Young Chiropractic LLC*

11953 S. Apopka Vineland Rd. Orlando, FL. 32836
PH: 407-238-2306 FX: 407-238-2309

Date:_____ Patient #_____ **Doctor: David Young, D.C.**

Name:_____ Birth Date: _____Social Security #_____

Address:_____City:_____ State:_____ Zip:_____

Phone#_____E-mail address:_____

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

How were you referred to our office?_____

Family Medical Doctor:_____

Please check any and all insurance coverage that may be applicable in this case:

π Major Medical π Worker's Compensation π Medicaid π Medicare π Auto Accident
π Medical Savings Account & Flex Plans π Other

Name of Primary Insurance Company:_____
Name of Secondary Insurance Company (if any):_____

AUTHORIZATION AND RELEASE: I authorize 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 that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

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. The following person(s) have my permission to receive my personal health information:**_____

INFORMED CONSENT: I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic.

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, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all 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 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/Legal Guardian X_____Date _____

*dba Lake Buena Vista Chiropractic

PATIENT NAME _____ DATE _____

HISTORY OF PRESENT AND PAST ILLNESS:

Briefly describe your symptoms:_____

Date symptoms first appeared:_____

How did your symptoms start: Auto____ Work____ Other_____

Current Pain Level: No pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

How has your symptoms interfered with your daily activites (including Work):

1 - not at all, 2 - a little bit, 3 - moderately, 4 - quite a bit, 5 - extremely

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

_____

What medications/drugs are you taking?_____

Do you have any allergies of any kind? _____

Days lost from work:_____ Date of last physical examination:_____

What is your overall health right now: 1–Excellent 2–Very Good 3–Good 4–Fair 5–Poor

Women: Are you pregnant?_____

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

Musculoskeletal	**Genitourinary**	**HEENT**
Neck pain/stiffness _____	Trouble urinating _____	Headaches _____
Midback pain/stiffness _____	Excessive period bleeding _____	Vision problems _____
Low back pain/stiffness _____	Menopause _____	Sinus problems _____
Osteoporosis _____	**Gastrointestinal**	Ringing in ears _____
Rheumatoid arthritis _____	Abdominal pain _____	Toothache _____
Osteoarthritis _____	Nausea/vomiting _____	Sore throat _____
Neurological	Diarrhea/constipation _____	**Psychiatric**
Numbness/tingling _____	Blood in stool _____	Depression _____
Muscle weakness _____	**Cardiovascular / Respiratory**	Anxiety _____
Loss of balance _____	Pacemaker _____	Difficulty concentrating _____
Changes in taste or smell _____	Loss of consciousness _____	Loss of memory _____
Seizures/epilepsy _____	Shortness of breath _____	**Integumentary**
Constitution	Chest pain _____	Lesions _____
Weight loss _____	Cough _____	Eczema _____
Fatigue _____	Inability to exercise _____	Lumps/masses _____
Sleeping problems _____	**Endocrine**	Rashes _____
Fever _____	Diabetes _____	**Immunologic**
Cancer _____	Hypertension _____	Allergies _____
Hematologic	Hyperthyroid _____	Swelling _____
Anemia _____	Hypothyroid _____	

Family History: list any serious or chronic health problems (high blood pressure, cancer, diabetes, etc.)

Mom age: _____ Health problems:_____

Dad age: _____ Health problems_____

Social History

Smoke: _____ packs / day Coffee: _____ cups / day Soda: _____ cans / day Alcohol: _____ drinks / week

Stress: _____ (0 no stress – 10 max stress) Sleep: _____hours/night Exercise: _____ times / week

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

Name of Patient _____

Patient's Signature/Legal Guardian X_____Date _____

BACK PAIN INDEX

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the **ONE** statement that applies to you.

Pain Intensity

0. The pain comes and goes and is very mild
1. The pain is mild and does not vary much
2. The pain comes and goes and is moderate
3. The pain comes and goes and does not vary much
4. The pain comes and goes and is very severe
5. The pain is very severe and does not vary much

Sleeping

0. I get no pain in bed
1. I get pain in bed but it does not prevent me from sleeping well
2. Because of pain my normal sleep is reduced by less than 25%
3. Because of pain my normal sleep is reduced by less than 50%
4. Because of pain my normal sleep is reduced by less than 75%
5. Pain prevents me from sleeping at all

Sitting

0. I can sit in any chair as long as I like
1. I can only sit in my favorite chair as long as I like
2. Pain prevents me from sitting more than 1 hour
3. Pain prevents me from sitting more than ½ hour
4. Pain prevents me from sitting more than 10 minutes
5. I avoid sitting because it increases pain immediately

Standing

0. I can stand as long as I want without pain
1. I have some pain while standing but it does not increase with time
2. I cannot stand for longer than 1 hour without increasing pain
3. I cannot stand for longer than ½ hour without increasing pain
4. I cannot stand for longer than 10 minutes without increasing pain
5. I avoid standing because it increases pain immediately

Walking

0. I have no pain while walking
1. I have some pain while walking but it doesn't increase with distance
2. I cannot walk more than 1 mile without increasing pain
3. I cannot walk more than ½ mile without increasing pain
4. I cannot walk more than ¼ mile without increasing pain
5. I cannot walk at all without increasing pain

Personal Care

0. I do not have to change my way of washing or dressing in order to avoid pain
1. I do not normally change my way of washing or dressing even though it causes some pain
2. Washing and dressing increases the pain but I manage not to change my way of doing it
3. Washing and dressing increases the pain and I find it necessary to change my way of doing it
4. Because of the pain I am unable to do some washing and dressing without help
5. Because of the pain I am unable to do any washing and dressing without help

Lifting

0. I can lift heavy weights without extra pain
1. I can lift heavy weights but it causes extra pain
2. Pain prevents me from lifting heavy weights off the floor
3. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned
4. Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned
5. I can only lift very light weights

Traveling

0. I get no pain while traveling
1. I get some pain while traveling but none of my usual forms of travel make it worse
2. I get extra pain while traveling but it does not cause me to seek alternative forms of travel
3. I get extra pain while traveling which causes me to seek alternate forms of travel
4. Pain restricts all forms of travel except that done while lying down
5. Pain restricts all forms of travel

Social Life

0. My social life is normal and gives me no extra pain
1. My social life is normal but increases the degree of pain
2. Pain has no significant affect on my social life apart from limiting my more energetic interests (eg dancing)
3. Pain has restricted my social life and I do not go out very often
4. Pain has restricted my social life to my home
5. I have hardly any social life because of the pain

Changing degree of pain

0. My pain is rapidly getting better
1. My pain fluctuates but overall is definitely getting better
2. My pain seems to be getting better but improvement is slow
3. My pain is neither getting better or worse
4. My pain is gradually worsening
5. My pain is rapidly worsening

_____ _____

Patient Name Date

Completely filled: Index score = Total score x 2 **Office Use**

If partially filled: Index score = [Total of all statements / (# of sections completed x 5)] x100 Back Index Score =