ACUPUNCTURE & CHIROPRACTIC CENTER OF PENSACOLA

P 850. 469.9633 | F 850.469.1590 | 945 W. Michigan Ave. 8B | Pensacola, FL 32505
www.acuchiroctr.com | chiroacucenter@bellsouth.net

Please Note: Please fill it out completely.

Name Last _____ First _____ Middle_____

Address _____ City _____ State ___ Zip code _____

Email address_____

Phone home ( ) _____ cell ( ) _____ Social Security _____

Age _____ Birth date _____/_____/_____ Gender: M / F No. Children _____

Marital Status: * Single * Married * Widowed * Separated * Divorced * Student

Occupation _____ Employer _____ Work Phone ( )_____

Employer Address _____ City _____ St./Zip Code _____

Spouse Name _____ Social Security #_____

Occupation _____ Employer _____ Work Phone (___)_____

Emergency Contact _____ Phone ( )_____ Relationship _____

How did you find out about our office? _____

I understand and agree that services rendered to me are charged directly to me and that I am personally responsible for payment of all charges related to the treatment, supplements or other supplies. Payment is due at the time treatment is rendered unless payment agreements have been made.

Disclaimer:
We, as your physician, use whole food supplements and herbs to supply nutrients to improve and balance the body's biochemistry. The supplements recommended are based on your evaluation and are not included in your initial or follow up visits. _____ (initial)

If the seal is broken on a supplement, there will be no return or refunds opened bottles. _____ (initial)

MY CERTIFICATION
I certify that the above information is correct and I request services _____ (initial)

I have read a copy of the Notice of Privacy Practices. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: Conduct, plan and direct my treatment and follow-up among the healthcare providers who may be directing and indirectly involved in providing my treatment.

I have read the Notice of Privacy Practices and do not understand. I require more information

X_____ _____
Signature of patient or person acting on the patients behalf Date

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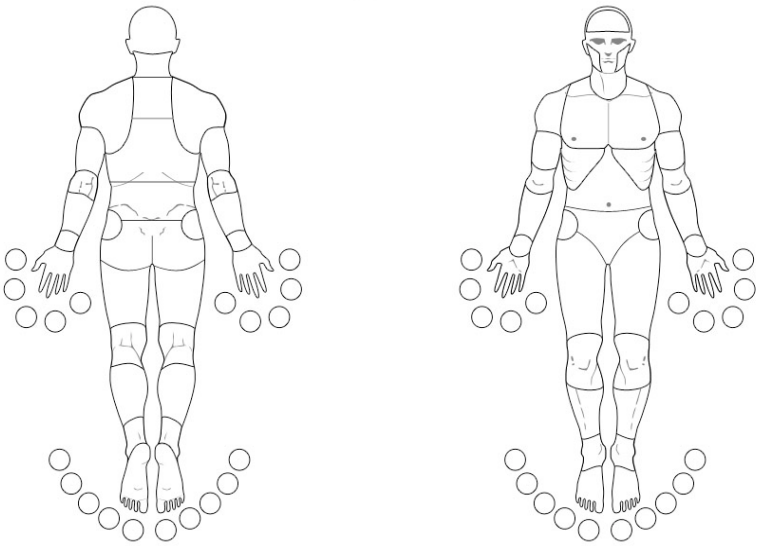
Name_____ **Age**_____ **HT**_____ **WT**_____ **RH** **LH**

What services are you interested in :: ____ **Chiropractic** _____ **Acupuncture**
What type of relief are you expecting ____ **Temporary Relief** _____ **Permanent Relief**

Please indicate the current complaints you are experiencing by marking the areas on the image below and providing details using the sections that follow

1. Headaches
2. Neck
3. Upper back
4. Mid Back
5. Lower Back
6. Hip
7. Buttock
8. Shoulder
9. Arm
10. Elbow
11. Forearm
12. Wrist
13. Hand
14. Fingers
15. Leg
16. Knee
17. Calf
18. Shin
19. Ankle
20. Foot



Area of Complaint		
Location		☐ Left ☐ Right ☐ Both ☐ Center
Pain Ratings		☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (Excruciating)
Frequency		☐ Infrequent < 25% ☐ Occasional 25% to 50% ☐ Frequent 50% to 75% ☐ Constant > 75%
Pain Type		☐ No Pain ☐ Pain ☐ Numbness ☐ Tingling ☐ Muscle Spasms ☐ Burning
Severity		☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe
What makes it better?		☐ Medication ☐ Lying Down ☐ Standing ☐ Sitting ☐ Stretching ☐ Range of Motion ☐ Nothing
What makes it worse?		☐ Movements ☐ Bending ☐ Twisting ☐ Weight Bearing ☐ Movements ☐ Neck flexion ☐ Sneezing ☐ Sitting ☐ Standing ☐ Walking ☐ Chewing ☐ Yawning ☐ Opening mouth ☐ Closing mouth ☐ Range of motion ☐ pushing/pulling ☐ Lifting ☐ Watching T.V. ☐ Reading ☐ Working ☐ Driving ☐ Housework ☐ Bright lights
Does the pain radiate to any other locations?	Upper Body	☐ Head ☐ Forehead ☐ Back of head ☐ Right side of head ☐ Left side of head ☐ Neck ☐ Right Ear ☐ Left Ear ☐ Right Eye ☐ Left Eye ☐ Face ☐ Right Jaw ☐ Left ☐ Right Upper back ☐ Left Upper back ☐ Right Shoulder ☐ Left Shoulder ☐ Right Chest ☐ Left Chest ☐ Right Ribs ☐ Left Ribs
	Mid Body	☐ Right Mid back ☐ Left Mid back ☐ Right Lower back ☐ Left Lower back ☐ Right Hip ☐ Left Hip ☐ Right Buttock ☐ Left Buttock ☐ Groin ☐ Right Arm ☐ Left Arm ☐ Right ☐ Left forearm ☐ Right hand ☐ Left hand ☐ Right fingers ☐ Left fingers
	Lower Body	☐ Right Thigh ☐ Left Thigh ☐ Right Knee ☐ Left Knee ☐ Right Calf ☐ Left Calf ☐ Right Toes ☐ Left Toes ☐ Right Foot ☐ Left Foot ☐ Right Toes ☐ Left Toes
Described as		☐ Aching ☐ Dull ☐ Sharp ☐ Stabbing ☐ Throbbing
At it's worst		☐ Morning ☐ Afternoon ☐ Evening ☐ Night After Activities: ☐ Light ☐ Moderate
Associated with		☐ Dizziness ☐ Nausea ☐ Visual Problems ☐ Ringing/Buzzing ears ☐ Bright light ☐ Sensitivity ☐ Loss of balance

HAVE YOU HAD ANY MEDICAL TREATMENT FOR THIS CONDITION:
YES NO DR._____ Last Visit _____
Please describe the type of treatment have you received?
_____

Please describe the type of treatment have you received?

_____

What you are doing at home to relieve your pain.(Ex.Heat, Ice, Medications, Rest) Please Explain.

_____

DIAGNOSTIC TESTING: (Because of your immediate problem have you ever had x rays or other tests taken.

_____

_____

Medical Information:

Who is your Family Physician:			
Address:	City:	State:	ZIP Code:
Date of last Visit: / /	Date of last exam: / /		

ALLERGIES: Are you allergic to any medications? Please list

_____

MEDICATIONS: Please list **ALL** medications you are taking: This includes vitamins or other remedies you may be taking

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

Have you had surgeries in the last 5 Years: ☐ Yes ☐ No If yes, Last Surgery Date:

Reason for Surgery:

Have you been diagnosis with any of the following conditions:

☐ AIDS	☐ Cancer	☐ Heart Problem	☐ Multiple Sclerosis	☐ Spinal Disc Disease	
☐ Allergies	☐ Cirrhosis/hepatitis	☐ High blood pressure	☐ Pacemaker	☐ Thyroid trouble	☐ Epilepsy
☐ Anemia	☐ Diabetes	☐ HIV/ARC	☐ Prostate trouble	☐ Tuberculosis	☐
☐ Arthritis	☐ Dislocated joints	☐ Kidney trouble	☐ Rheumatic fever	☐ Ulcer	☐
☐ Asthma	☐ Diverticulitis	☐ Low Blood Pressure	☐ Scoliosis	☐ Polio	☐
☐ Bone fracture	☐ Hay Fever	☐ Mental/ Emotional Difficulty	☐ Sinus trouble	☐ STD'S	☐

Other:

Please check if a family member has been diagnosis with any of these conditions:

☐ AIDS	☐ Cancer	☐ Multiple Sclerosis	☐ Spinal Disc Disease	☐ STD'S	
☐ Allergies	☐ Bone fracture	☐ Heart Problem	☐ Low Blood Pressure	☐ Sinus trouble	☐ Ulcer
☐ Anemia	☐ Cirrhosis/hepatitis	☐ HIV/ARC	☐ Mental/ Emotional Difficulty	☐ Epilepsy	☐ Polio
☐ Arthritis	☐ Diabetes	☐ High blood pressure	☐ Prostate trouble	☐ Thyroid trouble	☐ Scoliosis
☐ Asthma	☐ Dislocated joints	☐ Kidney trouble	☐ Rheumatic fever	☐ Tuberculosis	☐ Diverticulitus

Social History:

Alcohol? ☐ No ☐ Yes Drinks per week?	Cigarettes? ☐ No ☐ Yes Packs per day?	Caffeine? ☐ No ☐ Yes Drinks per day?	Exercise? ☐ No ☐ Yes Hours per week? (circle one) Light / Moderate / Strenuous
Misc.:			

_____ _____

Patient's Signature Date

Thank you for providing us with accurate information about your health, because it could save you some time

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ACUPUNCTURE
PATIENT QUESTIONNAIRE AND INFORMED CONSENT FORM

1. Are you now or have you recently been on any medications? Yes No
   If the answer to #1 is yes, what are they? _____

2. Are you now, or have you ever been on blood thinners or anticoagulants? Yes No

3. Have you ever taken cortisone or other drugs for arthritis? Yes No

4. Do you bleed easily? Yes No

5. Have you ever been told you have a heart problem? Yes No

6. Do you have a pacemaker or another device that has been surgically implanted in your body? Yes No

7. Have you ever had hepatitis or has your skin ever turned yellow in color? Yes No

8. Have you ever had a venereal disease or been in contact with AIDS?
   Yes No

9. Have you ever received a blood transfusion? Yes No
   If so, when?_____How many units?_____

10. Do you faint easily? Yes No

11.Have you ever used drugs: i.e Heroin, Cocaine, etc? Yes No

****

Meridian Therapy (Acupuncture) is an Oriental procedure that is still being researched and investigated in this country. Please read the following statements that relate to this procedure; this is to comply with guidelines formulated by the FDA. (If you cannot read, they will be read to you for your consideration.)

1. I, the undersigned, hereby authorize and direct Dr. Robert F. Cowan and associates to administer acupuncture, which involves the insertion of needles or staples at one or more points in the body, or the application of other Oriental forms of Meridian Therapy he may feel necessary at the time.

2. I understand that any and all questions posed by me regarding the acupuncture procedure to be used will be answered by Dr. Cowan or his assistants prior to receiving my initial treatment.

3. I understand that the exam and treatment may require that I partially disrobe and that if, for any reason I wish to have an assistant present during any part of the exam, I will be free to ask for one.

4. I understand that in no manner have I been warranted or guaranteed a beneficial result from treatment by acupuncture.

I have read the above statements, and I consent to the use of acupuncture and realize that it is not the standard treatment in the community and other forms of treatment may be available for my condition.

DATE_____ Patient's Signature_____

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- Robert F. Cowan DC, CAP

Informed Consent for the Chiropractic Adjustment

Patient: _____ Date: _____

The primary treatment used by doctors of chiropractic is the spinal adjustment. I will use that procedure to treat you.

- The nature of the Chiropractic Adjustment:
  I will use my hands or a mechanical device upon your body in such a way as to move your joints. That may cause an audible "pop" or "click", much as you have experienced when you "crack" your knuckles. You may feel or sense movement.
- The material risks inherent in chiropractic adjustment:
  As with any health care procedure, there are certain complications which may arise out of or during a chiropractic adjustment. Those complications include: fractures, disk injuries, dislocations or sprains of the vertebrae or ribs and muscle strain. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck, leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment.
- The probability of those risks occurring:
  Depending on what authority you wish to believe, the percentages vary greatly. Most of these risks are remote but they still exist.
- Do you have any questions about the risks of chiropractic adjustments?
  ____ No ____ Yes _____ Initials
  If yes, what is/are the question (s)
- Ancillary treatment:
  In addition to chiropractic adjustments, I may use one of the following treatments:

Electrical stimulation	Therapeutic exercise	Myofascial Release
Ultrasound	Vibration	Hot /Cold Packs

  These treatments involve the following additional risks:

- The availability and nature of other treatment options:
  Self Treatment
  Medical Treatment

- Since all possible problems could not possibly be covered and evaluated by your initial reason for coming to this office would you like to be referred to another doctor before you make a decision for treatment.
  _____ No _____ Yes _____ Initials

Do not sign until you have read and understand the above.
Please check the appropriate block and sign below

I have read I□ve not read the a□e explanation of the chiropractic adjustment and related treatment. I have discussed it with the above named Doctor and have had my questions answered to my satisfaction. Having no further questions and with an understanding of the potential risks and benefits of care in this clinic,. I choose to have care started as recommended.

Dated_____ Patient Name _____

_____

Signature (Signature of Guardian if Minor)