APPLICATION FOR TREATMENT Date: _____

Name:_____ Age:_____ Date of Birth:_____

Address:_____ City:_____ State: _____ Zip: _____

Phone (Home):_____ SSI#_____ Sex: M F Marital Status: S M D W

Referred by:_____ # of Children:_____ Occupation:_____

Employer:_____ Phone (Work):_____ Phone (Cell): _____

Email: _____ In case of an emergency please contact:_____ Phone#:_____

Spouse's Name _____ Date of Birth: _____ SSI#_____ Employer:_____

FORM OF PAYMENT: CASH CHECK CREDIT CARD INS. PERSONAL AUTO WORK

MAJOR SYMPTOMS: Please describe your major symptoms.

_____

_____

_____

Please mark the intensity of your pain today.

1 – NO PAIN

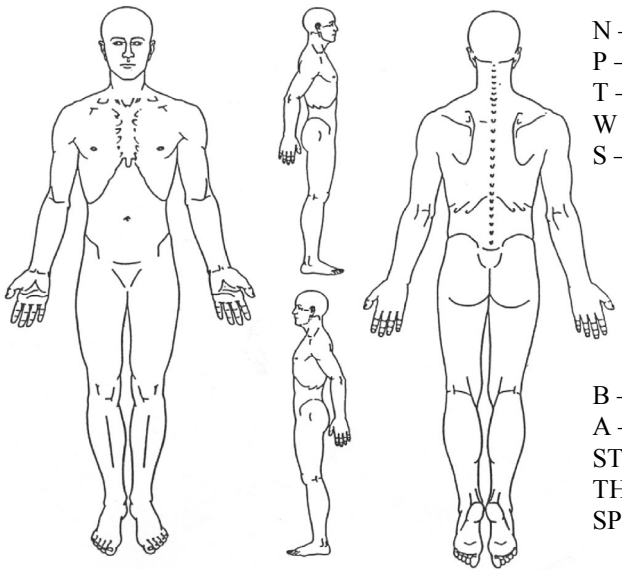
10 – MOST INTENSE PAIN EVER FELT

1. _____
   1 2 3 4 5 6 7 8 9 10
2. _____
   1 2 3 4 5 6 7 8 9 10
3. _____
   1 2 3 4 5 6 7 8 9 10
4. _____
   1 2 3 4 5 6 7 8 9 10

Family History

	Diabetes	Heart	Kidney	Cancer	Back
Mother	☐	☐	☐	☐	☐
Father	☐	☐	☐	☐	☐
Brother	☐	☐	☐	☐	☐
Sister	☐	☐	☐	☐	☐

Please mark the area & type of pain on the drawings using the code listed below.



N – Numbness
P – Pain (Sharp/Stabbing)
T – Tingling
W - Weakness
S – Soreness

B – Burning
A – Ache
ST – Stiffness
TH – Throbbing
SP – Spasm/Cramping

How did this condition develop? (What caused it?): _____

_____

When was the very first time you were aware of this problem?_____

Have you ever had this problem or similar problem before? If yes, please explain: _____

_____

Has this problem been getting better, worse, or staying the same?_____

Is there anything you do that makes your condition worse? _____

Is there anything you do that makes your condition better? _____

How has this condition affected your life?

A. Home life _____
B. Occupational life _____
C. Recreational life _____
D. Rest and Sleep life _____

(PLEASE COMPLETE REVERSE SIDE)

Have you ever been in an automobile accident? Past year Past 5 years Over 5 years Never

ANY ACCIDENTS, FALLS, ETC, THAT MIGHT HAVE CAUSED YOUR PROBLEM _____

_____

What surgery has been done? _____

_____

Are you pregnant? Yes No Date of LMP? _____

DRUGS YOU NOW TAKE: NERVE PILLS PAIN KILLERS MUSCLE RELAXERS BIRTH CONTROL PILLS

OTHER (Please List) _____

_____

ANY CHIROPRACTOR CONSULTED IN THE PAST? Name: _____

Dates Consulted: _____ For what problem? _____

Have you ever been diagnosed as having or suffering from: (check all that apply):

- ☐ Scoliosis
- ☐ Circulatory problems
- ☐ Seizures/Convulsions
- ☐ High or ☐ Low Blood Pressure
- ☐ Hepatitis
- ☐ Tuberculosis
- ☐ Headaches
  - Frequency ____ per week ____ per month
  - Do they wake you from sleep Yes No
  - Location of headache pain ☐ Forehead ☐ Left side ☐ Right side
  - ☐ Temple ☐ Left side ☐ Right side
  - ☐ Back of head ☐ Right side of head ☐ Left side of head
- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ Cancer
- ☐ Osteoporosis
- ☐ Kidney Stones
- ☐ Venereal Infection
- ☐ Gall Bladder (Stones)
- ☐ Pacemaker
- ☐ Ulcers
- ☐ Diabetes
- ☐ Broken or Fractured Bones
  - List _____
- ☐ HIV Positive
- ☐ Depression
- ☐ Tumors
- ☐ Heart Disease
- ☐ Hernia
- ☐ Other _____

Average Duration _____ minutes _____ hours

_____ height _____ weight

_____ blood pressure

_____ smoker (packs/day)

☐ Allergies _____

Alcohol - _____ Never ____ Socially _____Occasional _____ Frequent _____ Regularly

Exercise - _____ Never _____ Occasional _____ Frequent _____ Regularly

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that North Trail Chiropractic Clinic will prepare any necessary reports and forms to assist me in making collection from the insurance company and any amount authorized to be paid directly to North Trail Chiropractic Clinic will be credited to my account upon receipt. However I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. If for any reason that a third party must be utilized for collection of fees, I will be responsible all costs of collection included but not limited to a 40% surcharge, and any additional fees, including but not limited to attorney fees and court costs. All disputes will be venue Collier County, Florida and decided under the laws of Florida. Any past due amounts will be assessed 1.5 percent interest per month.

I authorize the Doctor to examine me/my minor child, and treat me or my child's condition as he deems appropriate, and I give authority for these procedures to be performed. It is understood and agreed the amount paid the Doctor for X-rays is for examination only and the X-ray negatives will remain the property of North Trail Chiropractic Clinic, being part of my file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office.

Patient's/Guardian's Signature X _____ Date _____

My Permanent address is (if different from the address on the other side)

Address _____

City _____ State _____ Zipcode _____ Telephone # _____

(PLEASE COMPLETE REVERSE SIDE)

David A. Dishauzi, D.C.
North Trail Chiropractic Clinic, Inc.
*4530 Tamiami Trail North, Suite 2 * Naples, FL * 34103*
239-261-5222

HIPAA
Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use and disclose "protected health information" or "PHI" about you. The Notice contains a Patients Rights section describing your rights under the law. You have the right to review our Notice before signing this consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information, PHI about you for treatment, payment, and health care operations. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- **Protected health information may be disclosed or used for treatment, payment, or health care operations**
- **The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this notice**
- **The Practice reserves the right to change the Notice of Privacy Practices**
- **The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions**
- **The patient may revoke this Consent in writing at any time and all future disclosures will then cease**
- **The Practice may condition receipt of treatment upon the execution of this Consent**

This Consent was signed by:

_____	_____	_____
Signature (Patient or Representative)	**Printed Name**	**Date**
_____	_____	_____
Witness (North Trail Chiropractic)	**Printed Name**	**Date**

David A. Dishauzi, D.C.
North Trail Chiropractic Clinic, Inc.
*4530 Tamiami Trail North, Suite 2 * Naples, FL * 34103*
239-261-5222

Name: _____ Date: _____

I give David A. Dishauzi, D.C. my permission to discuss any treatment received, test results or any other protected health information with the following:

☐ Myself Only ☐ Those Individuals listed below:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Does our office have permission to:

Leave a message on your answering machine at home concerning an appointment confirmation.

☐ Yes ☐ No

Leave a message on your cell phone concerning an appointment confirmation or to have you return a call

☐ Yes - Cell Number _____ ☐ No

Leave a message on your answering machine at home concerning any test results, or any other protected health information requested by you.

☐ Yes ☐ No

Leave a message at your place of employment to have you return a call?

☐ Yes ☐ No

I understand that I may change or rescind this authorization at any time.

_____ _____

Signature **Date**

Dear Patient:

Every type of health care is associated with some risk of a potential problem. This includes chiropractic healthcare. We want you to be informed about potential problems associated with chiropractic healthcare before consenting to treatment. This is called informed consent.

Chiropractic adjustments are the moving of bones with the doctor's hands or with the use of instruments. Frequently adjustments create a "pop" or "click" sound or sensation in the area being treated.

In our office, we use trained staff to assist the doctor with physical therapy modalities. Occasionally when your initially treating doctor is unavailable, another clinic doctor will treat you on that day.

STROKE: Stroke is the most serious problem associated with chiropractic adjustments. Stroke means that a portion of the brain does not receive enough oxygen from the blood stream. The results can be temporary or permanent dysfunction of the brain, with a very rare complication of death. Chiropractic adjustments have been associated with strokes that arise from the vertebral artery only; this is because the vertebral artery is actually found inside the neck vertebrae. The adjustment that is related to the vertebral artery stroke is called "extension-rotation-thrust atlas adjustment". We do not do this type of adjustment on patients. Other types of neck adjustments may also potentially be related to vertebral artery strokes, but no one is certain. The most recent studies (Journal of the CCA, Vol. 37 No 2, June 1993) estimate that the incident of this type of stroke is one per 3,000,000 upper neck adjustments. This means that an average chiropractor would have to be in practice for hundreds of years before they would be statistically associated with a single patient stroke.

DISC HERNIATIONS: Chiropractors utilizing chiropractic adjustments, physical therapy modalities and rehabilitation exercises frequently successfully treat disc herniations which create pressure on the spinal nerve or on the spinal column. This includes both in the neck and back. Yet, occasionally chiropractic treatments (adjustments, therapy, etc.) will aggravate the problem if the disc is in a weakened condition. These problems occur so rarely that there are no available statistics to quantify their probability.

SOFT TISSUE INJURY/BRUISING (ACUPUNCTURE): Soft tissues refer to muscles, tendons, and ligaments. Muscles move bones and ligaments limit joint movement, rarely, a chiropractic adjustment, therapy, etc. may tear some muscle or ligament fibers. The result is a temporary increase in pain and necessary treatments for resolution, but there are no long-term effects for the patient. These problems occur so rarely that there are no available statistics to quantify their probability. Some bruising may occur following an acupuncture treatment at the site of needle insertion.

RIB FRACTURES: The ribs are found only in the thoracic spine, or middle back. They extend from your back to your front chest area, and rarely a chiropractic adjustment will crack a rib bone, and this is referred to as a fracture. This occurs only on patients that have weakened bones from such things as osteoporosis. Osteoporosis can be noted on your X-rays. We adjust all patients very carefully, and especially those who have osteoporosis on their x-rays. These problems occur so rarely that there are no available statistics to quantify their probability.

SORENESS: It is common for chiropractic adjustments, therapy, massage, etc. to result in a temporary increase in soreness in the region being treated. Nearly always, this temporary symptom occurs while your body is undergoing therapeutic change. It is not dangerous, but please do tell the doctor about it.

OTHER PROBLEMS: There may be other problems or complication that might arise from the chiropractic treatment other than those noted above. These other problems or complications occur so rarely that it is not possible to anticipate and/or explain them all in advance of treatment.

Chiropractic is a system of health care delivery, and, therefore, as with any health care delivery system, we cannot promise a cure for any symptom, disease, or condition because of treatment in this clinic. We will always give you our best care, and if results are not acceptable, we will refer you to another provider whom we feel will assist your situation. If you are pregnant or think that you might be, please advise our office at this time. If you have any question on the above or do not understand something, please ask the treating doctor at this office. When you have a full understanding, please sign and date below.

_____ _____

Patient's Signature Date