CONFIDENTIAL HEALTH INFORMATION

Please allow our staff to photocopy your driver's license and insurance details. All information you supply is confidential. We comply with all federal privacy standards.

Christa Robben, D.C.
Beach Chiropractic
3000 N. Atlantic Ave. Ste. 105
Cocoa Beach, FL 32931
(321) 868-2225
(321) 868-2295
CocoaBeachChiropractic.com

PATIENT INFORMATION

Name _____ Date _____

Social Security # _____ Date of Birth _____ ○Male ○Female

Address_____City_____ State _____ Zip _____

Email Address_____

Phone _____ Mobile _____ Work _____

Primary Care Physician _____ Last Visit Date _____

○ Married ○Single ○Divorced ○Widowed Number of Children _____ Names and Ages _____

_____

Employer _____ City/State _____

Emergency Contact Name _____ Ph # _____

INSURANCE INFORMATION

Primary Insurance Co. Name _____ Policy # _____

Insured's name (if other than self) _____ relationship to insured _____

Secondary Ins. Co. Name _____ Policy # _____

Insured's name (if other than self) _____ relationship to insured _____

Whom may we thank for referring you to this office? _____

Signature _____ **Date** _____

NAME _____

1.The symptoms that have prompted you to seek care today: _____

_____

2.How did they start? ○Auto Accident ○ Work Injury ○Other _____

3.Onset (when did you first notice the symptoms?)_____

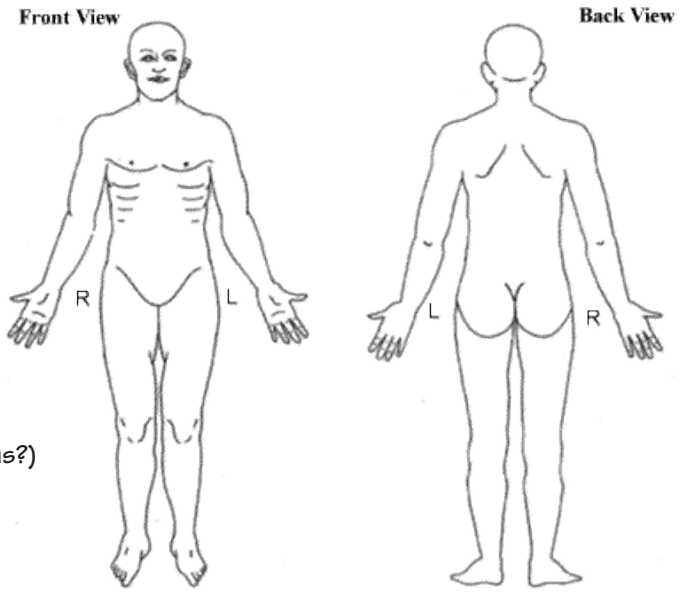
4. Intensity (How severe) at it's worst: 0 1 2 3 4 5 6 7 8 9 10 at it's best: 0 1 2 3 4 5 6 7 8 9 10

5. Duration & timing constant comes and goes How often?_____

6. Quality (what does it feel like?)

- ○ Pain
- ○ Numbness
- ○ Tingling
- ○ Stiff
- ○ Dull
- ○ Sharp
- ○ Cramping
- ○ Nagging
- ○ Burning
- ○ Shooting
- ○ Throbbing
- ○ Stabbing
- ○ Aching
- ○ Other _____

7. Location: Place an X on the illustration



8. Aggravating or Relieving (what makes it better and worse?)

Makes worse:_____

Makes better:_____

9. Radiation (Does the pain travel or shoot to other areas?)

Where? _____

10. Prior Interventions (What have you done to relieve the symptoms?)

- ○ Prescription Medication
- ○ Over the counter drugs
- ○ Massage
- ○ Physical Therapy
- ○ Surgery
- ○ Acupuncture
- ○ Chiropractic
- ○ Nothing

11. What else should Dr. Robben know about your condition? _____

12. How does your condition interfere with your:

Work _____

Recreational Activities_____

Household responsibilities _____

Personal Relationships _____

13. Activities of Daily Living (How does your condition interfere with your ability to function?)

	No Affect	Mild affect	Moderate affect	Severe affect
Sitting ————————	○	○	○	○
Rising from seated ————	○	○	○	○
Standing ————————	○	○	○	○
Walking————————	○	○	○	○
Lying Down————————	○	○	○	○
Bending over————————	○	○	○	○
Up/down stairs————————	○	○	○	○
Using a computer————————	○	○	○	○
Getting in/out of a car————	○	○	○	○
Driving a car————————	○	○	○	○
Looking over a shoulder————	○	○	○	○

	No affect	Mild affect	Moderate affect	Severe affect
Grocery Shopping————————	○	○	○	○
Household Chores————————	○	○	○	○
Lifting Objects———————-	○	○	○	○
Reaching Overhead———————--	○	○	○	○
Showering or bathing————————	○	○	○	○
Dressing myself————————	○	○	○	○
Love Life————————————	○	○	○	○
Getting to sleep————————	○	○	○	○
Staying asleep———————-	○	○	○	○
Concentrating———————--	○	○	○	○
Exercising———————————-	○	○	○	○

NAME_____

REVIEW OF SYSTEMS

Chiropractic care focuses on the interity of your nervous system which controls and regulates your entire body. Please darken the circles beside any condition that you have HAD or currently HAVE, and initial in the space provided. Thank you.

MUSCULOSKELETAL

○ NONE INITIALS_____

Had Have
- ○ ○ Osteoporosis
- ○ ○ Arthritis
- ○ ○ Scoliosis
- ○ ○ Neck Pain
- ○ ○ Back Pain
- ○ ○ Hip Disorders
- ○ ○ Knee Problems
- ○ ○ Foot/Ankle prob
- ○ ○ Shoulder Prob
- ○ ○ Elbow/Wrist Prob
- ○ ○ TMJ Prob
- ○ ○ Poor Posture

NEUROLOGICAL

○ NONE INITIALS_____

Had Have
- ○ ○ Anxiety
- ○ ○ Depression
- ○ ○ Headaches
- ○ ○ Dizziness
- ○ ○ Pins & Needles
- ○ ○ Numbness

CARDIOVASCULAR

○ NONE INITIALS_____

Had Have
- ○ ○ High Bld Pressre
- ○ ○ Low Bld Pressure
- ○ ○ High Cholesterol
- ○ ○ Poor Circulation
- ○ ○ Angina
- ○ ○ Excessive Bruising

RESPIRATORY

○ NONE INITIALS_____

Had Have
- ○ ○ Asthma
- ○ ○ Apnea
- ○ ○ Emphysema
- ○ ○ Hay Fever
- ○ ○ Shortness of breath
- ○ ○ Pneumonia

ENDOCRINE

○ NONE INITIALS_____

Had Have
- ○ ○ Thyroid problem
- ○ ○ Immune Disorder
- ○ ○ Hypoglycemia
- ○ ○ Frequent Urination
- ○ ○ Swollen glands
- ○ ○ Low Energy

DIGESTIVE

○ NONE INITIALS_____

Had Have
- ○ ○ Anorexia/Bulimia
- ○ ○ Ulcer
- ○ ○ Food Sensitivities
- ○ ○ Heartburn
- ○ ○ Constipation/diarrhea
- ○ ○ Digestive disorders

SENSORY

○ NONE INITIALS_____

Had Have
- ○ ○ Blurred Vision
- ○ ○ Ringing in ears
- ○ ○ Hearing loss
- ○ ○ Chronic ear infection
- ○ ○ Loss of smell
- ○ ○ Loss of taste

INTEGUMENTARY

○ NONE INITIALS_____

Had Have
- ○ ○ Skin Cancer
- ○ ○ Psoriasis
- ○ ○ Eczema
- ○ ○ Acne
- ○ ○ Hair Loss
- ○ ○ Rash

GENITOURINARY

○ NONE INITIALS_____

Had Have
- ○ ○ Kidney Stones
- ○ ○ Infertility
- ○ ○ Bedwetting
- ○ ○ Prostate Problem
- ○ ○ Erectile Dysfunction
- ○ ○ PMS symptoms

CONSTITUTIONAL

○ NONE INITIALS_____

Had Have
- ○ ○ Fainting
- ○ ○ Low Libido
- ○ ○ Poor appetite
- ○ ○ Fatigue
- ○ ○ Weight change
- ○ ○ Weakness

PERSONAL HISTORY

Please check any illnesses you have HAD in the past or currently HAVE now.

ILLNESSES

○ NONE INITIALS_____

Had Have
- ○ ○ AIDS
- ○ ○ Alcoholism
- ○ ○ Allergies
- ○ ○ Arteriosclerosis
- ○ ○ Arthritis
- ○ ○ Cancer
- ○ ○ Chicken Pox
- ○ ○ Diabetes
- ○ ○ Eczema
- ○ ○ Emphysema
- ○ ○ Glaucoma
- ○ ○ Goiter
- ○ ○ Gout

Had Have
- ○ ○ Heart Disease
- ○ ○ Hepatitis
- ○ ○ Malaria
- ○ ○ Measles
- ○ ○ Multiple Sclerosis
- ○ ○ Polio
- ○ ○ STD's
- ○ ○ Stroke
- ○ ○ Tuberculosis
- ○ ○ Thyphoid Fever
- ○ ○ Ulcer
- ○ ○ Other_____ _____

SURGERIES

○ NONE INITIALS_____

Had Have
- ○ ○ Appendectomy
- ○ ○ Bypass surgery
- ○ ○ Cancer
- ○ ○ Cosmetic
- ○ ○ Eye Surgery
- ○ ○ Hysterectomy
- ○ ○ Pacemaker
- ○ ○ Vasectomy
- ○ ○ Other

TREATMENTS

○ NONE INITIALS_____

Had Have
- ○ ○ Acupuncture
- ○ ○ Chiropractic
- ○ ○ Blood transfusion
- ○ ○ Dialysis
- ○ ○ Herbs
- ○ ○ Homeopathy
- ○ ○ Hormone Replacement
- ○ ○ Massage Therapy
- ○ ○ Physical Therapy
- ○ ○ Nutritional Supplements

FAMILY HISTORY

Some health issues are hereditary. Please tell us about your immediate family members.

Relative	Age (if living)	Illnesses	Age of Death	Cause of Death
Mother	_____	_____	_____	_____
Father	_____	_____	_____	_____
Sibling	_____	_____	_____	_____
Sibling	_____	_____	_____	_____
Sibling	_____	_____	_____	_____
Grandparent1	_____	_____	_____	_____
Grandparent2	_____	_____	_____	_____
Grandparent3	_____	_____	_____	_____
Grandparent4	_____	_____	_____	_____

NAME_____

SOCIAL HISTORY

	Heavy	Moderate	Light	None
Alcohol use	O	O	O	O
Coffee	O	O	O	O
Tobacco	O	O	O	O
Excerise	O	O	O	O
Pain Relievers	O	O	O	O
Soft Drinks	O	O	O	O
Diet products	O	O	O	O
Water intake	O	O	O	O
Stress level	O	O	O	O

MEDICATIONS

Please list all medications and supplements that you are currently taking:

_____
_____
_____
_____
_____
_____
_____
_____

ACKNOWLEDGEMENTS

To set clear expectations, improve communications, and help you get the best results in the shortest time, please read each statement and initial your agreement.

Initials _____ I instruct Dr. Robben to deliver the care that, in her professional judgement, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a seperate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.

Initials _____ I may request a copy of the privacy policy and understand how it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any third parties.

Initials _____ I grant permission to be called to confirm or reschedule appointments and to be sent occasional cards, letters, or emails to me as an extension of my care in this office.

Initials _____ I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services that I may receive.

Initials _____ To the best of my knowledge, the information that I have supplied is complete and truthful. I have not misrepresented the presence, severity, or cause of my health concern.

Signature _____ **Date** _____

If patient is a MINOR child

Print child's full name_____

Relationship to child_____

Signature of Guardian _____

Documentation of Guardianship_____

Beach Chiropractic
Christa Robben, D.C.

Patient Informed Consent and Responsibilities

The nature of the chiropractic adjustment: The doctor will use his/her hands or a mechanical device in order to move your spinal joints. This procedure is called a spinal adjustment and it is intended to reduce spinal subluxation.
You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as Electrical Stimulation, Ultrasound, Intersegmental Traction or hot packs may be used.

Possible Risks: I understand that, as in the practice of medicine, in the practice of chiropractic care there are some risks to treatment. While rare, these risks include but are not limited to fractures, disc injuries, strokes, and sprains. The risk of injuries or complications from treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same conditions, 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. The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can even be further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered rare.

Patient Responsibilities: I understand my responsibilities as follows:
I am responsible for notifying Beach Chiropractic immediately of any changes in or loss of insurance coverage.

I am responsible for notifying Beach Chiropractic immediately of an address or telephone change, whether temporary or permanent.

I authorize all medical or other medical facility personnel to submit to Beach Chiropractic all required and/or necessary information to Beach Chiropractic or my insurer(s) and or any third party payor who provides me with coverage, concerning my medical history, as it may relate to my condition, and consent to the review of my records including medical records by Beach Chiropractic or it's agents, or by any Federal, State, or accrediting body or Agency as required by the Regulatory, Licensing, or Accrediting Body. I authorize Beach Chiropractic to release and obtain all information necessary including my medical information as it relates to my medical treatment and/or therapy to any person or for any purpose reasonable necessary for Beach Chiropractic to secure payment for any benefit being provided under this agreement.

I hereby irrevocably assign and transfer to Beach Chiropractic and/or Christa Robben, D.C., the benefits of any and all insurance policies covering myself for the medical services provided, and to be rendered by Beach Chiropractic and/or Christa Robben, D.C. for the medical condition being treated.

I authorize Beach Chiropractic to release to my attorney, insurance provider, worker's compensation carrier, or my referring physician any and all medical information pertinent to medical services provided by Beach Chiropractic.

I understand that if any legal action is necessary to enforce the terms and conditions of this agreement, the prevailing party shall be entitled to recover all costs including attorney's fees. This agreement shall be governed by the laws of the jurisdiction where Beach Chiropractic is located which is currently within the state of Florida.

IF YOU AND/OR THE INDIVIDUAL LISTED BELOW UNDERSTAND THE ABOVE INFORMATION, PLEASE SIGN BELOW.

I have read or have had read to me the explanation above of chiropractic care. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the health plan recommended, and hereby give my full consent to treatment.

_____
Patient's Printed Name

_____ _____
Patient's Signature or Signature of Legal Guardian Date