Sambursky Chiropractic, LLC

Patient's Name: ____ [ ] Male [ ] Female

What do you prefer to be called/Nickname: _____________________________

Date of Birth:________________ Age: _____ Social Security Number: _________________________

Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Widowed [ ] Separated [ ] Student [ ]Other

Race: [ ] Asian [ ] Black/African American [ ] American Indian [ ] White [ ] Other:______ [ ] Declined

Primary Language: [ ] English [ ] Spanish [ ] Other _____________

Ethnicity: [ ] Hispanic or Latino [ ] Not Hispanic or Latino [ ] Declined

Home Address: ____

City: ____________________________________ State: ________ Zip: __________________________

Preference for Appointment Reminders: □ Phone □ Email □ Text ***must supply cell carrier for texting**

□ Home Phone: (______) __________________ □ ***Cell Carrier:**____________________

□ Mobile Phone: (______) __________________ □ Work Phone:___________________________

Email: ____ (please print clearly and accurately)

Occupation: _______________

Emergency Contact: ____________________________ Phone: (_______) _______________________

Spouses Name: _______________________ Spouse's Date of Birth (if the Insured) ________________

Who can we thank for referring us to you: _______________________________

*****Insurance information: Please present insurance card to Receptionist with Driver's License**

I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submission and authorize payment of medical benefits to the undersigned or Sambursky Chiropractic LLC for services described on any bill. Sambursky Chiropractic, LLC may use my health care information and disclose such information to the insurance company and other agents for purpose of obtaining payment for services and determining insurance benefits payable for related services**.** Should the insurance company perform an audit of records and determine that your treatment and/or massage treatment was not medically necessary or excessive, they may request monies back directly from Sambursky Chiropractic LLC. At that time, you can request an appeal but must understand that you, the patient, will be responsible for any monies owed to Sambursky Chiropractic for services rendered. This consent will end when my current treatment plan is completed or one year from the date signed below. I authorize the release of any medical or other information necessary to process any claim by Sambursky Chiropractic LLC. I also request payment of government benefits either to myself or the party who accepts assignment.

Signature of Patient or Guardian ____ Date______________

NOTICE OF PRIVACY PRACTICES

Sambursky Chiropractic, LLC
12627 San Jose Blvd Ste 305
Jacksonville, FL 32223

(904) 683-4376

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice takes effect on your first date of treatment and remains in effect until we replace it.

1. OUR PLEDGE REGARDING MEDICAL INFORMATION.

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe the rights and certain duties we have regarding the use and disclosure of medical information.

2. OUR LEGAL DUTY

Law Requires Us To:

1. Keep your medical information private.
2. Giving you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the current notice.

We Have The Right To:

1. Change our privacy practice and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice Of Change To Privacy Practices:

1. Before we make any important change in our privacy practices, we will change this notice and make the new notice available upon request.

3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked any time by writing to us at the address provided at the end of this notice.

FOR TREATMENT: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to Doctors, nurses, technician, medical students, or other people who are taking care of you. We may also share medical information about you to other health care providers to assist them in treating you.

FOR PAYMENT: We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your medical information.

PRIVACY PRACTICES ACKNOWLEDGEMENT

Sambursky Chiropractic, LLC

12627 San Jose Blvd Ste 305

Jacksonville, FL 32223

______

(904) 683-4376

Acknowledgement Form

I have received the notices of privacy practices and I have been provided an opportunity to read it.

Name____ Date of Birth ____________

Signature____

Date___________________________________

INFORMED CONSENT TO CHIROPRACTIC CARE

SAMBURSKY CHIRORPACTIC LLC
12627 San Jose Blvd Ste 305
JACKSONVILLE, FL 32223
______
(904) 683-4376

Patient Name______________________________________ Date of Birth ______________

I hereby request and consent to the performance of Chiropractic adjustments and other Chiropractic procedures, including various modes of physical therapy and diagnostic x-rays by any Doctor of Chiropractic employed by Sambursky Chiropractic, LLC.

I have had the opportunity to discuss with the Doctor and/or with other office or clinic personnel the purpose and benefits of the Chiropractic adjustments and other treatments outlined below. Alternatives to treatment have been reviewed.

Though Chiropractic adjustments and treatments are usually beneficial and seldom cause any problem, I understand and am informed that there are some risks to treatment. Risks include, but are not limited to, fractures, disc injuries, strokes, dislocations and sprains.

I understand that I may receive one or more of the following treatments:

- Chiropractic Adjustments/Manipulation
- Electric Muscle Stimulation
- *Heat/Cold Pack(s)*
- Ultrasound
- Traction
- Massage/therapeutic exercises and stretches
- Laser Therapy

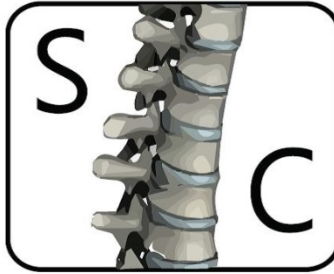
I understand that Chiropractic is not an exact science and that, therefore, reputable practitioners cannot fully guarantee the results. I acknowledge that no guarantee or assurance has been made by anyone regarding the Chiropractic treatment that I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

Please discuss any questions or concerns with the Doctor before signing this consent.

____ ___________________
Signature of Patient, Parent, guardian or personal Representative Date

Witness Signature____ Date_______________________________

Doctor's Signature____ Date_________________________________



Sambursky Chiropractic LLC
12627 San Jose Blvd, Ste 305
Jacksonville, FL 32223
(904)683-4376

RELEASE OF MEDICAL INFORMATION

I give permission for my protected health information to be disclosed for purposes of communicating results, findings, care decisions and billing inquires to the family members and other listed below.

Name of Person (family member/friend) who is authorized to receive information in your absence:	Release Info (please circle)
______________________________	Y N
______________________________	Y N
______________________________	Y N

***If the requestor/receiver of information is not a healthcare provider, the released information may no longer be protected from disclosure.**

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

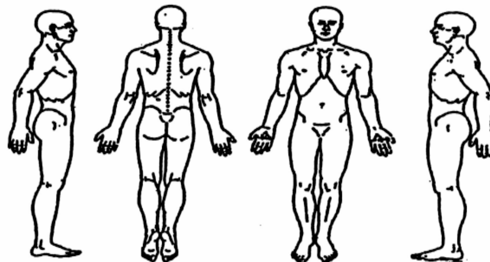
Patients Signature ____

Date ______________________________ **Patients Date of Birth** ______________________

PATIENT INTAKE FORM

Patient Name: _______________________________________ Date: ______________________

Mark The Area Of Pain



Where is your pain/what side? ____________________________

____

How do you think your problem started? ___________________

____

When did your pain start? ________________________________

____

Have you ever had this problem in the past? □**Yes** □ **No**

My pain is located on the □ Right □ Middle □ Left □ Both Sides

My pain is □ Getting Worse □ Staying the Same □ Getting Better

How would you describe the type of pain?

□ Sharp □ Numbness □ Dull □ Tingling
□ Diffuse □ Achy □ Burning □ Sharp with motion
□ Stiff □ Shooting □ Stabbing □ Electric like
□ sore □ Other:_________________________

Fill in your Pain scale 0-10 (10 being severe pain) _______ (1-3 Mild) (4-7 Moderate) (8-10 Severe)

How often do you experience your symptoms?

□ Constantly □ Frequently □ Intermittent (On & Off) □ Occasionally

Does your pain radiate? □**Yes** □**No** **If so, Where?** ____

The pain is worse during □ Morning □ Afternoon □ Evening □ During the night □ Pain does not change

Pain is worse? □ Sitting □ Standing □ Movement □ Sleeping □ Walking □ Other______________________________

Pain is better during □ Morning □ Afternoon □ Evening □ During the night □ Nothing feels better

What makes the pain feel better □ Rest □ Medication □ Cold □ Heat □ None □ Other__________________________

Do you have Numbness? □ **Yes** □ **No** **If so, Where?** ____

Headaches □ **Yes** □ **No** **If so, Where?** ____

This problem interferes with my work? □ None □ A little bit □ Moderately □ Extremely

Who else have you seen for your problem?

□ Chiropractor □ Primary Care Physician □ ER physician □ Orthopedist □ Massage Therapist
□ Physical Therapist □ No one □Other ____

What concerns you the most about your problem? What does it prevent you from doing?

What is your occupation?

How would you rate your overall health? □ Excellent □Very Good □ Good □ Fair □ Poor

What type of exercise do you do? □ Strenuous □ Moderate □ Light □ None

Name: ____ DOB: _____________ Date:____________

PAST MEDICAL HISTORY: Please select if condition applies to your medical history:

□ AIDS/HIV	□ Coronary artery disease	□ Hypertension (high blood pressure)	
□ Alcoholism	□ Crohn's disease	□ Inflammatory bowel disease	□ Peptic ulcer
□ Anemia	□ Degenerative joint disease	□ Rheumatoid Arthritis	□ Psoriasis
□ Angina (Chest Pain)	□ Depression	□ Kidney disease	□ PVD-vascular disease
□ Arthritis	□ Diabetes	□ Liver disease	□ Renal disease
□ AFib	□ Drug abuse	□ Lyme disease	□ Scoliosis
□ Enlarged Prostate	□ DVT (blood clot)	□ Migraines	□ Seizure disorder
□ Cancer:_____________	□ Fibromyalgia	□ Multiple Sclerosis	□ Sleep apnea
□ CVA (Stroke)	□ Gallbladder disease	□ Myocardial Infarction	□ SLE - Lupus
□ Congestive heart failure	□ GERD	□ Obesity	□ Spinal stenosis
□ COPD	□ Gout	□ Osteoarthritis	□ Spondyloarthropathy
□ Other _________________	□ Hepatitis	□ Osteoporosis	□ Thyroid disease
	□ High Cholesterol	□ Parkinson's disease	□ Valvular disease

PAST SURGICAL HISTORY:

FAMILY HISTORY:

	Father	Mother	Siblings	Grandparent
Arthritis	□	□	□	□
Cancer	□	□	□	□
Colitis	□	□	□	□
Diabetes	□	□	□	□
Epilespsy	□	□	□	□
Heart disease	□	□	□	□
High blood pressure	□	□	□	□
Kidney disease	□	□	□	□
Osteoporosis	□	□	□	□
Psoriasis	□	□	□	□
Stroke	□	□	□	□
Thyroid disease	□	□	□	□

SOCIAL HISTORY:

Tobacco Use: □ Yes □ No □ Former packs per day:________ Years smoked: ______ Year Quit: ______

Alcohol Use: □ Yes □ No □ Former Type: ________ Frequency: ______ Glasses / Day: ______

Caffeine Use: □ Yes □ No □ Former Type: ________ Cups/Day: ______

Activity: □ Sedentary □ Moderate □ Vigorous Frequency:___________ Type of exercise:______________________________

Hand Dominance: □ Right □ Left □ Ambidextrous

Occupation: Employer:__________________________ Job Title:______________________ Status: P/T F/T Disabled Retired

Name: ____ DOB: _____________ Date:____________

REVIEW OF SYSTEMS:

Constitutional

☐ Chills
☐ Fatigue
☐ Fever
☐ Malaise
☐ Night sweats
☐ Weakness
☐ Weight loss

Cardiovascular

☐ Chest pain
☐ Cyanosis
☐ Heart Murmur
☐ Irreg. heartbeat/ palpitations
☐ Leg swelling
☐ Syncope (fainting)

Skin/Integumentary

☐ Contact allergy
☐ Itchy skin
☐ Rash
☐ Skin infection
☐ Skin lesion

Metaboloc/endocrine

☐ Cold intolerant
☐ Hair loss
☐ Heat intolerant

HEENT

☐ Blurred vision
☐ Double vision
☐ Dysphagia (Problem swallowing)
☐ Ear drainage
☐ Facial pain
☐ Headache
☐ Hearing loss
☐ Hoarseness
☐ Nasal congestion
☐ Ringing in ears
☐ Vertigo
☐ Vision loss

Gastrointestinal

☐ Abdominal pain
☐ Constipation
☐ Diarrhea
☐ Heartburn
☐ Jaundice
☐ Loss of appetite
☐ Nausea
☐ Vomiting

Neurological

☐ Difficulty walking
☐ Dizziness
☐ Poor coordination
☐ Memory loss
☐ Muscle weakness
☐ Paresthesia (numbness/tingling)
☐ Seizures
☐ Tremors

Psychiatric

☐ Anxiety
☐ Depression
☐ Insomnia

Respiratory

☐ Painful breathing
☐ Cough
☐ Shortness of breath
☐ Recent infections
☐ Known TB exposure
☐ Wheezing

Genitourinary

☐ Dysuria
☐ Frequent urination
☐ Blood in urine
☐ Urge incontinence
☐ Urinary incontinence

Hematologic

☐ Bleeding
☐ Bruising

Immunological

☐ Asthma
☐ Bee sting allergies
☐ Contact dermatitis
☐ Seasonal allergies
☐ Food allergies
☐ Environmental - allergies

FEMALE ONLY: Are you pregnant? Yes / No If yes, how many weeks: __________

HEIGHT: _____________ Weight: __________

Office only **BP:_________/_________**

Name: ____ DOB: ______________ Date: ________________

<u>MEDICATIONS:</u> Please attach medication list if available.

MEDICATION OR VITAMIN NAME	DOSAGE	REASON FOR TAKING

DRUG ALLERGIES	REACTION

Have you been diagnosed with Hypertension (high blood pressure)? Yes or No

Treating Physician: ____

Have you been diagnosed with Diabetes? Yes or No If yes, Type I ____ or Type II ____

Treating Physician: ____

Primary Care Physician:____

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

Neck Index Score

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