

# ORANGE PARK & ARGYLE CHIROPRACTIC CENTERS

## NEW PATIENT QUESTIONNAIRE

Date: \_\_\_\_\_

Email Address: \_\_\_\_\_

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ Apt #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Sex: M F DOB: \_\_\_/\_\_\_/\_\_\_ Marital Status: S M D W

Weight: \_\_\_\_\_ Height: \_\_\_\_\_

Employed By: \_\_\_\_\_ Phone: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_

HEARD ABOUT OUR OFFICE BY: \_\_\_\_\_

**Is patient here as the result of an accident? Y N Date of Accident: \_\_\_/\_\_\_/\_\_\_**

Accident type: AUTO WORK HOME RECREATION SPORTS

Primary Insurance Company: \_\_\_\_\_

Insured: SELF SPOUSE PARENT/GUARDIAN

Insured's DOB: \_\_\_/\_\_\_/\_\_\_ Insured's SS#: \_\_\_\_\_

Insured Employer: \_\_\_\_\_

Who is your Primary Care Physician? \_\_\_\_\_

WHAT IS YOUR CURRENT AREA(S) OF COMPLAINT? \_\_\_\_\_

What surgeries have you had (type and when): \_\_\_\_\_

List any previous accidents and falls: (Auto, Work, Sports, Home, Other): \_\_\_\_\_

List any broken bones you may have had: \_\_\_\_\_

List any medications and/or supplements you may be taking:

Do you have any drug allergies?

Do you smoke: Y N Alcohol: Y N \_\_\_\_\_

### ASSIGNMENT OF BENEFITS

I, \_\_\_\_\_, hereby irrevocably assign to Argyle Chiropractic Center, P.A. / Orange Park Chiropractic Center, P.A. any and all benefits and rights I have under any policy of insurance, indemnity agreement, or any other collateral source as defined by the Florida Statutes for any service and/or charges provided by Argyle Chiropractic Center, P.A. / Orange Park Chiropractic Center, P.A.

In witness whereof, the undersigned have hereunto set their hands, this \_\_\_\_\_ day of \_\_\_\_\_ of 20\_\_\_\_.

\_\_\_\_\_  
Patient Name

X \_\_\_\_\_  
Patient Signature

PLEASE CIRCLE ALL CURRENT CONDITIONS

**SKIN**

Skin Disorder  
Shingles  
Bruises Easily  
Boils  
Hives or Allergies

**RESPIRATORY**

Difficulty Breathing  
Chronic Cough  
Coughing Phlegm/Blood  
Asthma

**NERVOUS SYSTEM**

Hot/Cold Spots  
Numbness/Tingling  
Dizziness  
Paralysis  
Fainting  
Convulsions  
Irritability  
Tremors  
Insomnia  
Depression  
Confusion  
Forgetfulness

**GENERAL**

Fever  
Thyroid Disorder  
Chills  
Diabetes  
Sweats  
Rheumatic Fever  
Chronic Fatigue  
Cancer  
Loss of Weight  
Weight Trouble

**GENIO-URINARY**

Urine Disorder Frequent  
Excessive/Scanty/Painful  
Discolored/Blood/Pus  
Kidney Infections/Stones  
Cancer  
Prostatitis  
Bladder Trouble

**FEMALE**

Periods-Painful  
Irregular/Cramps  
Hot Flashes  
Breast-Lumps/Congested  
Menopause Symptoms

**GASTRO-INTESTINAL**

Chronic Nausea  
Vomiting  
Vomiting Blood  
Difficulty Chewing  
Swallowing  
Excessive Thirst  
Gastritis/Heartburn  
Pain over Stomach  
Ulcers/Stomach Disorders  
Distention of Abdomen  
Constipation  
Diarrhea  
Liver Trouble  
Gallbladder Trouble

**PRIMARY SYMPTOMS**

Recurring Headaches  
Facial/Jaw Pain  
Restricted Movement  
Head/Neck  
Neck Pain  
Neck Spasms  
Poor Posture  
Upper Back Pain  
Sore Aching  
“Shawl Muscles”  
Pain Shoulder/Arm/Hand  
Restricted Movement  
Shoulder/Arm/Hand  
Swollen Arm/Hand  
Arthritis  
Pain Beneath/Under  
Shoulder Blade  
Pain around Collar Bone  
Mid Back Pain  
Scoliosis  
Low Back Pain  
Neuritis  
Buttock Pain  
Hip Pain  
Sciatica  
Restricted Movement  
Leg/Foot  
Leg Cramps  
Leg Pain/Lower/Upper  
Sore Weak Muscles  
Walking Problems

**CARDIO VASCULAR**

Heart Attack  
High Blood Pressure  
Low Blood Pressure  
Rapid Beating Heart  
Slow Beating Heart  
Pain Over Heart  
Hardening Arteries  
Swelling of Ankles  
Poor Circulation  
Stroke  
Varicose Veins

**EYES/EARS/NOSE**

**AND THROAT**

Zig Zag Flashes  
Chronic Earache  
Hearing Loss  
Ear Discharge  
Nose Pain  
Nose Bleeding  
Sore Throat  
Hoarseness

Sign \_\_\_\_\_ Date: \_\_\_\_\_

Witness \_\_\_\_\_ Date: \_\_\_\_\_

PLEASE USE THE FOLLOWING COLORS TO SHOW THE PRESENT AREAS OF COMPLAINTS AND THE TYPES OF PAIN:

BLUE	=	PAIN / ACHE / TENDERNESS
PINK	=	BURNING
GREEN	=	SPASMS / CRAMPING
YELLOW	=	PINS / NEEDLES / NUMBNESS / TINGLING
ORANGE	=	TIGHTNESS / STIFFNESS

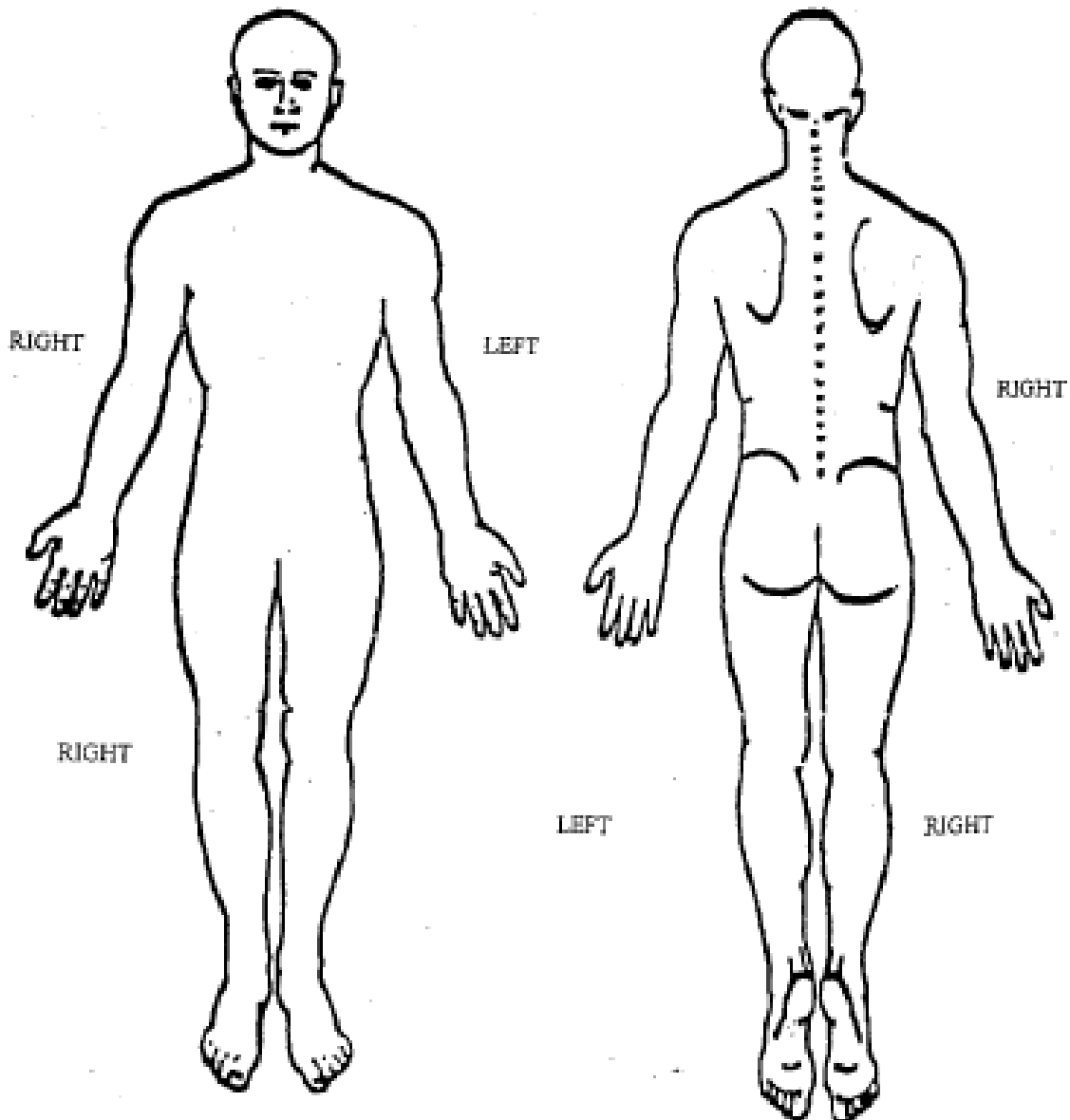
Comments: \_\_\_\_\_

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name Printed: \_\_\_\_\_

Using a scale of 1 – 10, Rate the Intensity of each complaint area:

1 = Least Intensity  
10 = Greatest Intensity



STRESS-RELAXATION PROFILE:

Circle all stressors: Coworker Boss Financial Home Personal Health Issues

Friend Parent Child Spouse Ex-Spouse Mental Health Issue Emotional

Circle all relaxation methods: Sleep TV Read Music Alcohol Smoking Drugs Eating Quietness

Walk Jog Run Swim Prayer Meditate Centering Solitude Deep Breathing

FAMILY HISTORY: Review the disease categories and use the appropriate letter (s):

GP (grandparent) F (father) M (mother) H (husband) W (wife) B (brother) S (sister) C (child)

Arthritis \_\_\_\_\_ Kidney/Liver \_\_\_\_\_

Asthma \_\_\_\_\_ Low Back Pain \_\_\_\_\_

Cancer \_\_\_\_\_ Mental Illness \_\_\_\_\_

Depression \_\_\_\_\_ Migraine \_\_\_\_\_

Diabetes \_\_\_\_\_ Multiple Sclerosis \_\_\_\_\_

Disc Degeneration \_\_\_\_\_ Polio \_\_\_\_\_

Emphysema/Lung \_\_\_\_\_ Scoliosis \_\_\_\_\_

Epilepsy \_\_\_\_\_ Sinus Infections \_\_\_\_\_

Headaches \_\_\_\_\_ Stomach \_\_\_\_\_

Heart Attack \_\_\_\_\_ Thyroid \_\_\_\_\_

High Blood Pressure \_\_\_\_\_ Tuberculosis \_\_\_\_\_

FOR WOMEN ONLY: Are you pregnant? N Y Any Chance? N Y

Use Birth Control? N Y Pills Condoms Shots Diaphragm Tubal Hysterectomy Vasectomy

Date last menstrual period began: \_\_\_\_/\_\_\_\_/\_\_\_\_ Do you have painful periods? N Y

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

**AUTHORIZATION TO RELEASE OR  
RECEIVE MEDICAL INFORMATION  
and  
AUTHORIZATION OF  
ASSIGNMENT OF BENEFITS**

We strongly feel that all patients deserve from us the very best medical care that we can provide. Further, we feel that everyone benefits when definitive financial arrangements are agreed upon. Accordingly, we have prepared this material to acquaint you with our policy.

Our professional services are rendered to you, not the insurance company. Therefore, payment for treatment is your responsibility.

**PLEASE READ AND SIGN THE FOLLOWING:**

- 1) I authorize this office to release or receive any information necessary for my medical file and to expedite insurance claims.
- 2) I hereby authorize this office to bill my insurance company directly for their services.
- 3) I authorize payment directly to this physician of any insurance benefits otherwise payment to me.
- 4) In the event I receive payment from my insurance carrier, I agree to endorse any payment I receive over to my physician for which these fees are payable.

I understand that I am directly and fully financially responsible to this physician for charges not paid by my insurance. I further understand that such payment is not contingent on any settlement, judgment or insurance payment by which I eventually recover that fee. I realize that if my insurance company fails to pay my balance in full, or there is no payment made within 60 days, it is my responsibility to pay my doctor's bill directly. Further, I agree to pay Orange Park Chiropractic Center, P.A. / Argyle Chiropractic Center, P.A. the difference, if any, between the total amount of charges and the amount paid to me by the attorney and/or insurance carrier.

I further understand and agree that if I had to make timely payments on my account, I will be responsible for any and all reasonable costs of collection, including filing fees as well as reasonable attorney's fee.

A photo static copy of these authorizations and agreement shall be as valid as the original.

I understand that if I am accepted as a patient at Orange Park Chiropractic Center, P.A. / Argyle Chiropractic Center, P.A., I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risks associated with chiropractic will be explained upon my request.

**Signature** \_\_\_\_\_

**Date** \_\_\_\_\_

**Witness** \_\_\_\_\_



ACKNOWLEDGEMENT 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.



***ORANGE PARK CHIROPRACTIC CENTER***  
***ARGYLE CHIROPRACTIC CENTER***

DR. KEITH A. SCHERTELL  
DR. JAMES W. DAUTEL  
DR. TINA WARREN

**MASSAGE NOTICE**

I agree that a No-show fee of 15.00 will be assessed for any missed Neuro Muscular Therapy appointments without a 24 hours cancellation notice.

X \_\_\_\_\_

## Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may effect the restoration and preservation of health. Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctors' objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

\_\_\_\_\_

Print Name

\_\_\_\_\_

Signature

\_\_\_\_\_

Date

### **Consent to evaluate and adjust minor child:**

I, \_\_\_\_\_, being the parent or legal guardian of \_\_\_\_\_ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

### **Pregnancy Release:**

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: \_\_\_\_\_

\_\_\_\_\_

Signature

\_\_\_\_\_

Date