Pathway Wellness Chiropractic Clinic

Tallahassee, FL

New Patient History Form

Last Name_____ **First Name**_____ **Date**_____
Last 4 of Social Security #_____ **Birth Date**_____ **Age**_____
Address_____ **City**_____ **State**_____ **Zip**_____
Home Phone_____ **Work Phone**_____ **Cell Phone**_____
Email address_____
Would you like appt. reminders sent via email or text message?
Occupation_____ **Primary Care Physician**_____
Marital Status_____
Have you ever been to a chiropractic clinic before? _____ **If Yes: When** _____
For What Condition? _____
How did you respond to treatment? _____
How did you hear about our clinic? _____
What type of insurance do you have **CHP** **Blue Cross** **Aetna** **Other**_____

Section A. *Describe your complaints in order of severity (1st complaint, 2nd complaint, etc...)*

1st Complaint _____ Date Started_____
What is the history of this injury or symptom?

What makes your problem worse?

What makes your problem better? _____
How would you describe your pain? _____
What is the location or radiation of your pain?

How bad is your pain on a scale of 0 to 10? (*0=no pain and 10=unbearable pain*)
Now: ___/10 Average: ___/10
What time of the day or week are your symptoms worse?_____
How often are your symptoms present? ☐ Occasionally ☐ Frequently ☐ Constant
What daily activities have been affected?_____
Does this pain wake you from sleep? Yes / No
Have you received any treatment for this condition and if so what?

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2nd Complaint _____ Date Started_____

What is the history of this injury or symptom?

_____

_____

_____

What makes your problem worse? _____

What makes your problem better? _____

How would you describe your pain? _____

What is the location or radiation of your pain? _____

How bad is your pain on a scale of 0 to 10? (*0=no pain and 10=unbearable pain*)

Now: ___/10 Average: ___/10

What time of the day or week are your symptoms worse? _____

How often are your symptoms present? □ Occasionally □ Frequently □ Constant

What daily activities have been affected? _____

Have you received any treatment for this condition and if so, what? _____

Section B *Please use a* **yes** *or* **no** *when answering any of the following. If you are not sure leave a ? .*

___ **Do you have a personal history of cancer?**
If yes, what type?_____
___ **Have you had any unexplained weight loss?**
___ **No response to 4-6 weeks of conservative care?**
___ ***RECENT* trouble *starting or stopping urination?***
___ ***RECENT Trouble with bowel movements?***
___ ***Numbness in the groin region?***
___ ***RECENT muscle weakness in the legs?***
___ **History of significant trauma?**
___ **Do you have osteoporosis (weak bones)?**
___ ***Any* history *of* prolonged *use* of *corticosteroids?***
___ ***do you have a Connective Tissue Disorder***
___ ***Current or recent infection (urinary,respiratory,etc)?***
___ ***History of Immunosuppression medication &/or condition?***
___ **Do you have *Hypertension?***
___ **Do you Smoke?**

PAST HISTORY

PREVIOUS INJURIES *(Please give dates, describe injury and care received)*

AUTO: _____

_____

WORK RELATED: _____

_____

PERSONAL: _____

_____

LIST ALL SURGERIES: _____

_____

CURRENT MEDICAL CONDITIONS: ie. (diabetes, hypertension, etc)

_____

_____

LIST ALL MEDICATIONS/VITAMINS:

_____

_____

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REVIEW OF SYSTEMS

Please use the numbers below when answering. If you have never had the condition please leave blank.

1. Current
2. Related to accident

GENERAL SYMPTOMS
___784.0 Headache
___780.6 Fever
___780.99 Chills
___780.8 Night Sweats
___780.2 Fainting
___780.4 Dizziness
___780.7 Fatigue
___799.2 Nervousness
___783.0 Loss of Weight
___782.0 Numbness or pain in arms/legs/hands

MUSCLE & JOINTS
___728.9 Weakness
___723.5 Stiff Neck
___724.5 Backache
___719.0 Swollen Joints

GASTRO-INTESTINAL
___787.0 Nausea
___787.0 Vomiting
___578.0 Vomiting Blood
___564.0 Constipation
___787.91 Diarrhea

CARDIO VASCULAR
___401.9 High Blood Pressure
___458.9 Low Blood Pressure
___429.9 Heart Trouble
___719.07 Swelling Ankles
___459.9 Poor Circulation
___454.9 Varicose Veins
___436.0 Strokes

EYE/EAR/NOSE/THROAT
___368.9 Poor Vision
___379.91 Pain in Eyes
___388.70 Earache
___388.30 Ear Noises
___784.7 Nose Bleeds

SKIN/ALLERGIES
___924.9 Bruising Easily
___782.0 Sensitive Skin
___708.9 Hives or Allergies
___692.9 Eczema

RESPIRATORY
___786.2 Chronic Cough
___786.2 Spitting Blood
___786.5 Chest Pain
___786.09 Difficult Breathing

GENITO-URINARY
___788.1 Painful Urination
___599.7 Blood in Urine
___590.0 Kidney Infection
___788.3 Inability to control Urine

Other conditions not listed above:

_____

_____

_____

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

_____ Date _____

Signature of patient (or parent of minor)

Pathway Wellness Chiropractic Clinic

Patient Financial
Individual Consideration Agreement
Time of service discount

Patient:_____
Date:_____

This agreement is between the above cited patient (PATIENT) and Pathway Wellness Chiropractic Clinic (CLINIC). The purpose of this agreement is to enable PATIENT to receive the benefit of chiropractic care and/or massage therapy at the CLINIC without the restriction of financial hardship.

The CLINIC has informed me of their usual fee for examination, testing and treatment procedures. PATIENT agrees that the financial issue(s) are not with the amount of charges or the utilization of services. The only issue is patient's current ability to meet the financial obligations that receiving the recommended care would create.

To enable PATIENT to receive the chiropractic services or massage therapy recommended CLINIC has agreed to offer PATIENT a time of service discount in lieu of 3rd party billing.

Examination Charge(s)	$_____
Office visit, with or without adjustment	$_____
Therapeutic Modalities, each	$_____
Massage therapy	$_____

I understand that in consideration for this special financial agreement I will be expected to pay my account balance at the time of service. This agreement only obligates the PATIENT for services actually provided by CLINIC. Patient understands that no insurance will be billed and if they wish to, a receipt will be provided.

This agreement may be cancelled at any time by either party with a written notice given prior to CLINIC providing care outside of the terms of the agreement. The PATIENT and CLINIC will only be liable to the terms of the agreement for services that were provided prior to any cancellation date.

_____
Patient's Signature and Date

_____
CLINIC agent or Doctor's signature

Pathway Wellness
2425-A Mahan Drive
Tallahassee, FL 32308

Jeffrey Farrah, DC

Dustin Bledsoe, DC

Pathway Wellness
2425-A Mahan Drive
Tallahassee, FL 32308

Informed Consent for treatment

I hereby request and consent to the performance of chiropractic and other chiropractic procedures, including various modes of physical therapy and acupuncture on me (or on the patient names below, for whom I am legally responsible) by the doctor of chiropractic named above and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed above.

I have had an opportunity to discuss with the doctor of chiropractic names above and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments, acupuncture and other procedures. I understand that results are not guaranteed

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. I also understand that while acupuncture is generally a safe method of treatment, certain adverse effects may result from treatment. These may be, but not limited to fainting, some local bruising, puffiness, redness, blood, and temporary pain or discomfort at the site of the needles. I do not expect the doctor to be able to anticipate and explain all the risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. 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 from to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Signature_____ Date_____

Witness Signature_____ Date_____

Doctor Signature_____ Date_____

Pathway Wellness
2425-A Mahan Drive
Tallahassee, FL 32308

Patient: _____
Date of Initial Exam: _____

The following modalities will be used during the treatment schedule:

Heat- To promote blood flow to area prior to CMT, promote muscle relaxation and encourage tissue healing.
Ice- To promote local vasoconstriction, local nerve inhibition, reduce swelling and edema.
EMS- Control acute and/or chronic pain, reduce muscle spasm promote release of naturally occurring endorphins.
Therapeutic Exercises L-Spine- Improve range of motion, circulation, muscle strength and coordination. Release contracted muscles, tendons, and fascia in order to improve regional function and activities of daily living.
Therapeutic Exercises T-Spine- Improve range of motion, circulation, muscle strength and coordination. Release contracted muscles, tendons, and fascia in order to improve regional function and activities of daily living.
Therapeutic Exercises C-Spine- Improve range of motion, circulation, muscle strength and coordination. Release contracted muscles, tendons, and fascia in order to improve regional function and activities of daily living.
Massage Therapy/Manual Therapy- Decrease muscle spasms, break up adhesions within fascia, promote relaxation and speed tissue healing.
Traction- Increase joint space, stretch contracted / spasm of soft tissue, promote an increase in circulation, reduces pressure on inter-vertebral discs while increasing nutrient and fluid exchange in inter-vertebral discs, and the area surrounding the nerve root.
Acupuncture/Intramuscular Stimulation – to treat myofascial pain, radiculopathic pain, shortened muscles, trigger points and loss of ROM due to the aforementioned.
Chiropractic Manipulative Therapy/ Spinal manipulative therapy-will be used to relieve pain, and improving the body's physical function by reducing muscle spasms, decreasing pain, and improving segmental range of motion.

Timed CPT codes used in this office follow the following guidelines:
8 min to 11 min is billed as 1 unit
23 min to 37 min is billed as 2 units
38min to 52 min is billed as 3 units
52 min and above billed as 4 units

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 Name (please print) Date

_____

Parent, Guardian or Patient's legal representative

_____

Signature

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

List below the names and relationship of people to whom you authorize the Practice to release PHI.

_____ _____

_____ _____

_____ _____