COCOA CHIROPRACTIC CENTER, P.A.
Dr. Andrew Canavan DC and Dr. Janaina Strater, DC
111 N. Fiske Blvd. Cocoa, FL 32922
Phone: (321) 636-6090 ~ Fax: (321) 632-5805

Confidential Patient Information

Patient's Name: _____

Address: _____

City/State: _____ Zip:_____

Home Phone: _____ Cell Phone: _____

Text Reminders: Y___ N___ Cell Carrier: _____

Email Address: _____

Birth Date: _____ Age: _____ Sex: M F

Marital Status: Married Single Widowed Divorced

Work Status: Part Time Full Time Not employed

Occupation: _____

Employer: _____

How did you hear about our office?
_____

Have you been to a Chiropractor in the past? Yes or No

Were you referred to a specific Doctor or have a preference?
Circle one: Dr. Andrew Canavan Dr. Janaina Strater
No preference

Are these injuries related to a car accident, slip and fall, or work injury? Yes or No

What brings you in today?

Primary complaint (Please describe location of pain and when it started):

_____

_____

- How would you describe the character of pain? Please circle all that apply:
  Achy Burning Cramping Dull Numb Sharp Shooting Sore Stabbing Stiff Tender Throbbing
- How would you rate the pain now? (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (severe pain)
- How often does the pain occur? Circle one: Constant Frequent Intermittent Occasional Varies
- Does this pain radiate to a different location? Yes or No, If yes to where?_____
- Have you found anything to help relieve the pain?_____
- What makes the pain worse?_____
- Have you had any treatment for this injury presently or in the past?_____
- How does this injury affect your ability to perform normal daily activity?
  _____
- Are there any other associated symptoms with this injury/complaint?
  _____

Secondary complaint (Please describe location of pain and when it started):

_____

_____

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Confidential Past Medical History

Is there a chance of pregnancy? ☐**Yes** ☐**No**

Do you have a Heart pacemaker or any electric stimulation device? ☐**Yes** ☐**No**

Surgeries: (Please list all procedures and year performed) _____
_____
_____
_____

Hospitalizations/Major Illnesses/Major Traumas/Car accidents: _____
_____
_____
_____

Medications: _____
_____
_____
_____

Allergies ☐**Yes** ☐**No** _____

Do you have any organ problems: (Check those that apply to you)
☐Brain ☐Eyes ☐Ears ☐Thyroid ☐Throat ☐Lungs ☐Heart ☐Pancreas ☐Prostate ☐Liver ☐Kidneys ☐Spleen
☐Stomach ☐Bowels ☐Bladder ☐Reproductive organs ☐Uterus ☐Rectum

Social History: (Check those that apply to you)
Exercise ☐Daily ☐ Weekly ☐Walk/Run ☐Never
Caffeine use ☐☐None ☐ >less than 3/day ☐3-6 per day ☐more than 6 per day
Alcohol use ☐Causal Drinker ☐Moderate Drinker ☐Heavy Drinker ☐Never
Tobacco use ☐Never ☐Current Smoker ☐ Current Some Day Smoker ☐Former Smoker

Family History:
Please describe your family's health conditions such as heart disease, diabetes, stroke, etc:
Mother _____
Siblings_____
Father _____
Children _____
Grandparents: Father's _____
Mother's_____

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Terms of Acceptance

The goal of our office is to enable patients to gain control of their health. TO attain this we believe communications is the key. There are often topics that are hard to understand and we hope this document will clarify those issues for you.

Please read below and if you have any questions please feel free to ask one of our staff members.

Women Only

To the best of my knowledge (I am/am NOT pregnant)

Missed Appointments

There is a possible $20 fee charged for all appointments that are not cancelled at least 24 hours prior to your scheduled visit.

Communication

In the event that we would need to communicate you r healthcare information, to whom may we do so?

_____ None

Name	Relationship	Phone Number
Name	Relationship	Phone Number
Name	Relationship	Phone Number

May we leave messages on any answering device, i.e. home answering machines or voicemails?
Yes_____ No_____

Acknowledgement

I have reviewed the notice of privacy practices (HIPAA) and have been provided an opportunity to discuss my right to privacy. Upon request I will be given a copy.

Print Name_____ Signature_____ Date_____

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service

FORM APPROVED: OMB NO. 0917-0030
Expiration Date: 09-30-2023
See OMB Statement on Reverse.

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

COMPLETE ALL SECTIONS, DATE, AND SIGN

I. I, _____ , hereby voluntarily authorize the disclosure of information from my health record. *(Name of Patient)*

II. The information is to be disclosed by:	**And is to be provided to:**
NAME OF FACILITY	NAME OF PERSON/ORGANIZATION/FACILITY Cocoa Chiropractic Center, P.A. (Fax: 321-632-5805)
ADDRESS	ADDRESS 111 N. Fiske Blvd.
CITY/STATE	CITY/STATE Cocoa, FL 32922

III. The purpose or need for this disclosure is:

☒ Further Medical Care ☐ Attorney ☐ School ☐ Research ☐ Other *(Specify)* _____
☐ Personal Use ☐ Insurance ☐ Disability ☐ Health Information Exchange (IHS/Other _____)

IV. The information to be disclosed from my health record: *(check appropriate box(es))*

☐ Only information related to *(specify)* _____

☐ Only the period of events from _____ to _____
☐ Other *(specify) (CHS, Billing, etc.)* _____
☐ Entire Record

If you would like any of the following sensitive information disclosed, check the applicable box(es) below:

☐ Alcohol/Drug Abuse Treatment/Referral ☐ HIV/AIDS-related Treatment
☐ Sexually Transmitted Diseases ☐ Mental Health *(Other than Psychotherapy Notes)*
☐ Psychotherapy Notes ONLY (by checking this box, I am waiving any psychotherapist-patient privilege)

V. I understand that I may revoke this authorization in writing submitted at any time to the Health Information Management Department, except to the extent that action has been taken in reliance on this authorization. If this authorization was obtained as a condition of obtaining insurance coverage or a policy of insurance, other law may provide the insurer with the right to contest a claim under the policy. If this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration date or *expiration event* is stated. For Health Information Exchange authorizations, it is recommended to expire in at least five years.

_____
(Specify new date)

I understand that IHS will not condition treatment or eligibility for care on my providing this authorization except if such care is: (1) research related or (2) provided solely for the purpose of creating Protected Health Information for disclosure to a third party.

I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42 CFR Part 2, may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164] , and the Privacy Act of 1974 [5 USC 552a].

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE *(State relationship to patient)*	DATE
SIGNATURE OF WITNESS *(If signature of patient is a thumbprint or mark)*	DATE

This information is to be released for the purpose stated above and may not be used by the recipient for any other purpose. Any person who knowingly and willfully requests or obtains any record concerning an individual from a Federal agency under false pretenses shall be guilty of a misdemeanor (5 USC 552a(i)(3)).

PATIENT IDENTIFICATION	NAME *(Last, First, MI)*	RECORD NUMBER
	ADDRESS	
	CITY/STATE	DATE OF BIRTH

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Assignment, Lien and Authorization
Insurance Benefits and Attorney

To whom it may concern,

I herby authorize and direct you, my insurance company, and/or attorney, to pay directly to **Cocoa Chiropractic Center, P.A.** Such sums as may be due and owing this office for services rendered me, both by reason of accident or illness and by reason of any other bills that are due to this office, and withhold such sums from any disability benefits, medical payments benefits, No-Fault benefits, health and accident benefits, workmen's compensations benefits, or any other insurance benefits obligated to reimburse me or from any settlement, judgments or verdict on my behalf as may be necessary to adequately protest said office. I hereby further give a lien to said office against any and all insurance benefits named herein , and any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of the injuries or illness for which I have been treated by said office. This is to act as an assignment of my rights and benefits to the extent of the office's services provided.

In the event my insurance company obligated to make payments to me upon the charges made by this office for their services refused to make such payments, upon demand by me or this office, I hereby assign and transfer to this office any and all causes of action that I might have or that might exist in my favor against such company and authorize this office to prosecute said cause of action either in my name or in the offices name, and further I authorize this office to compromise, settle or otherwise resolve said claim or cause of action as they see fit.

I understand that I remain personally responsible for the total amounts due to the office for their services. I further understand and agree that this Assignment, Lien and Authorization does not constitute any consideration for the office to await payments and they may demand payments from me immediately upon rendering services at their option.

I authorize this office to release any information pertinent to my case to any insurance company, adjuster or attorney to facilitate collection under this Assignment, Lien and Authorization. I agree that the above mentions office be given power of attorney to endorse/sign my name on any and all checks for payment of my doctor bill.

I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance police and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/ or employee health benefits claim submissions.

Date: _____ Signature: _____

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INFORMED CONSENT TO CHIROPRACTIC TREATMENT

The nature of chiropractic treatment: The doctor will use his hands in order to move your joints. 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 hot or cold packs, electrical muscle stimulation, therapeutic ultrasound or dry hydrotherapy may also be used.

Possible Risks: As with any health care procedure, there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. Some patients may notice stiffness or soreness after the first few days of treatment.

Probability of 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 and during examination and x-ray. The risk of stroke has been estimated at one in one million to one in twenty-five million.

Other treatment options which could be considered may include the following:

**Over the counter analgesics*: The risks of these medications include irritation to stomach, liver and kidneys, other side effects in a significant number of cases.

**Medical care,* typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.

*Hospitalization in conjunction with medical care adds risk of exposure to virulent Communicable disease in a significant number of cases.

**Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

I have read the explanation above of chiropractic treatment. 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 recommended treatment and herby give my full consent to treatment.

Printed Name	Signature	Date

WITNESS:

Printed Name	Signature	Date

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