Cleveland Heights
CHIROPRACTIC CLINIC

3740 Cleveland Heights Blvd. Lakeland, FL 33813

863-646-5707

OFFICE USE ONLY

Height _____In

Weight _____lbs.

Temp _____°F

Resp _____/min

BP _____mmHg

Pulse _____BPM

PATIENT INFORMATION & CONDITION FORM

PLEASE PRINT

Patient Name (as it appears on insurance card): _____ Today's Date: ___/___/___

Birth Date: ___/___/___ Age: ____ Gender: F M Primary Language _____

Marital Status: ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Single Name of Spouse _____

Children? ☐ Yes ☐ No How Many? _____

Current Address

Street _____

City _____ State _____ Zip _____

Home Phone (_____) _____ Cell Phone (_____) _____ Work Phone (_____) _____

Patient's E-mail address: _____

Your Occupation _____ Employer _____

Student at _____ ☐ Full time ☐ Part Time

Who should we contact in the event of an emergency? _____ Phone (_____) _____

Relationship of emergency contact to patient: _____

Health Insurance Information

Do you have health insurance? ☐ YES ☐ NO ☐ Not Sure Company: _____

Full Name of Policy Holder: _____ Policy Holder's Date of Birth ___/___/____

Health Insurance ID: _____ Group number: _____

Attorney name: _____ Contact info: _____

Current Symptoms

Describe your condition, symptoms, or the purpose of this appointment:

_____

Is your condition or injury due to an accident or work-related cause? ☐ YES ☐ NO Date of accident: ___/___/____

If the condition did not result from an automobile accident or relate to your work, where did the injury occur? _____

Approximately, when did your injury or condition occur? ___/___/_____

Have you ever had the same or similar condition? ☐ YES ☐ NO If yes, when and describe: _____

Please indicate any other healthcare providers who you've seen for this injury or condition, and when you last saw them.

Name: _____ Type of Practice: _____ Date of Last Visit: ___/___/____

Name: _____ Type of Practice: _____ Date of Last Visit: ___/___/____

NAME _____ **Date of Birth:** _____

***** Complete sections that apply to where you are experiencing pain*****

NECK

How would you rate your pain on a scale from 0 to 10? (no pain) **0 1 2 3 4 5 6 7 8 9 10** (worst pain possible)

Describe your pain: □ Sharp □ Dull □Stabbing □ Ache □Radiating: Where to?_____
□ Burning □Throbbing □ Numbing

Frequency: □ Infrequent □ Occasional □Intermittent □ Frequent □ Constant

What makes it worse: □ Bending □ Sneezing/Coughing □ Driving □ Household Chores □Lifting □ Lying down
□Moving □Sitting □Sleeping □Standing □Twisting □Walking □ Working

What relieves it: □ Adjustment Provided □ Exercise/Stretching □ Heat □ Ice □Lying Down □ Movement □NO Movement
□Ibuprofen □Prescription Medication □Rest □ Sitting □Standing □ Nothing

MID BACK

How would you rate your pain on a scale from 0 to 10? (no pain) **0 1 2 3 4 5 6 7 8 9 10** (worst pain possible)

Describe your pain: □ Sharp □ Dull □Stabbing □ Ache □Radiating: Where to?_____
□ Burning □Throbbing □ Numbing

Frequency: □ Infrequent □ Occasional □Intermittent □ Frequent □ Constant

What makes it worse: □ Bending □ Sneezing/Coughing □ Driving □ Household Chores □Lifting □ Lying down
□Moving □Sitting □Sleeping □Standing □Twisting □Walking □ Working

What relieves it: □ Adjustment Provided □ Exercise/Stretching □ Heat □ Ice □Lying Down □ Movement □NO Movement
□Ibuprofen □Prescription Medication □Rest □ Sitting □Standing □ Nothing

LOW BACK

How would you rate your pain on a scale from 0 to 10? (no pain) **0 1 2 3 4 5 6 7 8 9 10** (worst pain possible)

Describe your pain: □ Sharp □ Dull □Stabbing □ Ache □Radiating: Where to?_____
□ Burning □Throbbing □ Numbing

Frequency: □ Infrequent □ Occasional □Intermittent □ Frequent □ Constant

What makes it worse: □ Bending □ Sneezing/Coughing □ Driving □ Household Chores □Lifting □ Lying down
□Moving □Sitting □Sleeping □Standing □Twisting □Walking □ Working

What relieves it: □ Adjustment Provided □ Exercise/Stretching □ Heat □ Ice □Lying Down □ Movement □NO Movement
□Ibuprofen □Prescription Medication □Rest □ Sitting □Standing □ Nothing

OTHER AREA OF PAIN – Describe location _____

How would you rate your pain on a scale from 0 to 10? (no pain) **0 1 2 3 4 5 6 7 8 9 10** (worst pain possible)

Describe your pain: □ Sharp □ Dull □Stabbing □ Ache □Radiating: Where to?_____
□ Burning □Throbbing □ Numbing

Frequency: □ Infrequent □ Occasional □Intermittent □ Frequent □ Constant

What makes it worse: □ Bending □ Sneezing/Coughing □ Driving □ Household Chores □Lifting □ Lying down
□Moving □Sitting □Sleeping □Standing □Twisting □Walking □ Working

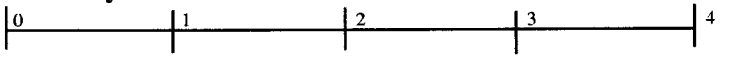
What relieves it: □ Adjustment Provided □ Exercise/Stretching □ Heat □ Ice □Lying Down □ Movement □NO Movement
□Ibuprofen □Prescription Medication □Rest □ Sitting □Standing □ Nothing

Functional Rating Index

For use with **Neck and/or Back Problems** only.

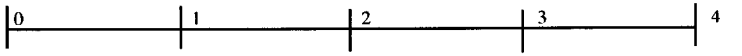
In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities.
For each item below, **please circle the number which most closely describes your condition right now.**

1. Pain Intensity



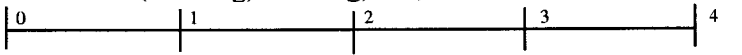
0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping



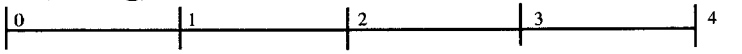
0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)



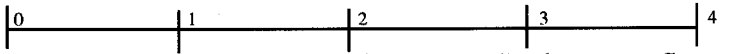
0	1	2	3	4
No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)



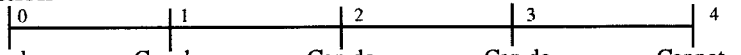
0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work



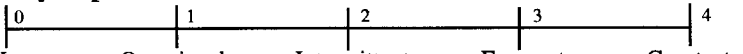
0	1	2	3	4
Can do usual work plus unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation



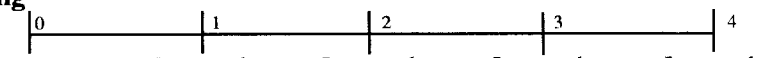
0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. Frequency of pain



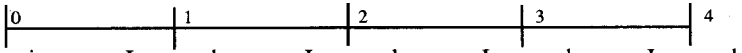
0	1	2	3	4
No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting



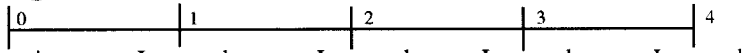
0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking



0	1	2	3	4
No pain; any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

10. Standing



0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

Total Score _____

Name _____
PRINTED

_____
Signature

_____
Date

Medical History

What surgery have you had? _____ When? _____

_____ _____

Serious illnesses or conditions? _____ When? _____

What medications or drugs are you taking?

Name_____ Dose _____ How often do you take it? _____

Name_____ Dose _____ How often do you take it? _____

Allergies (please list all): _____

Do you now or have you ever had:		Diabetes	Y N	Neuropathy	Y N
Abnormal Bleeding	Y N	Fibromyalgia	Y N	Open Sores	Y N
Acid Reflux	Y N	Gout	Y N	Pneumonia	Y N
Anemia	Y N	Heart Attack	Y N	Polio	Y N
Arthritis	Y N	Heart Disease/Failure	Y N	Rheumatic Fever	Y N
Asthma	Y N	HIV+/AIDS	Y N	Sickle Cell Disease	Y N
Back Trouble	Y N	High Blood Pressure	Y N	Skin Disorder	Y N
Bladder infections	Y N	Kidney Disease	Y N	Sleep Apnea	Y N
Blood Clots	Y N	Liver Disease	Y N	Stomach Ulcers	Y N
Blood Transfusion	Y N	Low Blood Pressure	Y N	Stroke	Y N
Bronchitis/Emphysema	Y N	Migraine headaches	Y N	Thyroid Disease	Y N
Cancer	Y N	Mitral valve Prolapse	Y N	Tuberculosis	Y N

Do you smoke? ☐ Yes ☐ No Do you drink alcohol? ☐ Yes ☐ No

Do you use recreational drugs: ☐ No ☐ Yes Type _____

Please note any of the following that you might have: ☐ Pacemaker ☐ Defibrillator ☐ Rods ☐ Other Implants _____

Family History

Do you have a family history of ☐ Diabetes ☐ Cancer ☐ Heart Disease ☐High Blood Pressure ☐ Stroke ☐ Coronary Artery Disease ☐ Thyroid Disease ☐Rheumatoid Arthritis

WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant? ☐ YES ☐ NO

****

I understand and agree that health and accident insurance policies are an arrangement between my insurance company and myself -- not between my insurance company and this office. I agree to pay my estimated patient responsibility and further understand that the estimated responsibility is neither a guarantee of payment by my insurance company, nor necessarily an accurate reflection of my actual responsibility as determined by my insurance company upon processing of my claims. In the event that my insurance company does not pay on my charges at the estimated rate or within a reasonable period of time, upon request of this office I will immediately pay the balance owing on my account unless otherwise agreed to in writing. I understand that an interest charge may appear on all accounts over 90 days. I further understand and agree, that if this office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse this office for all costs of such collection efforts, including, but not limited to, all court costs and attorney fees.

I authorize this office to release any medical information relating to my treatment to any insurance companies which may be responsible for paying benefits to me, and to any attorney s who may be representing me due to my condition, and to complete any usual and customary reports and forms at no charge to assist in collecting from my insurance companies, attorneys, or other payers. I have read, understood, and agree to the foregoing. The information which I have provided is true and complete to the best of my knowledge.

Patient's Signature: _____ Date: ___/___/____

Print Name: _____

Signature of Parent/Legal Guardian if under 18

Signature: _____ Print Name: _____

Relationship: _____

Cleveland Heights
CHIROPRACTIC CLINIC

PATIENT COMMUNICATION CONSENT FORM

TEXT/EMAIL MESSAGE ALERTS

I authorize Cleveland Heights Chiropractic Clinic/Ison Chiropractic PA, to send text message and/or email appointment reminders to me on my provided cell phone number. I understand that I may receive account information such as future appointments, office location and other alerts as described in our text message and/or email message. Text message charges from my cell phone provider may apply.

Name: _____ DOB: _____

Cell Phone: (_____) _____ - _____

Email Address (please print neatly): _____

My signature below indicates that I represent and warrant that I am the person legally responsible for all use of the account, that I am at least 18 years of age, and that I agree to all terms and conditions of use for the text and email messaging services. I understand that this authorization can only be revoked in writing.

Signature _____ Date: _____

It is important to note that text and email communication is not always secure. Text and email messages can be intercepted and for this reason, we do not communicate personal health information through this method. Complete terms and conditions can be requested from office staff.

Cleveland Heights
CHIROPRACTIC CLINIC

Scottie M. Ison, DC dba Cleveland Heights Chiropractic Clinic
Ison Chiropractic PA, Alexander Ison, DC

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

A copy of Cleveland Heights Chiropractic/Ison Chiropractic PA Notice of Privacy Practices is available to all patients. Please request a copy at the office front desk.

I understand that some of my health information may be used and or disclosed by Cleveland Heights Chiropractic Clinic/Ison Chiropractic PA to carry out treatment, payment or health care operations and that for a more complete description of these uses and disclosures I should refer to their privacy notice entitled Notice of Privacy Practices. I understand that I may ask for a copy of this privacy notice at any time prior to signing this form.

I acknowledge that I was offered 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.

I understand that for my protection any access to my medical records must be made in writing.

_____ _____
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 personal health information.

Name _____ /Relationship_____

Name _____ /Relationship_____

Name _____ /Relationship_____