakes
- ☐ Superfoods (bee pollen/phytonutrients)
- ☐ Liquid Meals
- ☐ Others _____

Sleep

- ☐ 8-10 hr/night
- ☐ 5-7 hr/night
- ☐ Less than 5 hr/night
- ☐ Heavy Sleeper
- ☐ Restless
- ☐ Sleep Apnea/Snoring
- ☐ Difficulty Falling Asleep
- ☐ Wake Easily
- ☐ Vivid Dreams
- ☐ Wake Rested
- ☐ Wake Fatigued

Current Medications

Rx & OTC

- ☐ None
- ☐ Blood Pressure _____
- ☐ Cholesterol _____
- ☐ Hormonal Replacement _____
- ☐ Thyroid _____
- ☐ Diabetes _____
- ☐ Anti-inflammatory _____
- ☐ Pain _____
- ☐ _____
- ☐ _____
- ☐ _____

If more room is needed, please feel free to use the back of this form.

Health Goals

Energy
- ☐ Feel More Vital
- ☐ Have More Energy
- ☐ More Endurance
- ☐ Less Tired After Lunch
- ☐ Sleep Better
- ☐ Be Free of Pain
- ☐ Less Colds/Flu
- ☐ Get Rid of Allergies
- ☐ Not Be Dependent Upon OTC Meds
- ☐ Stop Using Laxatives
- ☐ Improve Sex Drive

Body Composition
- ☐ Lose Weight
- ☐ Burn More Fat
- ☐ Be Stronger
- ☐ Better Muscle Tone
- ☐ More Flexibility

Stress/Mental/Emotional
- ☐ Reduce Stress
- ☐ Be More Focused
- ☐ Improve Memory
- ☐ Be Less Depressed
- ☐ Be Less Moody
- ☐ Be More Decisive
- ☐ Feel More Motivated

Life Enrichment
- ☐ Reduce Risk of Degenerative Disease
- ☐ Slow Down Accelerated Aging
- ☐ Maintain Healthier Life Longer
- ☐ Change from "Treating Illness" Orientation to "Creating Wellness" Lifestyle.

What therapies have you tried for your problems/conditions OR to improve your health over-all?
- ☐ None
- ☐ Diet Modification
- ☐ Fasting
- ☐ Vitamins/Minerals
- ☐ Herbs
- ☐ Homeopathy
- ☐ Chiropractic
- ☐ Acupuncture
- ☐ Massage
- ☐ Exercise Therapy
- ☐ Physical Therapy
- ☐ Conventional Drugs
- ☐ Surgery
- ☐ Other _____

What therapies offered at Orlando Sports Chiropractic are you interested in to treat your problems/conditions AND/OR to improve your health over-all?
- ☐ Diet Modification
- ☐ Fasting
- ☐ Vitamins/minerals
- ☐ Herbs
- ☐ Homeopathy
- ☐ Chiropractic
- ☐ Acupuncture
- ☐ Massage
- ☐ Exercise Rx
- ☐ Physical Therapy
- ☐ Trigger Point Injections
- ☐ B12 Injections
- ☐ Other _____

The information provided in these health history forms is true and accurate to the best of my knowledge and I freely give my permission for treatment at Orlando Sports Chiropractic.

I agree to inform the doctors and/or therapists of any experience of pain during any treatment. I understand that seeking treatment at Orlando Sports Chiropractic does not deter me from seeking medical treatment for other medical conditions. I agree to update the doctors and/or therapists in regard to changes in my health and understand that there shall be no liability on the doctor's or therapist's part should I forget to do so. I agree to hold harmless the establishment, all management, including volunteers, from and against any and all claims. I agree to handle suit at its sole expense and agree to bear all costs related even if claims, etc., are groundless, false, and fraudulent.

Signature: _____ Date: _____

CONSENT TO MASSAGE AND/OR CHINESE MEDICINE TREATMENT MODALITIES

By signing below, I give consent to be treated with Massage Therapies within the practice scope of massage therapy and /or acupuncture and other procedures within the practice scope of Traditional Chinese medicine. (or patient named below, for whom I am legally responsible)

_____**Acupuncture/Moxibustion:** I understand that acupuncture is performed by the insertion of needles through the skin or by the application of heat to the skin (or both) at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, and pain or discomfort. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time.

_____**Herbal Medicine:** I understand that the physician may recommend Chinese and Western herbs for treatment of bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that I am not required to take these herbs but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effect may result from taking such herbs. These could include, but are not limited to: changes in bowel movement, and abdominal pain or discomfort. *Should I experience any problems, which I associate with these substances, I should suspend taking them and call the clinic as soon as possible.*

_____**Acupressure/Tui-Na Massage/cupping/gua sha:** I understand that I may also be given acupressure/tui-na massage/cupping as part of treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, and sore muscles or aches. I understand that I may stop the treatment if it is too uncomfortable.

_____**Electro-Acupuncture:** I understand that I may be asked to have electro-acupuncture administered with the acupuncture. The impulses used are mild, but occasionally create discomfort. I will inform the practitioner of any discomfort produced during the treatment so that the stimulation can be adjusted.

_____**Injection Therap**y: I understand that the doctor/therapist may recommend the administering of trigger point injections using homeopathic solutions and/or B12 solution to aid in the healing of my condition. I understand that Homeopathy is a very safe, effective treatment modality with little to no known risk factors. However, I agree to inform doctor/therapist of any discomfort or side-effects I feel may be as a result of my therapy.

_____**Massage/Myofascial Therapy:** Including many forms or manual tissue mobilization. I give consent to such treatment. I will inform the therapist of any discomfort during treatment. I am aware that certain side-effects my result from myofascial therapy including but not limited to: bruising and sore muscles and aches. I understand that I may stop the treatment if it is too uncomfortable.

_____I agree to notify physician/therapist if I have a pacemaker, cardiac condition, bleeding disorder, history of seizures, is or may be pregnant. Further, I agree to update the physician/therapist in regard to changes in my health and I hold the physician/therapist harmless of any adverse reactions to any therapy administered if I fail to inform him/her and there shall be no liability on the physician/therapist's part should I forget to do so. I agree to hold harmless the establishment, all management, including all volunteers, from and against any and all claims.

_____I do not expect the physician/therapist to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the practitioner to exercise judgment during the course of treatment, which based on the facts then known is in my best interest. I am also aware that possible aggravation to my physical condition could occur post-treatment. Such aggravation is in most cases followed by a decrease and/or resolution of the condition. I understand that results are not guaranteed, and that there may be other treatment alternatives, including treatment offered by another licensed physician/therapist.

_____I understand that the practitioner and/or clinical staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my physician/therapist for a more detailed explanation. I give my permission and consent to treatment by the above initialed modalities.

Signature: _____ **Date:** _____

☐ Patient ☐ Parent ☐ Guardian

ORLANDO SPORTS CHIROPRACTIC

7513 West Sand Lake Road ♦ Orlando, FL 32819

PHONE 407-345-8686 FAX 407-345-8626

www.orlandosportschiropractic.com

Chiropractic · Massage · Acupuncture · Nutrition · Chinese Medicine · Exercise Therapy

MASSAGE, ACUPUNCTURE, CHINESE MEDICINE, AND NUTRITION POLICIES

It is a pleasure to have you as a patient here at Orlando Sports Chiropractic. These instructions are to help you receive the full benefit of your treatment sessions. We thank you for your understanding and cooperation.

YOUR APPOINTMENT TIME

- Please be 5 minutes early for your scheduled appointment.
- Your scheduled appointment time is set aside especially for you. If you are late for your scheduled appointment, you will be given only the remaining time for your massage.
- If you are running late, call ahead and advise the front desk that you are on your way and your remaining time will be held for you. Otherwise, the remaining time may be given to someone else.

SCHEDULING AND CANCELLATIONS

- A credit card/account number is needed to hold your appointment.
- The number is only to reserve your appointment slot and will not be charged.
- Cancellations without 24 hrs notice or no shows are subject to a $25 fee that will be charged to the card on the day of the reservation.
- Orlando Sports Chiropractic will keep all information entered on this form strictly confidential and in a secure file to ensure your privacy

Account/Card Type: _____
Name on Account/Card: _____
Account/Card #: _____Exp. Date:_____ CVV: _____

Reservation taken over the phone: _____ initials _____

TIPPING

- Tipping is allowed but NOT expected, as this is a clinical setting and not a spa. Tips in the form or cash or check are welcome and we are now able to process tipping through credit cards.

We do not offer to diagnose or treat any disease or condition beyond the scope of Massage or Chinese medicine in the state of Florida. Nor do we offer advice regarding treatment prescribed by others. However, if during the course of examination, we encounter unusual findings that require further evaluation and/or diagnosis, we will so advise you and we will recommend that you seek the services of a health care provider who specializes in that area.

By scheduling an appointment for a massage, Acupuncture, Chinese Medicine, or Nutrition, it is understood that you agree to these terms. Please sign below indicating you have read and understand of these terms.

I, _____ have read and fully understand the above statements.
(Print Name)

_____ _____
Patient's Signature Date

Complete if Patient is a minor child.

I, _____ being the parent or legal guardian of the aforementioned child have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive massage, Chinese medicine and/or nutritional evaluation and treatment.

_____ _____ _____
Child's Name Parent's Signature Date

INSURANCE INFORMATION

PLEASE COMPLETE THE ACCIDENT INJURY REPORT IF YOUR SYMPTOMS ARE A RESULT OF AN ACCIDENT

Relationship to Insured: □ Self □ Spouse □ Child □ Other

If insured is self, skip this section. If insured is someone other than yourself, please complete all information below.

Insured's Full Name _____ Insured's Date of Birth ____/____/____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Ext. _____

Insured's Employer _____ Phone _____

*Additional Insurance Company _____ Phone _____

Relationship to Insured: □ Self □ Spouse □ Child □ Other

Insured's Full Name _____Insured's Date of Birth _____/_____/_____

I understand that my insurance company states that this information is not a guarantee for payment and that my benefits could change or be denied. I also understand that my insurance company can take at least 60 days to respond to submitted claims and that it is my responsibility to inform this clinic of any changes in my policy. I agree to pay, in a current manner, any balance of said professional service charges over and above my insurance company's payments.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand Orlando Sports Chiropractic will prepare any necessary reports and forms to assist in making collections from the insurance company and that any amount authorized to be paid directly to Orlando Sports Chiropractic will be credited to my account upon receipt. HOWEVER, I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT (fee schedule is available upon request).

I also understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered to me will be immediately due and payable. I agree that I will be responsible for all attorney and legal fees, if legal action becomes necessary, to collect this account. I authorize Orlando Sports Chiropractic to obtain a credit report if deemed necessary.

_____ _____ _____

Name **Signature** **Date**

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO PROVIDER

I, _____, hereby instruct and direct my insurance company, pursuant to Florida Statute F.S.627.422, to pay by check or draft made out to and mailed directly to the above named provider for professional or medical services, and any reimbursements otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered by them. The payment is not to exceed my indebtedness to the above named provider.

I hereby assign all rights and benefits that I have under any Group Health, HMO plan, Individual Health, PIP, Disability or any other health, medical plan, policy, reimbursement plan that may pay patient benefits for service and treatment that I have received or will receive from the above named provider.

This assignment includes, but is not limited to, all rights to collect benefits directly from my insurance company or HMO for those services and treatments that I have received and all rights to proceed against my insurance company or HMO in any action, including legal suit, if for any reason my insurance company or HMO fails to make payments of benefits that are due to the above named provider. This assignment also includes the right to recover any attorney's fees and costs for such an action brought by the provider as my assignee.

I agree that the above mentioned provider be given Power of Attorney to endorse/sign my name on any and all checks for payment of services provided by them.

I also authorize the release of any information pertinent to my case or claim to the above named provider or any attorney involved in this case.

A photocopy of this assignment shall be considered as effective and valid as the original.

I hereby authorize the above named provider to file any formal or informal complaints that are necessary to the Insurance Commissioner's Office or any other agency or court they deem appropriate on my behalf.

_____ _____

Patient's (Claimant) Signature Date

IF POLICY HOLDER (INSURED) IS SOMEONE OTHER THAN PATIENT

_____ _____

Policy Holder Date