

ZUCKERMAN FAMILY WELLNESS CENTER Date: ___/___/___

Full Name _____	Nickname _____
Address _____	City _____ State ____ Zip _____
SSN ____ - ____ - ____	Marital Status _____ Sex ____ Age ____ DOB _____
Phone _____	Work Phone _____ Cell Phone _____
Occupation _____	Email _____ Employer _____
Spouse's Name _____	Emergency Contact Name & Phone _____
How did you hear about our office? _____	Who is your primary care doctor? _____
Who Is Responsible For Your Bill:	PPO ____ HMO ____ AUTO ____ CASH ____ Medicare ____

What brought you into our office today (chief complaint):

Is your condition due to: An Auto Accident A Personal Injury A Work Injury Other

HEALTH CARE AUTHORIZATIONS: *(Please Cross Out Any Permission You Would Like To Revoke)*

A. I hereby authorize release of any medical information necessary to process this claim and request payment of insurance benefits either to myself or to the party who accepts assignment.

B. I give permission to Zuckerman Family Wellness Center to use my address, phone number, email and clinical records to contact me with birthday cards, holiday related cards, information about treatment alternatives, office seminar dates, patient appreciation dates or other health related information such as newsletters.

C. I give permission to Zuckerman Family Wellness Center to use my name and clinical records to display my photos or x-rays and use my testimonial and experience in an effort to increase the public's awareness of chiropractic.

D. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with a doctor at any time in private, the doctor will provide a room for these conversations.

E. I understand that my travel card (Daily Visit Chart) contains protected health information and that I should keep it in my possession and upside down to prevent this information from being seen by another patient.

F. I authorize Zuckerman Family Wellness Center to take any x-rays the doctor determines will be beneficial to my case during the course of my care. I also recognize that if I am a female it is my responsibility to notify the doctor if I am pregnant or it is possible that I am pregnant.

Date of Last Menstrual Period _____.

G. I am giving Zuckerman Family Wellness Center permission to use and disclose my protected health information in accordance with the directives listed above.

H. I am giving Zuckerman Family Wellness Center permission to contact other health care providers, including my primary care physician, on my behalf to discuss treatment recommendations and co-management of my health care problems. Further, I am giving permission for Zuckerman Family Wellness Center to provide written information regarding my consultation and exam results to my primary care physician and any other related doctor.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand I have the following rights and privileges: The right to view the notice prior to signing this consent, the right to object to the use of my health information for directory purposes, and the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

RIGHT TO REVOKE AUTHORIZATION:

You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization. You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to Zuckerman Family Wellness Center. This AUTHORIZATION is requested by Zuckerman Family Wellness Center for its own use/disclosure of PHI.

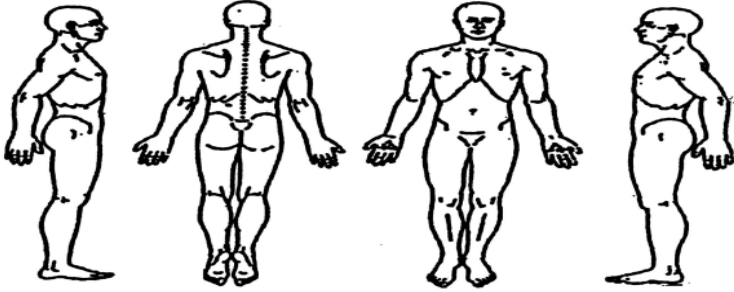
Patient Signature: _____ **Date:** _____

Parent or Guardian: _____ **Date:** _____

PATIENT INTAKE FORM

Patient Name: _____ Date: _____

Indicate on the drawings below all the areas where you have pain/symptoms:



First Complaint: _____

How often do you experience your symptoms?

- Constantly (76-100% of the time) Occasionally (26-50% of the time)
 Frequently (51-75% of the time) Intermittently (1-25% of the time)

How would you describe the type of pain?

- Sharp Numb
 Dull Tingly
 Diffuse Sharp with motion
 Achy Shooting with motion
 Burning Stabbing with motion
 Shooting Electric like with motion
 Stiff Other: _____

How are your symptoms changing with time? Getting Worse Staying the same Getting Better

Using a scale from 0-10 (10 being the worst), how would you rate your problem?

Indicate Pain Level (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Shoot Me Pain)
--

How much has the problem interfered with your work?

- Not at all A little bit Moderately Quite a bit Extremely N/A

How much has the problem interfered with your social activities?

- Not at all A little bit Moderately Quite a bit Extremely

Who else have you seen for your problem?

- Chiropractor Massage Therapist Primary Care Physician Neurologist
 Orthopedist ER physician Physical Therapist Other: _____

Provider Name / Date of visit: _____

How long have you had this problem? _____

How do you think your problem began? Cause Not Known Auto Accident Work Injury Slip / Fall
 Sports Injury Other _____

What aggravates your problem?

- Nothing Sneezing Bending Coughing Lifting Walking Reaching Sitting Straining at Stool
 Standing Pulling Turning Other – Describe: _____

What makes your problem better?

- Nothing Rest Sitting Stretching Exercise Standing Heat Ice Medications Massage
 Adjustments Sleeping Other – Describe: _____

Do you consider this problem to be severe? Yes Yes, at times No

What concerns you the most about your problems; what does it prevent you from doing?

PATIENT INTAKE FORM

Second Complaint: _____

How often do you experience your symptoms?

- Constantly (76-100% of the time) Occasionally (26-50% of the time)
 Frequently (51-75% of the time) Intermittently (1-25% of the time)

How would you describe the type of pain?

- Sharp Numb
 Dull Tingly
 Diffuse Sharp with motion
 Achy Shooting with motion
 Burning Stabbing with motion
 Shooting Electric like with motion
 Stiff Other: _____

How are your symptoms changing with time? Getting Worse Staying the same Getting Better

Using a scale from 0-10 (10 being the worst), how would you rate your problem?

Indicate Pain Level (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Shoot Me Pain)
--

How much has the problem interfered with your work?

- Not at all A little bit Moderately Quite a bit Extremely N/A

How much has the problem interfered with your social activities?

- Not at all A little bit Moderately Quite a bit Extremely

Who else have you seen for your problem?

- Chiropractor Massage Therapist Primary Care Physician Neurologist
 Orthopedist ER physician Physical Therapist Other: _____

Provider Name / Date of visit: _____

How long have you had this problem? _____

How do you think your problem began? Cause Not Known Auto Accident Work Injury Slip / Fall Sports Injury Other _____

What aggravates your problem?

- Nothing Sneezing Bending Coughing Lifting Walking Reaching Sitting Straining at Stool
 Standing Pulling Turning Other Describe: _____

What makes your problem better?

- Nothing Rest Sitting Stretching Exercise Standing Heat Ice Medications
 Massage Adjustments Sleeping Other – Describe: _____

Do you consider this problem to be severe? Yes Yes, at times No

What concerns you the most about your problems; what does it prevent you from doing?

What is your: Height _____ Weight _____ Date of Birth _____

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

Indicate if you have any immediate family members with any of the following:

- Rheumatoid Arthritis Diabetes Lupus Heart Problems Cancer ALS

PATIENT INTAKE FORM

For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present	Past	Present	Past	Present
<input type="checkbox"/>	<input type="checkbox"/> Headaches	<input type="checkbox"/>	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/> Diabetes
<input type="checkbox"/>	<input type="checkbox"/> Neck Pain	<input type="checkbox"/>	<input type="checkbox"/> Heart Attack	<input type="checkbox"/>	<input type="checkbox"/> Excessive Thirst
<input type="checkbox"/>	<input type="checkbox"/> Upper Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Chest Pains	<input type="checkbox"/>	<input type="checkbox"/> Frequent Urination
<input type="checkbox"/>	<input type="checkbox"/> Mid Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Stroke	<input type="checkbox"/>	<input type="checkbox"/> Smoking/Tobacco Use
<input type="checkbox"/>	<input type="checkbox"/> Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Angina	<input type="checkbox"/>	<input type="checkbox"/> Drug/Alcohol Dependence
<input type="checkbox"/>	<input type="checkbox"/> Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/> Allergies
<input type="checkbox"/>	<input type="checkbox"/> Elbow/Upper Arm Pain	<input type="checkbox"/>	<input type="checkbox"/> Kidney Disorders	<input type="checkbox"/>	<input type="checkbox"/> Depression
<input type="checkbox"/>	<input type="checkbox"/> Wrist Pain	<input type="checkbox"/>	<input type="checkbox"/> Bladder Infection	<input type="checkbox"/>	<input type="checkbox"/> Systemic Lupus
<input type="checkbox"/>	<input type="checkbox"/> Hand Pain	<input type="checkbox"/>	<input type="checkbox"/> Painful Urination	<input type="checkbox"/>	<input type="checkbox"/> Epilepsy
<input type="checkbox"/>	<input type="checkbox"/> Hip Pain	<input type="checkbox"/>	<input type="checkbox"/> Loss of Bladder Control	<input type="checkbox"/>	<input type="checkbox"/> Dermatitis/Eczema/Rash
<input type="checkbox"/>	<input type="checkbox"/> Upper Leg Pain	<input type="checkbox"/>	<input type="checkbox"/> Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/>	<input type="checkbox"/> Knee Pain	<input type="checkbox"/>	<input type="checkbox"/> Abnormal Weight Gain/Loss	<u>For Females Only</u>	
<input type="checkbox"/>	<input type="checkbox"/> Ankle/Foot Pain	<input type="checkbox"/>	<input type="checkbox"/> Loss of Appetite	<input type="checkbox"/>	<input type="checkbox"/> Birth Control Pills
<input type="checkbox"/>	<input type="checkbox"/> Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/> Hormonal Replacement
<input type="checkbox"/>	<input type="checkbox"/> Joint Pain/Stiffness	<input type="checkbox"/>	<input type="checkbox"/> Ulcer	<input type="checkbox"/>	<input type="checkbox"/> Pregnancy
<input type="checkbox"/>	<input type="checkbox"/> Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Hepatitis	<input type="checkbox"/>	<input type="checkbox"/> Pregnancy
<input type="checkbox"/>	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Liver/Gall Bladder Disorder		
<input type="checkbox"/>	<input type="checkbox"/> Cancer	<input type="checkbox"/>	<input type="checkbox"/> General Fatigue		
<input type="checkbox"/>	<input type="checkbox"/> Tumor	<input type="checkbox"/>	<input type="checkbox"/> Muscular Incoordination		
<input type="checkbox"/>	<input type="checkbox"/> Asthma	<input type="checkbox"/>	<input type="checkbox"/> Visual Disturbances		
<input type="checkbox"/>	<input type="checkbox"/> Chronic Sinusitis	<input type="checkbox"/>	<input type="checkbox"/> Dizziness		
<input type="checkbox"/>	<input type="checkbox"/> Other: _____				

List all prescription medications you are currently taking: (feel free to include separate list if needed)

List all of the supplements you are currently taking:

List all surgical procedures you have had:

What activities do you do at work? Do Not Work / Retired

<input type="checkbox"/> Sit:	<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half the day	<input type="checkbox"/> A little of the day
<input type="checkbox"/> Stand:	<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half the day	<input type="checkbox"/> A little of the day
<input type="checkbox"/> Computer work:	<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half the day	<input type="checkbox"/> A little of the day
<input type="checkbox"/> On the phone:	<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half of the day	<input type="checkbox"/> A little of the day

What activities do you do outside of work?

Have you ever been hospitalized? No Yes

if yes, when and why _____

Have you had significant past trauma? No Yes If yes, please list all previous traumas

Anything else pertinent to your visit today? _____

Patient Signature _____ Date: _____

Zuckerman Family Wellness Center

Dr. Adam D. Zuckerman P.A.

8280 Jog Road

Boynton Beach, Fl 33472

Phone: (561) 752-4646 Fax: (561) 737-7664

Authorization For Release of Protected Health Information

Patient Name _____ Date of Birth _____

Social Security # _____

I hereby authorize the release of medical records to Zuckerman Family Wellness Center. I understand that I may revoke this authorization at any time. My revocation must be in writing, on a form that will be provided to me upon request. I am aware that my revocation will not be effective to the extent that Zuckerman Family Wellness Center has acted in reliance on this authorization. I understand that if my protected health information is disclosed to someone who is not required to comply with the Federal Privacy regulations, then such information may be re-disclosed and no longer protected by the Federal Privacy regulations. I release Zuckerman Family Wellness Center and it's workforce members from all liability arising from the disclosure of my health information pursuant to this agreement. I authorize the disclosure of protected health information as stated above.

Signature of Patient/Patient Representative

Date

Print Name of Patient/Patient Representative

Relationship to Patient

Dr. Adam D. Zuckerman

Family Chiropractor

4895 Windward Passage Drive * Suite 9 * Boynton Beach, FL 33436

Ph: (561) 752-4646 * Fax: (561) 737-7664

Informed Consent for Chiropractic Care

A patient coming to the Doctor of Chiropractic gives the doctor permission and authority to care for the patient in accordance with chiropractic tests, diagnostics and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course will not give a chiropractic adjustment, or health care, if he is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures whatever he / she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the Doctor of Chiropractic. The patient should look to the correct specialist for the proper diagnostic and clinical procedures. The Doctor of Chiropractic provides a specialized, non-duplicating health service. The Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

I hereby request and consent to the performance of chiropractic adjustment and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays on me (or on the patient named below for whom I am legally responsible) by Zuckerman Family Wellness Center and / or other licensed Doctors of Chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for Zuckerman Family Wellness Center.

I have had the opportunity to discuss with the Doctor of Chiropractic the nature and purpose of Chiropractic adjustments and other procedures.

I have had read to me the above consent. I have also had the opportunity to ask questions about its content, and by signing below, I agree to the above-named procedures.

PATIENT NAME: _____ DATE: _____

PATIENT SIGNATURE: _____

WITNESS: _____

TO BE COMPLETED BY PATIENTS REPRESENTATIVE IF PATIENT IS A MINOR OR PHYSICALLY OR LEGALLY INCAPACITATED

PATIENT NAME: _____ DATE: _____

SIGNATURE OF REPRESENTATIVE: _____

RELATIONSHIP TO PATIENT: _____

TERMS OF ACCEPTANCE

ZUCKERMAN FAMILY WELLNESS CENTER

Dr. Adam D. Zuckerman, P.A.

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. 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 by specific adjustments of the spine.

Health: a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Massage Therapy: To decrease discomfort, decrease the muscle tone, decrease any swelling, break up any adhesions, increase the vascular flow, and speed up the healing process.

Vertebral Subluxation: a misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate 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 a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area. In accordance with the Florida state statute 64B2-17.0055, our office will release records such as written reports and/or x-rays upon request for the cost of reproducing the copies.

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 a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____ have read and fully understand the above statements.
(Print Name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

Signature

Date

Pregnancy Release

I certify that to the best of my knowledge I am not pregnant and the above doctor has my permission to perform an x-ray evaluation. I have been advised that x-rays can be hazardous to an unborn child. Date of last menstrual period: _____

(Signature)

(Date)

Consent to evaluate and adjust a minor child

I, _____ being the parent or legal guardian of _____

Have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive Chiropractic care.