Womack Chiropractic Center

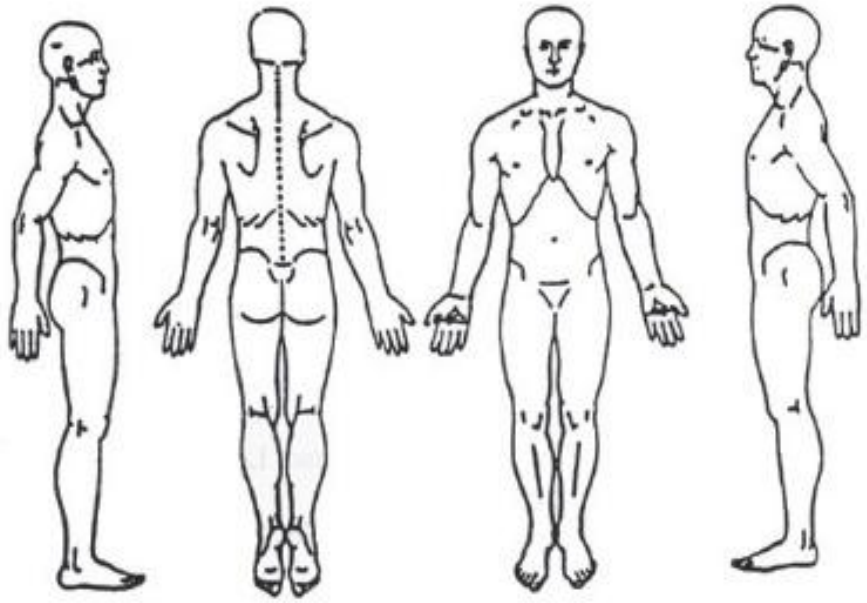
1430 Palm Bay Rd. N.E. Suite C
Palm Bay, FL 32905

CONFIDENTIAL PATIENT HISTORY

PLEASE PRINT:

Name _____ Date _____

1. Describe your symptoms: _____
2. When and how did your symptoms start? _____
3. Frequency of symptoms: ☐ Constant ☐ 75% of time ☐ 50% of time ☐ 25% of Time ☐ Rare
4. Nature of your symptoms? ☐ Sharp ☐ Dull Ache ☐ Numb ☐ Shooting ☐ Burning ☐ Tingling
   Other, please describe: _____
5. Which phrases best describe changes in your symptoms throughout the day: (check all that apply)
   ☐ Worse in morning ☐ Worse in afternoon ☐ Worse at night ☐ Changes with weather ☐ Does not Change
6. Indicate where your symptoms are located, and rate pain level from 0 to 10:



None **Unbearable**

0 1 2 3 4 5 6 7 8 9 10

7. Do you have increased symptoms after any of the following activities, if so after how long?
   Sitting _____ minutes Standing _____ minutes Walking _____ minutes Other _____
8. Does anything help relieve your symptoms? ☐ Ice ☐ Heat ☐ Stretches ☐ Rest
   Medications _____ Other_____
9. Have you ever received any treatment or had any x-rays/MRI/CT scans for your symptoms with any other healthcare provider prior to coming to our office? _____
10. Please briefly list any general health issues you have _____
11. Do you have a family history of neck or back problems if so please describe:
    Father _____ Mother_____
    Brother _____ Sister _____ Rev 10/15

CONFIDENTIAL PATIENT CASE HISTORY
WOMACK CHIROPRACTIC CENTER

PLEASE PRINT:

Patient Full Name _____ Referred by _____

Address _____ City _____

State _____ Zip _____ Email _____

Cell Ph _____ Home Ph _____ Work Ph _____

Birth Date _____ Age _____ Sex: ☐ Male ☐ Female SS# _____

Marital Status: ☐ M ☐ S ☐ D ☐ W Spouse's Name _____

Full Time Student? ☐ Yes ☐ No Emergency Contact _____Phone_____

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic ☐ Declined ☐ Unknown

Race ☐White ☐ Black/African American ☐Declined ☐ Unknown ☐ Other _____

Preferred Language: ☐ English ☐ Spanish ☐ Other: _____

Height _____ Weight _____ Previous Chiropractic Care? ☐ No ☐ Yes - If so, When _____

Date of most recent Annual Physical _____ Date of most recent X-ray/MRI/CT (spine) _____

Women Only: Start of most recent menstrual cycle _____ Are you currently Pregnant? ☐ Yes ☐ No

Family Physician _____

Current Medications: _____

Medications you are allergic to: _____

Have you ever smoked cigars or cigarettes? ☐ No ☐ Yes Do you currently smoke? ☐ No ☐Yes

If yes, how many packs per: Day _____ Week _____

Do you drink alcohol? ☐ No ☐ Yes If so, how many drinks per: Day _____ Week _____

Primary Insurance Co. _____ ID#_____ Your Employer _____

Policyholder's Full Name _____

Address (if different) _____

Policyholder's Date of Birth _____ Policyholder's Relationship to you: _____

Policy holder's Employer _____

Payment is due when services are rendered.

Method of payment for today's charges/co-pay: ☐ Check ☐ Cash ☐ Credit Card

Patient signature: _____ Date _____

Parent name (if minor): _____ Person responsible for this account: _____

For Office use only: Blood Pressure _____/_____ Pulse _____ Respiration _____

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PATIENT NAME: _____

Treatment Consent Form
Womack Chiropractic Center

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment.

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click", much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment

As a part of the analysis, examination and treatment, you are consenting to the following procedures:

- spinal manipulative therapy, palpation, range of motion testing
- orthopedic testing, basic neurological testing, radiographic studies
- muscle strength testing, electric muscle stimulation, hot/cold therapy

The material risks inherent in chiropractic adjustment.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history, during examination and upon examination/review of available diagnostic tests. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options.

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain killers
- Hospitalization
- Surgery

If you choose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated.

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW.

I have read [ ] or have had read to me [ ] the above explanation of chiropractic adjustment and related treatment. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated:_____ **Dated:**_____

_____ **Michael W.Womack, D.C. or Mitchell A. Womack, D.C.**

Patient's name **Doctor's Name**

_____ _____

Signature **Doctor Signature**

_____

Signature of parent or Guardian
(if a minor)

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ACKNOWLEDGMENT 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

_____

Signature

_____

Parent, Guardian or Patient's legal representative

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.

List below the names and relationship of people to whom you authorize the Practice to release PHI.

_____ _____

_____ _____

_____ _____

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