MOVMNT
SPINE-REHAB-SPORT

Today's date: ____________Whom may we thank for referring you to this office _______________________________________?

PATIENT DEMOGRAPHICS

Name: ____ Birth Date: _____-_____-_____ Age: _______ □ Male □ Female

Address: ____ City: _________________________________ State: _____ Zip: ____________

E-mail Address: ____________________________________ Home Phone: ________________________Mobile Phone:_______________

Occupation/Employer: ____________________________________ Number of children and Ages: _________________________________

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed Spouse's Name __________________________

Do you have Insurance: ❑ Yes ❑ No Policy Holder Name _______________________Policy Holder DOB ____ ____ _____

Ins. Company______________________________ Policy #_____________________________ Group # ___________________________

Name & Number of Emergency Contact: ______________________ ___________________Relationship: ___________________________

HISTORY of COMPLAINT

Please identify the condition(s) that brought you to this office: Primarily: ____

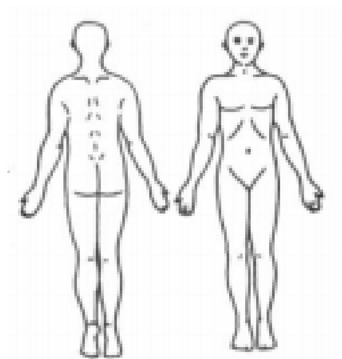
Secondarily: __________________________ Third: _____________________________ Fourth: ___________________________________

On a scale of **1** to **10** with **10** being the worst pain and **zero** being no pain, rate your above complaints by c***ircling the number*:**
Primary or chief complaint is : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Second complaints is : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Third complaint: : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Fourth complaint: : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

When did the problem(s) begin? ____________________ When is the problem at its worst? □ AM □ PM □ mid-day □ late PM How long does it last? □ It is constant **OR** □ I experience it on and off during the day **OR** □ It comes and goes throughout the week

How did the injury happen?_____________________ **Was this due to any type of accident?** □ Yes □ No **C**ondition(s) ever been treated by anyone in the past? □No □ Yes **If yes,** when: ______ by whom? ________________________________ How long were you under care: ____________ What were the results? ____

Name of Previous Chiropractor: _____________________________ □ **N/A**



***PLEASE MARK** the areas on the Diagram with the following **letters** to describe your symptoms:
R = **R**adiating **B** = **B**urning **D** = **D**ull **A** = Aching **N** = **N**umbness **S** = **S**harp/ **S**tabbing **T**= **T**ingling

What relieves the symptoms? ________________What makes them feel worse?__________________

Identify any other injury(s) to your spine, minor or major, that the doctor should know about:

____

LIST RESTRICTED ACTIVITY: **CURRENT ACTIVITY LEVEL** **USUAL ACTIVITY LEVEL**

___________________________________: ____

___________________________________: ____

___________________________________: ____

PAST HISTORY

Have you suffered with any of this or a similar problem in the past? ❑ No ❑ Yes **If yes** how many times? __________

When was the last episode? _____________________

Other forms of treatment tried: □ No □ Yes **If yes,** please state **what** type of treatment: ___________________________________, and who provided it: _________________________ **How long ago? _______**What were the results?. □ Favorable □ Unfavorable→ please explain. ____ ____________________________________

Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body:
____

If you have ever been diagnosed with any of the following conditions, please indicate with a **P** for in the ***Past***, **C** for ***Currently*** have and **N** for ***Never** have had***:**

___ Broken Bone ___Dislocations ___ Tumors ___Rheumatoid Arthritis ___ Fracture ___Disability ___Cancer ___ Heart Attack ___Osteo Arthritis ___ Diabetes ___Cerebral Vascular ___ Other serious conditions:

PLEASE identify ALL PAST and any **CURRENT** conditions you feel may be contributing to your present problem:

	HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM
INJURIES →			
SURGERIES →			
CHILDHOOD DISEASES→			
ADULT DISEASES →			

SOCIAL HISTORY

1. Smoking: ❑cigars ❑ pipe ❑ cigarettes → How often? ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never

2. Alcoholic Beverage: consumption occurs → ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never

3. Recreational Drug use: ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never

FAMILY HISTORY:

1. Does anyone in your family suffer with the same condition(s)? ❑ No ❑ Yes

If yes whom: ❑ grandmother ❑ grandfather ❑ mother ❑ father ❑ sister(s) ❑ brother(s) ❑ son(s) ❑ daughter(s)

Have they ever been treated for their condition? ❑ No ❑ Yes ❑ I don't know

2. Any other hereditary conditions the doctor should be aware of. ❑ No ❑Yes: ___________________________

COVID HISTORY:

1. Have you tested positive for COVID-19 in the past? ❑ No ❑ Yes If yes, please list date: ________________

2. Have you received the COVID-19 vaccine? ❑ No ❑ Yes Have you received both doses? ❑ No ❑ Yes

3. Which vaccine brand did you receive? ❑ Pfizer ❑ Moderna ❑ Johnson & Johnson/ Janssen

4. What date did you receive your first dose? ______________

5. What date did you receive your second dose? ______________

6. Have you had any side effects since receiving the vaccine? If yes, please list. ____________________________________

____

____

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working toward the same objective. Chiropractic has only one goal: to eliminate misalignments within the spinal column which interfere with the expression of the body's innate healing ability. It is important that each patient understand both the objective and the method that will be used to attain our goal. This will prevent any confusion or disappointment.

Adjustment: The specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is specific adjustments of the spine.
Health: A state of optimal physical, mental and social well-being, not merely the absence of disease, pain, or infirmity.
Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulse, resulting in the lessening of the body's ability to express its maximum health potential. We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will recommend that you seek the services of a health care provider who specializes in that area. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate major interference to the expression of the body's innate healing wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I hereby authorize payment to be made directly to MOVMNT Spine-Rehab-Sport, for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to MovMnt for any and all services I receive at this office.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I have read and fully understand the above statements.

I, ___________________________, , therefore accept chiropractic care on this basis. _________________________

Signature **Date**

Financial Agreement

I hereby authorize payment to be made directly to MOVMNT Spine & Rehab, for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to MOVMNT Spine & Rehab for any and all services I receive at this office.

____ ________ - ______ - ______

Patient or Authorized Person's Signature **Date Completed**

Consent to Evaluate and Adjust a Minor

I, ___________________________, being the parent/guardian of ___________________________ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

____ ________ - ______ - ______

Patient or Authorized Person's Signature **Date Completed**

Media Release

I hereby give MOVMNT Spine and Rehab the irrevocable right and permission to use photographs and/or video recordings of me on Social Media, promotional flyers, educational materials, derivative works, or for any other similar purpose without compensation to me. I understand and agree that such photographs and/or video recordings of me may be placed on the Internet for the purposes of promoting specific results. I also understand that any use of my name and or video and pictures will be at my discretion and can only be shared with permission.

I, ___________________________, have read and fully understand the above statements. ___________________________,

Print Name **Signature**

MOVMNT SPINE & REHAB CANCELLATION/ NO SHOW POLICY

Thank you for trusting your care to MovMnt Spine & Rehab. When you schedule an appointment with MovMnt Spine & Rehab we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment.

Please see our Appointment Cancellation/No Show Policy below:

- Effective June 7, 2021 any ESTABLISHED who fails to show or cancels/reschedules an appointment and has not contacted our office with **at least 24 hours notice** will be considered a No Show and charged a **$25.00 fee.**
- Any established patient who fails to show or cancels/reschedules an appointment with no 24 hour notice a second time will be charged a **$50.00 fee.**
- If a third No Show or cancellation/reschedule with no 24 hour notice should occur the patient may be dismissed from MovMnt Spine & Rehab. If not dismissed, a **$50.00 fee** will apply.
- Any NEW PATIENT who fails to show or cancels/reschedules an appointment and has not contacted our office with **at least 24 hours notice** will be considered a No Show and charged a **$50.00 fee.**
- Any NEW PATIENT who fails to show or cancels/reschedules an appointment and has not contacted our office with at least 24 hour notice a second time **will not be rescheduled.**
- The fee is charged to the patient, not the insurance company, and is **due at the time of the patient's next office visit**.
- As a courtesy, when time allows, we make reminder calls for appointments. If you do not receive a reminder call or message, the above Policy will remain in effect.

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances please contact our office. You may contact MovMnt Spine & Rehab 24 hours a day, 7 days a week at 239-513-9004 or at help@movmntnaples.com. Should it be after regular business hours Monday through Thursday, or a weekend, you may leave a message. Messages or emails are acceptable.

I have read and understand the Cancellation/ No Show Policy and agree to its terms.

______________________________	____________________
Signature	**Date**

Patient's Name: ____ Date: ___________________

ACTIVITIES OF DAILY LIVING

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

Activity				
Carrying Groceries	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Sit to Stand	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Pet Care	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Driving	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Extended Computer Use	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Lifting Children	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Concentration	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Bathing	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Dressing	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Shaving	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Sexual Activities	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Static Sitting	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Static Standing	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Yard work	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Walking	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Sweeping/Vacuuming	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Dishes	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Laundry	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Garbage	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Climbing Steps	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Sleep	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Other: ______________	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform

<u>Please mark P</u> <u>for in the</u> **<u>Past, C</u>** <u>for</u> **<u>Currently</u>** <u>have and</u> **<u>N</u>** <u>for</u> **<u>Never</u>**

___Headache

___Neck Pain

___Jaw Pain, TMJ

___Tremors

___Upper Back Pain

___Mid Back Pain

___Low Back Pain

___Hip Pain

___Back Curvature

___Scoliosis

___Numb/Tingling upper extremities

___Numb/Tingling lower extremities

___Pregnant (Now)

___Frequent Colds/Flu

___Convulsions/Epilepsy

___Double Vision

___Chest Pain

___Pain w/ Cough/Sneeze

___Foot or Knee Problems

___Frequent Sinus Drainage

___Swollen or Painful Joints

___Skin Problems

___Dizziness

___Loss of Balance

___Fainting

___Colon Trouble

___Blurred Vision

___Ringing in Ears

___Hearing Loss

___Depression

___Irritibility

___Mood Changes

___ADD/ADHD

___Austism

___Anxiety

___Trouble Sleeping

___Prostate Problems

___Impotence/Sexual Dysfun.

___Digestive Problems

___High Blood Pressure

___Diarrhea/Constipation

___Menopausal Problems

___Menstrual Problems

___PMS

___Bed Wetting

___Learning Disability

___Hepatitis (A/B/C)

___Eating Disorder

___Ulcers

___Heartburn

___Shoulder Pain

___Low Blood Pressure

___Allergies

___Asthma

___Difficulty Breathing

___Lung Problems

___Kidney Trouble

___Gallbladder Trouble

___Liver Trouble

List Prescription & Non-Prescription drugs you take:

____

____

____

Patient signature: ________________________________ Today's Date: ___/___/___