ADVANCEDHEALTHCARE
& PHYSICAL MEDICINE
www.ormondbeachchiro.com

Date: _____

NEW PATIENT

First Name: _____ Middle Initial: _____ Last Name: _____

Home Phone #: _____ Cell Phone #: _____ Work Phone #: _____

Address: _____City: _____

State _____ Zip: _____ E-mail Address: _____ Profession: _____

SS#:_____-_____-_____ Age: _____ DOB: __ __ /__ __ /_____ __ Male / Female

Primary Care Physician Name:_____ Physician Phone Number: _____

Do we have permission to contact your doctor regarding your care in our office? _____Yes _____No

How did you hear about our office? _____

Have you had any accidents **within the past 6 – 12 months** that affected your symptoms? Auto Slip/Fall Other NONE

What is your main health concern? _____

How long have you had it? _____

How often does it occur? _____

What does it feel like? (describe) _____

What have you done that has helped this problem? _____

What activities would you like to do if this was not a problem? _____

Does this cause you to be:	**Does this affect your work:**	**Does this affect your life:**
Moody	Decision making	Lose patience with spouse/children
Irritable	Poor attitude	Restricted household duties
Interrupt sleep	Decreased productivity	Hinders ability to exercise or sports
Restricted in your daily activities	Exhausted at the end of the day	Interferes with ability to do hobbies
	Unable to work long hours	or other activities

What have you tried to help relieve/get rid of this problem and how much did it help? (circle appropriately)

Medications…	Helped:	Little	Some	Much	Exercise…	Helped:	Little	Some	Much
Physical Therapy	Helped:	Little	Some	Much	Nutrition…	Helped:	Little	Some	Much
Chiropractic…	Helped:	Little	Some	Much	Stretching…	Helped:	Little	Some	Much

OTHER _____

Is there a family history of any of the following conditions? *(indicate family member - parents, grandparents & siblings)*

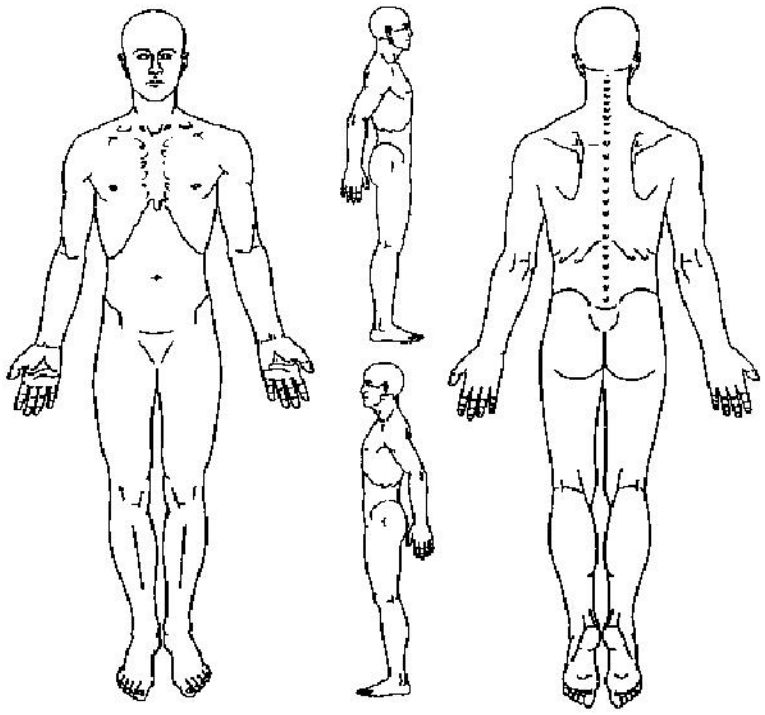
Heart Disease _____ Diabetes _____ Cancer _____
Arthritis _____ Other _____

Do you exercise: Daily 3 – 4x / week 1 -2x / week None
Do your work activities mostly involve: Sitting Standing Light Labor Heavy Labor
Do you sleep on your: Back Side Stomach Do you use a cervical pillow? Yes No
What is your daily/weekly intake of the following:
Caffeine _____ cups/day Alcohol _____ drinks/week Cigarettes _____ packs/day

PATIENT HEALTH HISTORY

Please check to indicate if you are <u>CURRENTLY</u> experiencing any of the following conditions and then circle problematic areas on body to right:

Neck Pain/Stiffness	Pins/Needles in Arms
Back Pain/Stiffness	Pins/Needles in Legs
Arm/Hand Pain	Light Bothers Eyes
Leg/Knee Pain	Recent Weight Change
Headaches	Loss of Memory
Night Pain	Nausea
Depression	Loss of Taste
Cold Extremities	Fatigue
Nervousness	Chest Pain
Sleeping Difficulties	Tension
Jaw Problems	Fever
Loss of Smell	Cold Sweats
Fainting	Constipation/Diarrhea
Dizziness	Allergies
Stomach Problems	Shortness of Breath
Asthma	Blurred/Double Vision
Swollen Joints	Bowel/Bladder Changes
Mood Changes	Trouble Concentrating
Foot Trouble	Loss of Balance



Please check if you have ever had any of the following:

ADD/ADHD	Cancer	Heart Attack	Mouth Sores or	Sexual Difficulty
Aids/HIV	Cataracts	Heart Problems	Bleeding Gums	Stroke
Alcoholism	Chemical	Hemorrhoids	Multiple Sclerosis	Suicide Attempt
Allergy Shots	Dependency	Hepatitis	Mumps	Thyroid Problems
Anemia	Chicken Pox	Hernia	Nosebleeds	TMJ Pain
Anorexia	Colon Trouble	Herniated Disc	Osteoporosis	Tonsillitis
Appendicitis	Contacts/Glasses	Herpes	Pacemaker	Tremors
Arthritis	Diabetes	High Cholesterol	Parkinson's Disease	Tuberculosis
Asthma/Wheezing	Dry Skin	Hormone/Gland Problems	Pinched Nerve	Tumors/Growths
Bad Breath/Bad Taste	Ear Infections		Pneumonia	Typhoid Fever
	Epilepsy	Insomnia	Polio	Ulcers
Bleeding Disorders	Fractures	Kidney Problems	Prostate Problems	Vaginal Infections
Blood Pressure:	Gall Bladder	Liver Disease	Prosthesis	Venereal Disease
High or Low (circle)	Glaucoma	Measles	Psychiatric Care	
Breast Lump	Goiter	Menopausal Prob.	Rheumatoid	Other: _____
Broken Bones	Gonorrhea	Migraines	Arthritis	_____
Bronchitis	Gout	Miscarriage	Rheumatic Fever	_____
Bulimia	Heartburn	Mononucleosis	Scarlet Fever	_____

Are you currently under drug and/or medical care? Yes No If yes, explain _____

Please list any and all medications you are currently taking: _____

_____

Please list any surgeries and/or hospitalizations you have had (type & date): _____

_____

_____

Please complete the following food and chemical sensitivity questionnaire. Score each symptom based upon your experiences over the last 60 days. This survey should be taken again after the completion of the Alcat Test, prior to reintroduction of "reactive" foods. Typically 3-6 months after initial testing. This comparison will help to assess the success of the eating modification program.

Symptom Scoring System:
●○○○ = No Symptoms (*Zero Points*)
○●○○ = Experience Mild Symptoms (*One Point*)
○○●○ = Experience Moderate Symptoms (*Two Points*)
○○○● = Severe Symptoms (*Three Points*)

Digestive Symptoms
○○○○ Stomach Pains or Cramping
○○○○ Constipation
○○○○ Diarrhea
○○○○ Reflux,Acid, Heartburn
○○○○ Bloating
○○○○ Gas
○○○○ Nausea or Vomiting

Weight
○○○○ Inability to Lose Weight
○○○○ Food Cravings
○○○○ Binge Eating
○○○○ Water Retention

Sinus/Respiratory
○○○○ Stuffy or Runny Nose
○○○○ Asthma
○○○○ Chest Congestion
○○○○ Chronic Cough
○○○○ Wheezing
○○○○ Frequent Sneezing

Head/Ears
○○○○ Migraines
○○○○ Headaches
○○○○ Earaches
○○○○ Ear Infection
○○○○ Ringing in Ears

Eyes/Throat
○○○○ Itchy Eyes
○○○○ Watery Eyes
○○○○ Sore Throat
○○○○ Persistent Canker Sores

Emotional/Mental
○○○○ Depression
○○○○ Anxiety
○○○○ Mood Swings
○○○○ Irritability
○○○○ Poor Concentration

Energy
○○○○ Fatigue
○○○○ Hyperactivity
○○○○ Lethargy
○○○○ Restlessness
○○○○ Insomnia

Skin Disorders
○○○○ Eczema
○○○○ Dermatitis
○○○○ Excessive Sweating
○○○○ Rashes
○○○○ Hives

Other Symptoms:
○○○○ Joint Pain
○○○○ Arthritis
○○○○ Irregular Heartbeat
○○○○ Chest Pains
○○○○ Muscle Aches

Please list any symptoms not mentioned above:
_____
_____

Total Score: _____

Advanced Healthcare & Physical Medicine 801 W. Granada Blvd. suite 101, Ormond Beach, FL 32174 386.673.2000

OFFICE USE ONLY

Food and Chemical Sensitivity Survey

Date: __/__/____
Patient Name: _____
Gender: M / F
Height: Feet ____Inches ____
Weight: _____lbs.
Please list all medications you are currently taking: _____

NEUROLOGICAL / MRI / VASCULAR PATIENT QUESTIONNAIRE

NAME _____ **DATE** _____

For any YES answer, please explain under comment and notify the Doctor:

1. Do you suffer from neck pain with pain in your shoulder, arms or hands? NO YES
   Comment: _____
2. Do you have weakness, numbness or burning in your shoulder, arms or hands? NO YES
   Comment: _____
3. Do your hands or arms fall asleep regularly? NO YES
   Comment: _____
4. Do you have reduced feeling (sensation) or swelling in your hands or arms? NO YES
   Comment: _____
5. Do you suffer from a loss of handgrip strength? NO YES
   Comment: _____
6. Do you suffer from back pain with pain in your buttocks, legs or feet? NO YES
   Comment: _____
7. Do you have weakness, numbness or burning in your buttocks, legs or feet? NO YES
   Comment: _____
8. Do our legs or feet fall asleep regularly? NO YES
   Comment: _____
9. Do you have reduced feeling (sensation) or swelling in your legs, feet? NO YES
   Comment: _____
10. Do you suffer from cold hands or feet? NO YES
    Comment: _____
11. Have you tried any medications such as anti-inflammatory? NO YES
    If yes, what kind of medication? _____
12. Have you tried any Physical Therapy or Chiropractic treatments before? NO YES
    If yes: When? For how long? What kind? _____
13. Have you had an MRI? NO YES
    If yes: When? Who ordered it? What was it ordered for? _____
    _____
14. Have you used any splint or braces or other prescribed treatment by an MD? NO YES
    If yes: When? What kind? Who ordered it? _____
    _____
15. If you have tried any treatment or medications, did this make your problem better? NO YES
    Comment: _____

TERMS OF ACCEPTANCE AND CONSENT FOR CARE

We will attempt to identify and diagnose any ailments you may have that may be corrected through physical medicine, active/passive rehabilitation, chiropractic care, and/or massage therapy. If any condition or disease appears to be present out of our scope of practice, we will refer you to an appropriate physician to diagnose and/or treat that condition.

The primary focus of care in this office is the detection and correction of Neuromusculoskeletal conditions as well as lifestyle modification for the correction or amelioration of physiological and physical ailments.

Through specific tailored treatment plans, we reduce and/or correct physical or physiological disturbances. It may be necessary to examine an individual each time a new injury occurs and often x-rays or other diagnostic procedures are necessary to maintain the utmost safety when dealing with your body. The risks of physical medicine, active/passive rehabilitation, chiropractic care, and/or massage therapy are minimal when dealing with a licensed professional; however, if you have concerns about these risks, please discuss them with the doctor prior to the examination.

Also, for your protection, portions of our office where patients do not disrobe are under video surveillance, specifically, but not limited to, the front desk check-out stations.

I have read and I accept the terms above and understand them fully. I hereby give consent to the Advanced Healthcare Physical Medicine, to evaluate me to determine my condition and treat me for such conditions. I also understand that I may at any time discontinue with the exam and/or x-rays or any treatment if I so choose.

☐ **CHECK IF YOU HAVE INSURANCE**

I certify that I (or my dependent) have insurance coverage with _____ and I AUTHORIZE, REQUEST, AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PHYSICIAN PRACTICE, Advanced Healthcare & Physical Medicine, INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me in order to secure payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

I also understand that if I suspend or terminate my care at this office, any outstanding charges 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 amount.

I, _____ have read and fully understand the above statements.
(PRINT NAME)

_____ _____
(SIGNATURE) (DATE)

In case of an emergency, please contact _____ at _____
(Name) (Phone number)

Privacy Notice

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In the course of your care as a patient at Advanced Healthcare, LLC, we may use or disclose personal and health related information about you in the following ways:

- Your personal health information, including your clinical records, may be disclosed to another healthcare provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
- Your healthcare records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or may be responsible for the payment of your services.
- Your name, address, phone number, and healthcare records may be used to contact you regarding appointment reminders, information about alternative to your present care, or other health related information that may be of interest to you.

If you are not at home to receive an appointment reminder, a message may be left on your answering machine. Furthermore, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provided to you or the reimbursement avenues associated with your care.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in the following circumstances:

- If we are providing healthcare to you based on the orders of another healthcare provider.
- If we provide healthcare services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain our consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
- If we are ordered by the courts or another appropriate agency.

Any use or discloser of your protected health information, other than as outlined above, will only be made upon your written authorization.

We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your healthcare or about the status of your account. If you would like to receive this information at an address other than your home or if you would like the information in a different form, please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. In addition you have the right to request an amendment to your health information. Requests to inspect, copy or amend our health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply to all of your information in our files.

Information that we use or disclose based on this privacy notice may be subject to re-discloser by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to Dr. Michael O'Connor. If you would like further information about our privacy policies and practices please contact Dr. Michael O'Connor.

This notice is effective as of December 1, 2012. This notice, and any alterations or amendments made hereto will expire seven (7) years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

_____	_____	_____
Name (Print)	Signature	Date