Lake Buena Vista Chiropractic*

11444 S. Apopka Vineland Rd. #106A Orlando, FL. 32836
PH: 407-238-2306 FX: 407-238-2309
Doctor: David Young, D.C.

Name:_____ **Date of Birth**: ____/____/____**Social Security #**_____-_____-_____

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

Phone#_____**E-mail address**:_____

Marital status (circle): Married Single Divorced **Occupation**:_____

Race (circle): White – Hispanic – Black – Asian – Other **Preferred Language**: _____

How were you referred to our office?_____

Have you been to a chiropractor before: YES / NO

AUTHORIZATION AND RELEASE: I authorize and payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand there is no guarantee that my insurance companies or prepaid health plan will cover or pay for all of my charges. Notwithstanding denial, reduction of benefits or failure to pay for any reason, I understand that I am responsible for all remaining charges.

HEALTH INFORMATION USAGE: **The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.**

INFORMED CONSENT: I hereby request and give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues. I understand the procedures may consist of manipulations/adjustments involving movement of the joints and soft tissues. Physical therapy, exercises, and acupuncture may also be used (or on the patient named below, for whom I am legally responsible).

Although spinal manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows:

Soreness: I am aware that like exercise it is common to experience muscle soreness in the first few treatments.
Dizziness: Temporary symptoms like dizziness and nausea can occur but are relatively rare.
Fractures/Joint Injury: I further understand that in isolated cases underlying physical defects, deformities or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disk, or other abnormality is detected, this office will proceed with extra caution.
Stroke: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage including stroke is reported to occur once in one million to once in ten million treatments. Once in a million is about the same chance as getting hit by lightening. Once in ten million is about the same chance as a normal dose of aspirin or Tylenol causing death.

I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits

I realize that the practice of medicine, including chiropractic is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures.

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 form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient's Signature X_____Date _____

*dba for Young Chiropractic llc

HISTORY OF PRESENT AND PAST ILLNESS

Enter date symptoms started: _____. Are your problems due to an injury?: Yes / No

List symptoms you are experiencing today: Choose the severity level associated with each symptom

_____ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe

_____ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe

_____ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe

List any past **injuries**, **illnesses**, **auto accidents**, or **surgeries**? (include dates): _____

_____

What medications/drugs are you taking?_____

Days lost from work:_____ Work Restrictions_____:_____

Any Allergies?_____

Women: Are you pregnant?_____

Review of systems: **Mark all problems you currently have.**

Musculoskeletal	**Respiratory**	**Endocrine**
Osteoporosis _____	Asthma _____	Thyroid Issues _____
Arthritis _____	Sleep Apnea _____	Excessive Thirst _____
Scoliosis _____	Shortness of breath _____	Excessive Urination _____
Neck Pain _____	Allergies / Hay Fever _____	Frequent Infections _____
Back Problems _____	Sputum _____	Hot/Cold Intolerance _____
Hip Disorders _____	Cough _____	Low Energy _____
Knee Injuries _____	**GastroIntestinal**	**Genitourinary**
Foot/Ankle Pain _____	Anorexia/bulimia _____	Kidney Stones _____
Shoulder Problems _____	Abdominal pain or blood _____	Burning on urination _____
Elbow/Wrist Pain _____	Nausia / Vomiting _____	Bedwetting _____
TMJ issues _____	Heartburn _____	Prostate Issues _____
Poor Posture _____	Constipation _____	Erectile Dysfunction _____
Neurological	Diarrhea _____	PMS symptoms _____
Headache _____	**HEENT**	**Constitutional**
Dizziness _____	Blurred Vision _____	Fainting _____
Numbness / Tingling _____	Ringing in ears _____	Low Libido _____
Pins & Needles _____	Hearing loss _____	Fever _____
Ataxia _____	Runny Nose _____	Chills _____
Fainting _____	Congestion _____	Sudden Weight loss _____
Cardiovascular	Sore Throat _____	Fatigue / Weakness _____
High blood pressure _____	**Integumentary**	**Psychiatric**
Chest Pain / Angina _____	Skin Cancer _____	Anxiety _____
Poor Circulation _____	Psoriasis _____	Depression _____
Palpitations _____	Eczema _____	**Lymphatics**
Hematologic	Acne _____	Enlarged lymph nodes _____
Excessive Bruising _____	Hair Loss _____	Splenectomy _____
Anemia _____	Rash _____	

Family History: (M=Mother, F=Father, S=Sibling

❑Heart Disease ____ ❑Back Pain____ ❑Cancer____ ❑Blood Pressure____ ❑Diabetes____ ❑Other:_____

Social History

❑Smoker (packs /day)____ ❑Alcohol Consumption (cups/day)____ ❑Coffee (cups/day)____ ❑Water (cups/day) ____

Exercise: ❑None ❑Moderate ❑Daily Type: _____

I certify the information provided is accurate to the best of my knowledge:

Patient's Signature X _____ Date _____

Functional Rating Index

In order to properly assess your condition, we must understand how much problems have affected your ability to manage everyday activities. For each item below, **please circle the number which most closely describes your condition right now**.

I. Pain Intensity
- **0.** No Pain
- **1.** Mild Pain
- **2.** Moderate Pain
- **3.** Severe Pain
- **4.** Worst Possible Pain

II. Sleeping
- **0.** Perfect Sleep
- **1.** Mildly disturbed sleep
- **2.** Moderately disturbed sleep
- **3.** Greatly disturbed sleep
- **4.** Totally disturbed sleep

III. Personal Care (washing, dressing, etc.)
- **0.** No pain, no restrictions
- **1.** Mild pain, no restrictions
- **2.** Moderate pain, need to go slowly
- **3.** Moderate pain, need some assistance
- **4.** Severe pain, need 100% assistance

IV. Traveling (driving)
- **0.** No pain on long trips
- **1.** Mild pain on long trips
- **2.** Moderate pain on long trips
- **3.** Moderate pain on short trips
- **4.** Severe pain on short trips

V. Work
- **0.** Can do usual work plus unlimited extra work
- **1.** Can do usual work, no extra work
- **2.** Can do 50% of usual work
- **3.** Can do 25% of usual work
- **4.** Cannot work

VI. Recreation
- **0.** Can do all activities
- **1.** Can do most activities
- **2.** Can do some activities
- **3.** Can do a few activities
- **4.** Cannot do any activity

VII. Frequency of Pain
- **0.** No Pain
- **1.** Occasional pain, 25% of the day
- **2.** Intermittent pain, 50% of the day
- **3.** Frequent pain, 75% of the day
- **4.** Constant pain, 100% of the day

VIII. Lifting
- **0.** No pain with heavy lifting
- **1.** Increased pain with heavy lifting
- **2.** Increased pain with moderate weight
- **3.** Increased pain with light weight
- **4.** Increased pain with any weight

IX. Walking
- **0.** No pain, any distance
- **1.** Increased pain after 1 mile
- **2.** Increased pain after ½ mile
- **3.** Increased pain after ¼ mile
- **4.** Increased pain with all walking

X. Standing
- **0.** No pain after several hours
- **1.** Increased pain after several hours
- **2.** Increased pain after 1 hour
- **3.** Increased pain after 1/2 hour
- **4.** Increased pain with any standing

X _____ _____

Patient Signature Date