Slossberg Chiropractic & Wellness

Dr. David Slossberg Dr. Aimee Slossberg
4640 Hypoluxo Rd., Ste. 2 Lake Worth, FL 33463 (561) 296-1715
www.slossbergchiropractic.com

PATIENT INFORMATION Date:____________

Last Name _______________________ First Name _________________ Nick Name ______________

Address _____________________________________City ______________ State _____Zip ______

Home Phone______________ Work Phone________________ Cell Phone ___________________

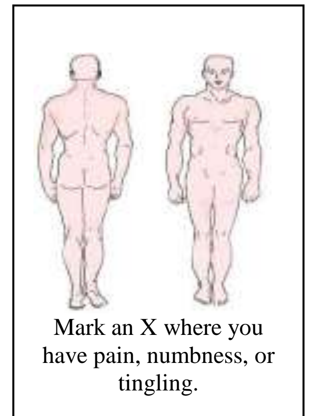
Employed: FT PT Ret NA S.S. Number: _____-_____-_______ Date of Birth: ___/___/___

Sex: M F Age: ________ Marital Status: S M W D Height: _____ Weight: _____

Spouse's Name _____________________ Email Address_______________________________

#1 Complaint: ____
____

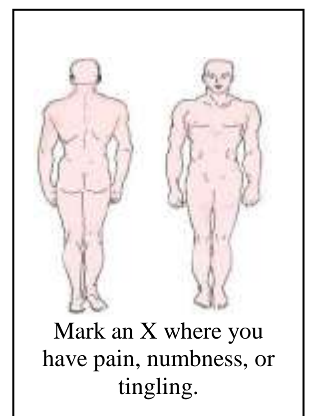
When did your symptoms appear? ________________________________
Is this the result of an ☐ injury ☐ auto accident ☐ work injury ☐ other
Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown
Severity of your pain on a scale from 1 (least pain) to 10 (severe) ________
Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Knife-like ☐ Numbness
☐ Aching ☐ Shooting ☐ Burning ☐ Tingling ☐ Cramps
☐ Stiffness ☐ Swelling ☐ Sore ☐ Deep ☐ Other
How often do you experience the problem? ☐ Daily ☐ 3-4x/wk ☐ 1-2x/wk
☐ 1x/wk ☐ 2x/mo ☐ 1x/mo ☐ 1x / 2-3 mo's ☐ 2x / yr ☐ 1x / yr
Is it ☐ constant or does it ☐ come and go? Worse in the ☐ AM ☐ PM
Does it radiate in to the: ☐ Right Arm ☐ Right Hand ☐ Left Arm ☐ Left Hand
☐ Right Leg ☐ Right Foot ☐ Left Leg ☐ Left Foot
What makes it worse? ____
What makes it better? ____
Have you had similar problem(s) before? Y N If so, when? ___________________________
Types of Treatment received: Meds Surgery Phys. Therapy Chiropractic Other _____________



Mark an X where you have pain, numbness, or tingling.

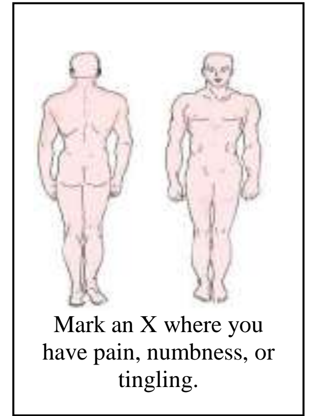
#2 Complaint: ____
____

When did your symptoms appear? ________________________________
Is this the result of an ☐ injury ☐ auto accident ☐ work injury ☐ other
Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown
Severity of your pain on a scale from 1 (least pain) to 10 (severe) ________
Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Knife-like ☐ Numbness
☐ Aching ☐ Shooting ☐ Burning ☐ Tingling ☐ Cramps
☐ Stiffness ☐ Swelling ☐ Sore ☐ Deep ☐ Other
How often do you experience the problem? ☐ Daily ☐ 3-4x/wk ☐ 1-2x/wk
☐ 1x/wk ☐ 2x/mo ☐ 1x/mo ☐ 1x / 2-3 mo's ☐ 2x / yr ☐ 1x / yr
Is it ☐ constant or does it ☐ come and go? Worse in the ☐ AM ☐ PM
Does it radiate in to the: ☐ Right Arm ☐ Right Hand ☐ Left Arm ☐ Left Hand
☐ Right Leg ☐ Right Foot ☐ Left Leg ☐ Left Foot
What makes it worse? ____
What makes it better? ____
Have you had similar problem(s) before? Y N If so, when? ___________________________
Types of Treatment received: Meds Surgery Phys. Therapy Chiropractic Other _____________



Mark an X where you have pain, numbness, or tingling.

#3 Complaint: ____
____
When did your symptoms appear? _________________________________
Is this the result of an ☐ injury ☐ auto accident ☐ work injury ☐ other
Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown
Severity of your pain on a scale from 1 (least pain) to 10 (severe) _______
Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Knife-like ☐ Numbness
☐ Aching ☐ Shooting ☐ Burning ☐ Tingling ☐ Cramps
☐ Stiffness ☐ Swelling ☐ Sore ☐ Deep ☐ Other
How often do you experience the problem? ☐ Daily ☐ 3-4x/wk ☐ 1-2x/wk
☐ 1x/wk ☐ 2x/mo ☐ 1x/mo ☐ 1x / 2-3 mo's ☐ 2x / yr ☐ 1x / yr
Is it ☐ constant or does it ☐ come and go? Worse in the ☐ AM ☐ PM
Does it radiate in to the: ☐ Right Arm ☐ Right Hand ☐ Left Arm ☐ Left Hand
☐ Right Leg ☐ Right Foot ☐ Left Leg ☐ Left Foot


Mark an X where you have pain, numbness, or tingling.

What makes it worse? ____
What makes it better? ____
Have you had similar problem(s) before? Y N If so, when? ______________________________
Types of Treatment received: Meds Surgery Phys. Therapy Chiropractic Other _____________

Father, mother, brother, sister, children with similar problems? Y N If so, who? _________________
____
Other doctors you have seen for this problem: ____
Names of other doctors who have treated you for this condition: ______________________________
Date of Last: Physical Exam _______ Spinal X-ray _______ Blood Test _______ Urine Test _______
Spinal Exam ________ Chest X-ray _______ MRI,CT Scan, Bone Scan __________
Who is responsible for your health insurance: Self Medical Ins. Medicare Auto Ins. Other_____
Name of Medical Insurance carrier: ____
Occupation________________________ Date of last motor vehicle accident: ___________
Date of last slip/fall: _____________
Surgeries you have had: ____
Medication you are currently taking: ____
Hospitalizations: ____

Trauma History: Slip & Falls ____
Sports ____
Auto Accidents ____
Work ____
Other ____

Effects on life: (Have you discontinued, limited, or modified any activities in the following categories?)
Home: ____
Work: ____
Hobbies: ____
Relationships: ____

How would you rate your quality of sleep: ☐ Poor ☐ Average ☐ Good ☐ Great
In regards to your sleep quality: ☐ Difficult falling asleep ☐ wakes up more than 1 time per night

How would you rate your energy level on a scale of 1 – 10: _________

Is there a chance you are pregnant? Y N
Emergency Contact: ________________ Phone Number______________ Relationship __________

Who may we thank for referring you? ______________________
Have you ever been to a chiropractor before? Y N

MEDICAL HISTORY FORM

Below is a list of diseases that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of chiropractic care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

☐ Pneumonia	☐ Mumps	☐ Influenza	☐ AIDS/HIV	☐ Rheumatoid Arthritis
☐ Rheumatic Fever	☐ Smallpox	☐ Asthma	☐ Alcoholism	☐ Bleeding Disorders
☐ Polio	☐ Chicken Pox	☐ Arthritis	☐ Liver Disease	☐ Bronchitis
☐ Tuberculosis	☐ Diabetes	☐ Epilepsy	☐ Multiple Sclerosis	☐ Chemical Dependency
☐ Whooping Cough	☐ Cancer	☐ Mental Disorders	☐ Parkinson's	☐ Fractures
☐ Anemia	☐ Heart Disease	☐ Hepatitis	☐ Ulcers	☐ Venereal Disease
☐ Measles	☐ Thyroid Disease	☐ Kidney disease	☐ Gout	☐ Psychiatric Care
☐ Migraine Headaches	☐ Miscarriage	☐ Osteoporosis	☐ High Cholesterol	☐ Emphysema

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD IN THE PAST SIX MONTHS:

MUSCULO-SKELETAL
- ☐ Low back pain
- ☐ Pain between shoulders
- ☐ Neck pain
- ☐ Arm pain
- ☐ Joint Pain/Stiffness
- ☐ Walking Problems
- ☐ Difficulty Chewing/Clicking jaw
- ☐ General stiffness
- ☐ Joint swelling

GASTROINTESTINAL
- ☐ Gas/bloating after meals
- ☐ Heartburn
- ☐ Black/bloody Stool
- ☐ Colitis
- ☐ Constipation
- ☐ Diarrhea
- ☐ Vomiting
- ☐ Frequent nausea
- ☐ High Triglycerides
- ☐ Poor/excessive appetite
- ☐ Excessive thirst
- ☐ Weight trouble
- ☐ Abdominal cramps / pain
- ☐ Gall bladder problems
- ☐ Liver problems
- ☐ Hemorrhoids
- ☐ Anorexia ☐ Bulimia
- ☐ Blood sugar problems

GENITOURINARY
- ☐ Bladder trouble
- ☐ Painful Urination
- ☐ Excessive Urination
- ☐ Prostate Problems
- ☐ Sexual Dysfunction
- ☐ Discharge
- ☐ Pelvic Pain
- ☐ Other ___________

NERVOUS SYSTEM
- ☐ Nervous
- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Confusion/depression
- ☐ Fainting
- ☐ Convulsions
- ☐ Cold/tingling extremities
- ☐ Stress
- ☐ Anxiety
- ☐ Burning Pain

EAR/NOSE/THROAT
- ☐ Vision problems
- ☐ Dental problems
- ☐ Sore throat
- ☐ Earaches
- ☐ Stuffed Nose
- ☐ Hearing problems
- ☐ Sinus problems

FEMALES ONLY
- ☐ Menstrual irregularity ☐ Vaginal pain/lumps
- ☐ Menstrual cramps ☐ Breast pain/lumps

When was your last period? _______________

Are you pregnant? ☐ Yes ☐ No

EXERCISE:
- ☐ None ☐ Moderate
- ☐ Daily ☐ Heavy

WORK ACTIVITY:
- ☐ Sitting ☐ Standing
- ☐ Light Labor ☐ Heavy Labor

INTAKE
- ☐ Coffee ☐ Tea ☐ Alcohol
- ☐ Cigarettes ☐ Non-prescription drugs

GENERAL
- ☐ Fatigue
- ☐ Allergies
- ☐ Loss of sleep
- ☐ Headaches
- ☐ Fever

FAMILY HISTORY

The following members have the same or similar problem(s) as I do:

☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Spouse ☐ Child ☐ Other

Which problems did they have? ____

Vitamins/Herbs:____

How many times a year do you get sick? _____ How many bowel movements do you have per day? _____

How many hours of sleep do you get per night? _____ How would you rate your energy level (1-10)? _____

Please fill out any other health information you feel is important: ____________________________________
____
____
____

_____________________________ Patient or Guardian Name

_____________________________ Patient or Guardian Signature

____________ Date

OUR PRACTICE OBJECTIVE & INFORMED CONSENT FOR CARE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. Chiropractic has only one goal: to eliminate vertebral subluxations which are misalignments within the spinal column and extraspinal joints, which interfere with the expression of the body's innate wisdom. It is important that each patient understand both the objective and the method that will be used to attain our goal. This will prevent any confusion or disappointment.

We at Slossberg Chiropractic & Wellness only offer to diagnose and care for either vertebral subluxation or neuro-muscular conditions. We do not offer to treat or diagnose any disease. Nor do we offer advice regarding treatment prescribed by others. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider that specializes in that area. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom and healing.

A patient coming to the Doctor of Chiropractic gives the doctor permission and authority to care for the patient in accordance with chiropractic tests, diagnostics and analysis. Chiropractic care, like all forms of health care, while offering considerable benefit may also provide some level risk. In very rare cases underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course will not give a chiropractic adjustment, or health care, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures whatever he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the Doctor of Chiropractic. The patient should look to the correct specialist for the proper diagnostic and clinical procedures. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and rarely, fracture. One of the rarest complications associated with chiropractic care, occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to stroke. This complication is primarily associated with a high velocity rotary (twisting) type of adjustment to the neck. In our office we do not use that type of an adjustment, and primarily use an instrument to adjust the neck. This reduces the possibly of complication to nearly zero percent.

Prior to receiving chiropractic care we will perform a health history and physical examination. These procedures are performed to assess your specific condition, your overall health and, in particular, your spinal health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported directly to you.

I hereby request and consent to the performance of chiropractic adjustment 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 Slossberg Chiropractic & Wellness and/or other licensed Doctors of Chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for Slossberg Chiropractic & Wellness.

I have read and fully understand the above statements. If determined to be a chiropractic candidate, I therefore accept chiropractic care on this basis.

____ Signature

_______________________ Date

Consent to evaluate and adjust a minor child

I hereby authorize Slossberg Chiropractic & Wellness to administer treatment as they so deem necessary to my daughter / son / other, _________________________________ (name)

____ Signature

_______________________ Date

Slossberg Chiropractic & Wellness
4060 Hypoluxo Road Suite 2
Phone: (561) 296-1715 Fax: (561) 296-1716
Dr. David Slossberg & Dr. Aimee Slossberg

Massage Therapy Policy

1.) All massage appointments are scheduled for the time that the massage is to start. Please come in 5-10 minutes early to allow time to get ready for the massage.

2.) All massage appointments are scheduled at 15 minute increments. If you are scheduled for a 45 minute massage & you are late, we will only be able to do a 30 minute massage although the fee will still be for 45 minutes.

3.) We will require at least a 24 hour notice to cancel a massage. There will be a $35 fee for not showing or calling to re-schedule the massage.

4.) We will do everything possible to work with your insurance company for reimbursement of the massage. Ultimately you are responsible for all services rendered. The following is our massage therapy fees with an included time of service discount.

15 mins = $20 30 mins = $40 45 mins = $60 60 mins = $70

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Patient's Signature Date

Slossberg Chiropractic Wellness, Inc.
Patient Record of Disclosures

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that applies):

☐ Primary Telephone (___) _____________
- ☐ OK to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Secondary Telephone (___) _____________
- ☐ OK to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Written Communication
- ☐ OK to mail my home address
- ☐ OK to mail my work address
- ☐ OK to fax to this number _____________

☐ OK to e-mail my web address ____

☐ Other ____
____

____
Patient Signature Date

____ ______________________________
Print Name Birth date

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use of disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.
Health care entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.
Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

~OFFICE USE ONLY~

Record of Disclosure of Protected Health Information

Date	Disclosed to Whom Address or Fax #	(1)	Description/Purpose Of Disclosure	By Whom Disclosed	(2)	(3)

(1) Check this box if the disclosure is authorized
(2) Type key: T=Treatment Records P=Payment Information O=Healthcare Operations
(3) Enter how disclosure was made: F=Fax P=Phone E=Email O=Other

Receipt of Notice of Privacy Practices Written Acknowledgement Form
Slossberg Family Chiropractic Center, Inc.

I, ______________________________ have read a copy of Slossberg Family Chiropractic Center, Inc. Notice of Patient Privacy Practices.

____ ______________________
Signature of Patient or Parent or Legal Guardian Date

**ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR
PRIVATE AND GROUP ACCIDENT AND HEALTH INSURANCE**

Patient:____
Claim/Group#:____
SSN/ID#:____

I hereby instruct and direct the ________________________ Insurance Company to pay by check made out and mailed directly to:

**Slossberg Chiropractic & Wellness
4640 Hypoluxo Rd., Ste.2
Lake Worth, FL. 33463**

The professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay in a current manor any balance of said professional service charges over and above this insurance payment.

If my current policy prohibits direct payment to doctor, then I hereby also instruct and direct you to make out the check to SLOSSBERG CHIROPRACTIC & WELLNESS, INC. and bring it in to the office or mail it to: 4640 Hypoluxo Rd., Ste.2, Lake Worth, FL 33463

A photocopy of this assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

SLOSSBERG CHIROPRACTIC & WELLNESS

MEDICAL RELEASE

A photocopy of this document shall be sufficient to authorize any person having records of medical treatment, services, or supplies pertaining to me to release true copies of same to SLOSSBERG CHIROPRACTIC & WELLNESS, or any insurer providing coverage to me in connection with the processing of any claim for benefits made by me or by the assignee herein.

A photocopy of this document shall be as binding as an original signature page.

Dated on: _________________________ 2011

____________________________ ____________________________
Signature of Policy Holder Witness

____
Signature of Claimant, if other than policyholder