Simple Relief Wellness Center
625 North Washington Blvd.
Sarasota, Florida 34236
Phone: 941-363-9000
Fax: 941-951-1808

Patient Intake

Today's Date:_____/_____/_____

Name: _____ Age_____ Date of Birth_____

Local Address_____ City_____ State____ Zip_____

Out of Town Address_____ City_____ State____ Zip_____

Marital Status_____ Sex_____ S.S.# _____ Home Phone_____ Cell. Phone_____

Email Address: _____ Employer_____

Occupation _____ Address/Phone _____ Spouse _____

Emergency Contact_____Phone_____Relationship_____

How did you hear about our office?

☐ Yellow Pages ☐ Drive By ☐ Walk-In ☐ Internet ☐ Referral (Please tell us who) _____ ☐ Other: _____

Health Insurance Information

Primary Insurance _____ Policy Holder's Name _____ DOB _____

Policy Holder's Relationship to Patient _____ Policy Holder's Employer _____

Accident Information (SKIP this section if you were not involved in an accident)

Is your condition due to an: ☐ ***Auto Injury*** ☐ ***Work Injury*** ☐ ***Slip and Fall*** ☐ ***Other Accident (describe below)***

Date of Accident_____ Place (City/State)_____

Auto/Work Insurance Company_____ Insured's Name and DOB_____

If Auto Injury, have you reported the accident to your insurance company? ☐ No ☐ Yes Claim #_____

If Work Injury, have you reported the accident to your supervisor/boss? ☐ No ☐ Yes Claim #_____

If Slip and Fall or Other Type of Injury, please describe: _____

*Do you have an **Attorney** for your Auto or Work Comp. injury* ☐ Yes ☐ No

Please provide Attorney Name, address and phone # _____

Current complaint

I. Please list your **worst** complaint: _____ How long have you had it: _____

How did it start: _____ ***A) Is it:*** ☐*Improving* ☐*Worsening* ☐*Staying the Same* ***B) Is it:*** ☐*Mild* ☐*Moderate*

☐*Severe* ***C) What worsens it:*** ☐*General activity* ☐*Moving Wrong* ☐*Bending* ☐*Lifting* ☐*Walking* ☐*Sports* ☐*Getting up from a chair*

☐ *Using a computer/desk work* ☐*Other:* _____ ***D) What makes it better:*** ☐*Rest* ☐*General Activity* ☐*Ice Packs*

☐*Heating Pad* ☐*OTC Meds* ☐*Rx Meds* ☐*Massage* ☐*Chiropractic* ☐*Other:*_____ ***E) Is it worse in the:*** ☐*AM* ☐*PM*

☐*After day wears on* ☐*Steady* ☐*Off and on* ***F) Is the symptom:*** ☐*Dull and Achy* ☐*Tight and Stiff* ☐*Sharp and Stabbing*

☐*Numb and Tingly* ☐*Shooting* ☐*Burning* ☐ *Cramping*

II. Please list your **2nd worst** complaint: _____ How long have you had it: _____

How did it start: _____ ***A) Is it:*** ☐*Improving* ☐*Worsening* ☐*Staying the Same* ***B) Is it:*** ☐*Mild* ☐*Moderate*

☐*Severe* ***C) What worsens it:*** ☐*General activity* ☐*Moving Wrong* ☐*Bending* ☐*Lifting* ☐*Walking* ☐*Sports* ☐*Getting up from a chair*

☐ *Using a computer/desk work* ☐*Other:* _____ ***D) What makes it better:*** ☐*Rest* ☐*General Activity* ☐*Ice Packs*

☐*Heating Pad* ☐*OTC Meds* ☐*Rx Meds* ☐*Massage* ☐*Chiropractic* ☐*Other:*_____ ***E) Is it worse in the:*** ☐*AM* ☐*PM*

☐*After day wears on* ☐*Steady* ☐*Off and on* ***F) Is the symptom:*** ☐*Dull and Achy* ☐*Tight and Stiff* ☐*Sharp and Stabbing*

☐*Numb and Tingly* ☐*Shooting* ☐*Burning* ☐ *Cramping*

III. Please list your **3rd worst** complaint: _____ How long have you had it: _____

How did it start: _____ ***A) Is it:*** ☐*Improving* ☐*Worsening* ☐*Staying the Same* ***B) Is it:*** ☐*Mild* ☐*Moderate* ☐*Severe* ***C) What worsens it:*** ☐*General activity* ☐*Moving Wrong* ☐*Bending* ☐*Lifting* ☐*Walking* ☐*Sports* ☐*Getting up from a chair* ☐ *Using a computer/desk work* ☐*Other:* _____ ***D) What makes it better:*** ☐*Rest* ☐*General Activity* ☐*Ice Packs* ☐*Heating Pad* ☐*OTC Meds* ☐*Rx Meds* ☐*Massage* ☐*Chiropractic* ☐*Other:*_____ ***E) Is it worse in the:*** ☐*AM* ☐*PM* ☐*After day wears on* ☐*Steady* ☐*Off and on* ***F) Is the symptom:*** ☐*Dull and Achy* ☐*Tight and Stiff* ☐*Sharp and Stabbing* ☐*Numb and Tingly* ☐*Shooting* ☐*Burning* ☐ *Cramping*

On a scale of 0-5, rate how your pain affects the following: Self Care____ Lifting ____ Walking ____ Working ____

Sitting ____ Standing ____ Sleeping ____ Sporting/Social Activities ____ Driving/Traveling ____

Current Health

• Name, address and phone number of family doctor _____

• Are you currently under any doctor's care for an illness or injury? If so, please list his/her name and

address _____ Nature of illness or injury_____

• If you are currently taking any prescription or nonprescription medications, please list them below with dosages:

Medication: _____ Dose: _____ Medication: _____ Dose: _____

Medication: _____ Dose: _____ Medication: _____ Dose: _____

• Please list any medications you are allergic to: _____

• Please indicate your height and weight _____What is your usual blood pressure_____/_____

Health History

• List any operations, surgeries or medical procedures:

Date:_____ Procedure: _____ Date:_____ Procedure: _____

Date:_____ Procedure: _____ Date:_____ Procedure: _____

• If you have ever had in the past or currently have any serious illnesses or injuries, please list:

Date:_____ Condition: _____ Date:_____ Condition: _____

Date:_____ Condition: _____ Date:_____ Condition: _____

Any current loss of bowel or bladder control: ☐Yes ☐No Any current seizures, paralysis, speech, vision problems: ☐Yes ☐No

Any unexplained recent weight loss: ☐Yes ☐No Current fever: ☐Yes ☐No Current nutritional problems: ☐Yes ☐No

• Please list any significant family illnesses_____

• Have you had spinal X-Rays within the past 5 years? If yes, when and where _____

• **Do you have a pacemaker? ☐Yes ☐No If yes, please ALERT our doctor and/or chiropractic assistant**

• Please list any other electrical device that you currently wear_____

• Please select one: ☐ I have never smoked ☐ Former smoker ☐ Current smoker, if so how much: ____ pk./day ____ pk./wk.

• Please select one: ☐ I don't drink alcohol ☐ Rarely drink ☐ Social drinker ☐ Heavy drinker (_____ oz. per day/week)

• Have you ever had chiropractic care ☐Yes ☐No If yes, last date of treatment_____ Results: _____

What are your overall expectations from your treatment with our doctor: _____

I, the undersigned, hereby give my consent for the doctor to examine and treat my condition as he/she deems appropriate through the use of Chiropractic care. I also give my consent to the doctor to take x-rays (if needed) or to perform other diagnostic aids as he/she deems appropriate in my case. • ***WOMEN ONLY*** *I hereby declare that to the best of my knowledge,* ☐***I am*** ☐***I am not pregnant****. If there is a chance that I may be pregnant, I will inform the doctor prior to my examination.*

Patient Signature_____

(Parent/Guardian signature if under 18 years of age)

GENERAL/FINANCIAL POLICY

Welcome to Simple Relief Wellness Center. We strive to provide you with excellent Chiropractic care in a clean, friendly, professional setting and our goal is to make your visits as convenient as possible.

By signing below, you confirm that you have read this policy and understand that:

- It is your responsibility to inform our office of any address or telephone number changes.
- Your account is to be kept current. All self pay or insurance copayments, co-insurances and deductibles will be collected at the time of service payable by cash, check, Visa, MasterCard, Discover, American Express or Care Credit.
- If you do not have your payment (s), your appointment may be rescheduled.
- If you are unable to keep a scheduled appointment, please notify us no later than the day before so that we may offer that time to another patient. **There is a $25.00 charge for missing a half hour massage appointment and a $50.00 charge for missing a full hour massage appointment without proper notification. Hour massage appointments will be booked with a credit card on file.**
- A returned check will result in a $25.00 service charge and all future payments being required in the form of cash or credit card.
- You will only be sent a statement if your balance exceeds $5.00.
- There is a $35.00 charge for the completion of paperwork (ex: disability, FMLA, etc).
- If your account is turned over to a collection agency, you will be responsible for any costs incurred in collection of said balance, which may include collection agency fees up to 35% of your outstanding balance, court costs and attorney fees.

IF YOU HAVE HEALTH INSURANCE COVERAGE: As a courtesy to you, our office will attempt to pre-verify your primary insurance coverage for your Chiropractic care. Coverage information is obtained from your insurance company using information provided by you prior to your initial visit. **We must emphasize that as medical providers, our relationship is with you, not your insurance company.** Please be advised that the information provided by your insurance company is not a guarantee of payment, only an estimate of what might be covered under your policy at the time of inquiry.

By signing below you confirm you understand that:

- It is your responsibility to inform us of any changes to your insurance policy so that your coverage can be re-verified.
- Not all services are a covered benefit with all insurance plans.
- It is your responsibility to be aware of what service (s) is being provided to you and if it is a covered benefit under your insurance.
- You are responsible for any non-covered charges not payable by your insurance policy.
- We will send all required claim forms and documentation to ensure your claims are processed in a timely manner.
- Final determination of benefits available is determined when the claim is sent to your insurance company and we receive an explanation of benefits from them.
- After all co-pays, contracted plan reductions and insurance payment credits are applied to your account, any remaining portion will be your responsibility.
- If you are a **MEDICARE PATIENT**, please be advised that Medicare **only covers** Spinal Adjustments in a Chiropractor's office. All services outside of the Spinal Adjustment in our office will be your financial responsibility.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we urge you to contact us promptly for assistance in the management of your account. If you have any questions about the above information, *please* do not hesitate to ask us. **WE ARE HERE TO HELP YOU.**

By signing below, you have read and understand the above Financial Policy and agree to meet all financial obligations.

_____	_____	_____
Printed Name	Signature of Patient/Legal Guardian	Date

CONSENT TO RELEASE INFORMATION: In the event that you ever wish to have a family member or friend come to our office and get a copy of your medical records for whatever reason, we ask that you sign below allowing them to do so. By signing below I hereby give my consent for Simple Relief Wellness Center to release my medical records to:

_____	_____	_____
Name of Family Member/Friend	Signature of Patient/Parent/Legal guardian	Date

CONSENT TO TREAT A MINOR: I hereby authorize and give consent for the Chiropractic Physicians at Simple Relief Wellness Center to examine, and if needed, treat my minor child _____.

Print child's name here

_____	_____	_____
Printed Name	Signature of Patient/Legal Guardian	Date

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History of Auto Accident

Patient's Name_____ Date of Birth _____Today's Date_____

Address_____ Date of Accident_____

City_____ State_____ Zip_____ Time of Accident_____

Please describe in detail how the accident happened_____

_____

_____

_____

☐ I was the driver

☐ I was the passenger sitting in the

☐ middle front seat ☐ right front seat ☐ left rear seat ☐ middle rear seat ☐ right rear seat

☐ I was a pedestrian ☐ standing ☐ sitting ☐ riding a bike ☐ walking ☐ other_____

I was traveling in a vehicle: Year_____ Make_____ Model _____

Transmission type: ☐ manual ☐ automatic

The vehicle I was traveling in was ☐ stopped ☐ traveling at_____m.p.h.

Road conditions were: ☐ dry ☐ damp ☐ wet

The road was made of: ☐ concrete ☐ asphalt ☐ gravel ☐ dirt ☐ other_____

Did you car have a head rest: ☐ yes ☐ no

If your car had a head rest, what position was it in: ☐up ☐middle ☐ down

Were you: wearing your seat belt ☐yes ☐ no Wearing your harness ☐ yes ☐ no

Head position: At the time of the accident my head was looking:

☐ straight ahead ☐ to the right ☐ to the left ☐up ☐ down ☐ other_____

Brakes: Were your brakes applied at the time of the impact ☐ yes ☐ no

Elbows: My ☐ left ☐ right elbow was on the arm rest. Other_____

Hands: ☐ both ☐ right ☐ left hand was on the steering wheel.

☐ can't remember ☐other_____

Were you aware of the impending collision before it happened: ☐ yes ☐ no

Did you tighten your body and brace for the collision: ☐ yes ☐ no

☐ Your hands, as a result of the impact:

☐ grabbed the steering wheel tightly ☐ were forced off the steering wheel/stick shift

☐ other_____

As a result of the impact, your body was thrown: ☐ forward ☐ backward ☐ right ☐ left

☐ turned to the right (clockwise) ☐ can't remember

As a result of the impact, your head hit the: ☐ front windshield ☐ rearview mirror

☐ steering wheel ☐ back of the seat ahead of me ☐ side driver/passenger – inside window/door

☐ another person's body ☐ nothing ☐ other_____

As a result of the impact your shoulders were: ☐ Impacted with the inside of the door/car

☐ pressed firmly against the shoulder harness ☐ other_____

As a result of the collision, what other parts of your body struck the inside of the vehicle:

☐ ankles ☐ elbows ☐ face ☐ chest ☐ thighs ☐ forearms ☐ other_____

Did your vehicle strike or impact with a second object after the first impact: ☐ yes ☐ no

Did your vehicle strike another car: ☐ car ☐ truck ☐ road/median ☐ building

☐ other_____

Were you wearing glasses at the time of the accident: ☐ none ☐ yes ☐ no

If yes, were your glasses still on following the accident: ☐ yes ☐ no

Did you lose consciousness as a result of the accident: ☐ yes ☐ no

If yes, how long were you unconscious:_____

Estimate cost to repair your car: $_____

After the accident the car was: ☐ totaled ☐ drivable ☐ not drivable

At the time of the accident, how many people were in the car with you:

Names of other occupants:

1._____ 4._____

2._____ 5._____

3._____ 6._____

Were the other occupants injured: ☐ yes ☐ no if yes, explain:_____

_____

Were the police called to the scene: ☐ yes ☐ no

Was a police report written: ☐ yes ☐ no

Was a ticket given to you: ☐ yes ☐ no

Was a ticket given to the other driver: ☐ yes ☐ no

As a result of the accident I felt my symptoms:

☐ immediately ☐ within one hour ☐ within 6 hours ☐ during the night

☐ next morning ☐ next day ☐ other _____

As a result of the accident I felt:

☐ headaches ☐ upper back pain ☐ chest pain/soreness ☐ wrist/elbow pain/soreness

☐ neck pain ☐ low back pain ☐ stomach pain/soreness ☐ knew/ankle pain/soreness

☐ shoulder pain ☐ numb/tingling/burning arms ☐ numb/tingling/burning legs

☐ loss of bowel/bladder control ☐ other_____

Please list location of any cuts or bruises if applicable:_____

_____

Did you go to the hospital: ☐ yes ☐ no

If yes: ☐ immediately ☐ next day ☐ later in same day ☐ other _____

Did you go to the hospital by: ☐ ambulance ☐ private transportation

Name of hospital:_____ City:_____

Were you admitted to hospital: ☐ yes ☐ no

If yes, how long was your stay: _____

Hospital diagnosis:_____

What recommendations were made: ☐ see your own doctor ☐ see orthopedist/neurologist

☐ physical therapist ☐ braces/collars ☐ prescription ☐ released ☐ other _____

Please list all doctors you have seen since the accident

Name	Address	City	Released
1._____	_____	_____	_____
2._____	_____	_____	_____
3._____	_____	_____	_____
4._____	_____	_____	_____

Are you working now: ☐ yes ☐ no

Are you currently working with restrictions: ☐ yes ☐ no

Has the doctor placed you on: ☐ total disability ☐ partial disability

Please list work restrictions:_____

Please list any special test ordered by the hospital or doctor _____

_____

Since the accident do you feel: ☐ worse ☐ no improvement ☐ better ☐ other_____

Prior to this incident, have you been involved in any other past Motor Vehicle Accidents: ☐ yes ☐ no

If yes, approximately what date did the accident occur:_____

Did you experience any trauma:_____

If so, what was your diagnosis:_____

Do you still experience symptoms from your prior accident: ☐ yes ☐ no

If yes, have the symptoms been exasperated by your most recent accident: ☐ yes ☐ no

Patient/Insured:_____ Date of loss: _____ Insurer: _____Claim #: _____

Irrevocable Doctor's Lien

To Attorney: _____ My Patient/Your Client: _____

I hereby authorize **Simple Relief Wellness Center** to furnish you, my attorney, with all of my medical records in regards to my accident in which I was involved in. I also authorize and direct you, my attorney, to withhold monies from any settlement, judgments or verdict and to pay directly to **Simple Relief Wellness Center** any balances owed for professional services rendered to me both by reason of this accident and by reason of any other bills owed to **Simple Relief Wellness Center.** I further herby give a lien on my case to **Simple Relief Wellness Center** against any and all proceeds of any settlement, judgment, or verdict which may be paid to you, my attorney, or myself as the result of the injuries for which I have been treated or injuries in connection therewith. I also understand that, regardless of the outcome of any settlement, judgment, or verdict, I am directly and fully responsible to **Simple Relief Wellness Center** for any and all balances owed for professional services. This agreement is made solely for **Simple Relief Wellness Center** additional protection and in consideration of awaiting payment for services rendered.

Patient/Insured Signature: _____ Date Signed: _____

Authorization to Release Auto Insurance Information and/or Obtain PIP Benefit Payout Information

I hereby grant my authorization for Simple Relief Wellness Center to request and obtain my PIP insurance policy benefits for the accident noted above. I also hereby authorize and direct my insurer to send to Simple Relief Wellness Center an accounting ledger showing all PIP benefit payouts for the above noted accident.

Patient/Insured Signature: _____ Date Signed: _____

Assignment of PIP Benefits

I hereby assign my PIP automobile insurance policy benefits relating to the above captioned accident to Simple Relief Wellness Center for professional services rendered and covered under my PIP and/or Medical payments policy. All payments for such services shall be forwarded directly to Simple Relief Wellness Center. All payments will be overdue if not paid within the allowed 30-day period after the insurer is furnished with properly completed claim form and medical records. Overdue payments will bear 10% interest per annum. In the event an insurer fails to pay Simple Relief Wellness Center the full amount of the treatment allowed by current fee schedules, I authorize and direct the insurer to set aside/escrow an amount equal to the full amount of any such reduction until Simple Relief Wellness Center has exercised its rights under this assignment and the dispute is resolved. This assignment will remain in effect until 48-hours after Simple Relief Wellness Center receives written notice that it is being revoked. It is specifically agreed that any such revocation of this assignment will not apply to any treatment or associated expenses incurred on or before the date of notice of revocation is received by Simple Relief Wellness Center. The undersigned agrees to pay any applicable deductible and/or co-payments not covered under the available PIP and/or Medical Payments policy. Furthermore, the undersigned agrees to pay all outstanding balances in excess of the available insurance coverage limits.

Patient/Insured Signature: _____ Date Signed: _____