# FIRST MERRITT CHIROPRACTIC/ACUPUNCTURE., P.A.

## APPLICATION FOR TREATMENT

Date:_____

Name:_____ Date of Birth:_____

Address:_____ City:_____ State:_____ Zip:_____

Home #:_____ Cell#:_____ Text Alert : Y__ N__ Carrier (for text only):_____

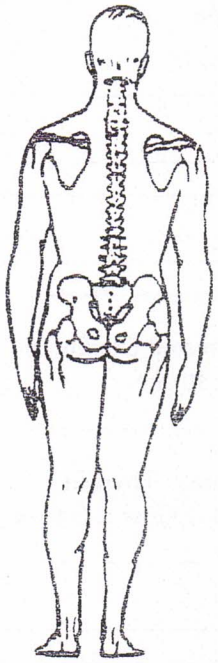
E-mail:_____

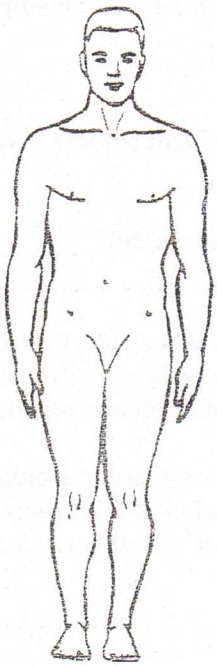
Check if you are: □ Single □ Married □ Divorced □ Widowed □ Separated

Name of Spouse: _____ Referred to our office by:_____

Payment will be made via: □ Health Ins □ Auto Ins □ Worker's Comp □ Cash □ Credit □ Check

**Please mark the exact location of your pain on the diagram below. Please write the type of pain: Dull, Sharp, Ache, Burning, Stabbing, Throbbing. Mark the area in which you experience Numbness, Tingling or Weakness. Indicate number on pain scale ranging from 0-10; 0 =No pain - 10 = Excruciating pain. Indicate frequency of pain i.e. Constant or Intermittent (comes and goes)**





What is your **chief complaint**?_____

_____

_____

_____

When did this develop? Days:_____ Weeks:_____ Months:_____ Years:_____

How did this develop? Fall:_____Accident:_____ Trauma:_____ Lifting:_____Other:____

Arms or legs weakness? □ No □ Yes; Where_____

Anything makes it better?_____ Anything makes it worse?_____

What Limitation are you experiencing (circle)? Standing, Driving, Walking, Lifting, Sitting, Sleeping, Bathing, Dressing, Washing, Focusing, Reading, Exercising

Received any treatments? □ No □ Yes, If yes, circle: MD/DO Chiropractor Physical Therapy Massage

Their Name:_____ Seen other Specialist: Ortho_____ Neuro_____ Pain manag_____

Name of the Specialist:_____ Date Consulted:_____ EMG/NCV_____

X-rays? □ Neck □ Mid back □ Low back □ Shoulder □ Other_____ When_____Where_____

MRI's? □ Neck □ Mid back □ Low back □ Shoulder □ Other_____ When_____Where_____

Do you have a herniated disc? □ No □ Yes, Where_____

Is your condition getting better, worse, or staying the same? _____

Please check any other symptoms that you are experiencing:

| | | | | |
|---|---|---|---|---|
| □ Headache | □ Dizziness | □ Loss of Consciousness | □ Loss of Balance | □ Loss of Smell |
| □ Loss of Taste | □ Memory Loss | □ Loss of Coordination | □ Sensory Loss | □ Tremors |
| □ Nausea | □ Vomiting | □ Difficulty Speaking | □ Depressed | □ Irritability |
| □ Seizures | □ Blurry Vision | □ Difficulty Swallowing | □ Anxiety | □ Bipolar |
| □ Ringing in ears | □ Double Vision | □ Difficulty Breathing | □ Chest Pain | □ Hearing Loss |
| □ Apnea | □ Sleep Loss | □ Increase Sweating | □ Palpitation | □ Incontinence |
| □ Loss of Bowel | □ Swelling | □ Difficulty Focusing | □ Fever | □ Coughing |
| □ Constipation | □ Falling down | □ Shortness of breath | □ Burning upon urination | |

Symptoms other than above: _____

Have you ever had this problem or similar problem before? If yes, please explain_____

_____

How has this condition affected your life? 1. Home life:_____
2. Occupational life:_____ 3. Recreational life:_____

Check if you have history of: □ Cancer □ Cardiovascular □ Diabetes □ High Blood Pressure □ Thyroid Condition □ M.S. □ Parkinson □ Polyneuropathy □ Pace maker □ Sciatica □ Rheumatoid Arthritis □ Gout □ Stroke □ High Cholesterol □ Kidney Stones □ Prostate Condition □ Bladder Infection □ Other: _____

Check if you have family history of: □ Cancer □ Cardiovascular □ Diabetes □ High Blood Pressure □ Thyroid Condition □ M.S. □ Parkinson □ Polyneuropathy □ Pace maker □ Sciatica □ Rheumatoid Arthritis □ Gout □ Stroke □ High Cholesterol □ Kidney Stones □ Prostate Condition □ Bladder Infection □ Other: _____

History of falls, trauma or accidents?_____

_____

List all Surgeries:_____

_____

List all Medications you are taking:_____

_____

Any chiropractor consulted in past? Name:_____ When: _____ Where:_____
For what problem:_____

Do you play sports or exercise? _____ Smoke: □ Yes □ No * Alcohol: □ Yes □ No
Are you pregnant? □ Yes □ No □ N/A

Your Goals/ expectation from treatment:_____

_____

Patient's Signature:_____ Social Security #:_____ Date:_____

**FIRST MERRITT CHIROPRACTIC/ACUPUNCTURE., P.A.**
**80 Fortenberry Road**
**Merritt Island, FL 32952**
**(321) 453-1345 · Fax (321) 453-3131**

# AUTHORIZATIONS AND RELEASES

## CONSENT FOR EXAMINATION & TREATMENT

I, the undersigned, hereby authorize Amit Patel, D.C. and whomever he may designate as his assistant(s) to perform, examination and diagnostic tests, including but not limited to radiographs, and to administer treatment as is necessary. I also certify that no guarantee or assurance has been made to the results that may be obtained. The clinical procedure performed are usually beneficial and seldom cause any problem. In rare cases underlying physical defects, deformities or pathologies, may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it know or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illness, or deformities which would otherwise not come to the attention of the physician. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse remittances for the conveyance of credit to my account upon receipt. I permit this office to endorse remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.

Patient's Signature:_____ Date:_____

## CONSENT FOR EXAMINATION & TREATMENT OF MINOR

I hereby authorize Amit Patel, D.C. and whomever he may designate as his assistant(s) to perform examination and diagnostic tests, including but not limited to radiographs, and to administer treatment as he deems necessary to my (child's name) _____. I also certify that no guarantee or assurance has been made to the results that may be obtained. I also certify that no guarantee or assurance has been made to the results that may be obtained. The clinical procedure performed are usually beneficial and seldom cause any problem. In rare cases underlying physical defects, deformities or pathologies, may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it know or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illness, or deformities which would otherwise not come to the attention of the physician.I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse remittances for the conveyance of credit to my account upon receipt. I permit this office to endorse remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered to my child are charged directly to me and that I am personally responsible for payment.

Parent or Guardian's name :_____Signature:_____Date:_____

## AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize the release of any medical information necessary to process my insurance claim(s) and also certify that all insurance information given to this clinic is correct and complete.

Patient's (Parent's/Guardian's) Signature:_____ Date:_____

## DIRECT PAYMENT AUTHORIZATION WITHOUT ASSIGNMENT OF BENEFITS

By way of original or copy hereof, I hereby direct my applicable personal injury protection and/or medical payments insurance carrier to make payment directly to Amit Patel, D.C. for services and/or supplies rendered to me by said provider which were necessitated by a work related injury, motor vehicle accident, or other accident occurring on _____.

Additionally, I hereby authorize and direct my applicable personal protection and/or medical payments insurance carrier to make any and all checks out to Amit Patel, D.C. only and to forward same to this provider's place of business.

This authorization for direct payment should not be deemed as assignment of benefits in that I, the patient, retain all rights to enforce my applicable insurance contract. Furthermore, this Direct Payment Authorization without Assignment of Benefits transfers no rights, title or interest in said contract other than the right to receive direct payment as specified herein above.

Patient's (Parent's/Guardian's) Signature:_____ Date:_____

# Back Index

Form BI100

rev 3/27/2003

**Patient Name** _____ **Date** _____

*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. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.*

## 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 is moderate 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 1/2 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 1/2 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 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 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 (e.g., on a table).
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 alternate 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 (e.g., dancing, etc).
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.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

*Back Index Score*

# Neck Index

Form N1-100

rev 3/27/2003

***Patient Name*** _____ ***Date*** _____

*This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.*

## *Pain Intensity*

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
③ The pain is fairly severe at the moment.
④ The pain is very severe at the moment.
⑤ The pain is the worst imaginable at the moment.

## *Sleeping*

⓪ I have no trouble sleeping.
① My sleep is slightly disturbed (less than 1 hour sleepless).
② My sleep is mildly disturbed (1-2 hours sleepless).
③ My sleep is moderately disturbed (2-3 hours sleepless).
④ My sleep is greatly disturbed (3-5 hours sleepless).
⑤ My sleep is completely disturbed (5-7 hours sleepless).

## *Reading*

⓪ I can read as much as I want with no neck pain.
① I can read as much as I want with slight neck pain.
② I can read as much as I want with moderate neck pain.
③ I cannot read as much as I want because of moderate neck pain.
④ I can hardly read at all because of severe neck pain.
⑤ I cannot read at all because of neck pain.

## *Concentration*

⓪ I can concentrate fully when I want with no difficulty.
① I can concentrate fully when I want with slight difficulty.
② I have a fair degree of difficulty concentrating when I want.
③ I have a lot of difficulty concentrating when I want.
④ I have a great deal of difficulty concentrating when I want.
⑤ I cannot concentrate at all.

## *Work*

⓪ I can do as much work as I want.
① I can only do my usual work but no more.
② I can only do most of my usual work but no more.
③ I cannot do my usual work.
④ I can hardly do any work at all.
⑤ I cannot do any work at all.

## *Personal Care*

⓪ I can look after myself normally without causing extra pain.
① I can look after myself normally but it causes extra pain.
② It is painful to look after myself and I am slow and careful.
③ I need some help but I manage most of my personal care.
④ I need help every day in most aspects of self care.
⑤ I do not get dressed, I wash with difficulty and stay in bed.

## *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, but I can manage if they are conveniently positioned (e.g., on a table).
③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
④ I can only lift very light weights.
⑤ I cannot lift or carry anything at all.

## *Driving*

⓪ I can drive my car without any neck pain.
① I can drive my car as long as I want with slight neck pain.
② I can drive my car as long as I want with moderate neck pain.
③ I cannot drive my car as long as I want because of moderate neck pain.
④ I can hardly drive at all because of severe neck pain.
⑤ I cannot drive my car at all because of neck pain.

## *Recreation*

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

## *Headaches*

⓪ I have no headaches at all.
① I have slight headaches which come infrequently.
② I have moderate headaches which come infrequently.
③ I have moderate headaches which come frequently.
④ I have severe headaches which come frequently.
⑤ I have headaches almost all the time.

~~Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100~~

*Neck Index Score*