ABUNDANCE
CHIROPRACTIC

HEALTH PROFILE

INFORMATION

Last Name_____**First Name**_____**Goes By**_____

Date of Birth____/____/_____ **Gender**: □Male □Female **Status**: □Single □Married □Divorced □Widowed

Spouse's Name_____**Children:** □No □Yes: *Names*_____

Address_____**City**_____**State**_____**Zip**_____

Cell Phone_____**Work Phone**_____

Email_____**Best Contact Method:** □Cell Phone □Email

Occupation_____ **Employer** _____

Emergency Contact Name_____**Emergency Contact Phone Number**_____

LIFESTYLE

Are you physically active? □Not at all □Somewhat □For the Most Part □Yes □Very

Physical Activities_____

Quality of sleep: □Poor □Fair □Average □Good □Excellent

Do you have any emotional or behavioral issues: □No □Yes: _____

Your opinion on chiropractic care: □Skeptical □Curious □Passionate □Indifferent □Nervous □Excited

SYMPTOMS

CHECK ALL THAT APPLY

- ❑ Neck pain
- ❑ Headaches
- ❑ Migraines
- ❑ Vertigo
- ❑ Dizziness
- ❑ Nausea
- ❑ TMJ
- ❑ Ear Infections
- ❑ Anxiety
- ❑ Chronic Sinusitis
- ❑ Arm Numbness
- ❑ Hand Numbness
- ❑ Arm Pain
- ❑ Throat Issues
- ❑ Thyroid Problems
- ❑ Chronic Fatigue
- ❑ Fibromyalgia
- ❑ Lupus
- ❑ Mid back pain
- ❑ Shoulder pain
- ❑ Heart Disease
- ❑ Asthma
- ❑ Gastric Reflux
- ❑ Ulcers
- ❑ Chest Pain
- ❑ Chronic Illness
- ❑ Liver Disease
- ❑ Low back pain
- ❑ Hip Pain
- ❑ Leg pain
- ❑ Leg Numbness
- ❑ Numbness in feet
- ❑ Knee Pain
- ❑ Kidney Problems
- ❑ IBS
- ❑ Bladder Problems

Top 3 Health Concerns	Severity 1=mild 10=unbearable	Date of Onset	Did the problem begin with an injury?	Are symptoms constant or intermittent?
1.				
2.				
3.				

Notes (CA only):

PAIN SCALE

On a scale of 1 to 10, 10 being the worst possible pain

1. What is your pain level **right now**?_____
2. What is your **average** level of pain?_____
3. What is your pain level at its **worst**?_____

HEALTH HISTORY

List Current Medications_____

_____

List all Surgical Operations and Dates_____

_____

Have you ever been in an auto accident? □No □Yes: *Date(s)*_____*Injury?*_____

Have you ever had/have? □Stroke □Cancer □Heart Disease □Spinal Surgery □Seizures

□Spinal Bone Fracture □Scoliosis □Diabetes □Bone Fracture □Severe Fall □Concussion

Have you ever been under regular Chiropractic Care? □No □Yes

*If yes, where*_____*Date of last adjustment*_____

Why are you seeking Chiropractic Care? □Spinal Correction □Pain Relief □Pain Management

□Maintain health □Sports Performance □Symptom Relief □Quality of Life Improvement

What is your main goal in seeking care in our office? _____

_____

FAMILY HISTORY (Please Check All that Apply)

Condition	Spouse	Son	Daughter	Mother	Father
Arthritis					
ADHD/ADD					
Bed Wetting					
Cancer					
Carpal Tunnel					
Deceased					
Diabetes					
Digestive Problems					
Ear Infections					
Fibromyalgia					
High Blood Pressure					
Migraines					
Scoliosis					

INSURANCE

Primary Insurance Carrier_____Name of Insured_____

Insured DOB_____Member ID_____Group ID_____

Secondary Insurance Carrier_____Name of Insured_____

Insured DOB_____Member ID_____Group ID_____

Policies and Fees Schedule

Consultation- includes practice member history (this service is complimentary)
Assessment (new or established practice member)- includes one or more of the following: thermography, surface electromyography, range of motion, motion and/or static palpation, leg check ($50-$100)
Chiropractic Adjustment- The actual re-alignment of the vertebra done by hand or instrument. Often a sound will be heard, but if there is no auditory result, it does not mean that the adjustment has not taken place ($40-$70)
X-Rays- Specific X-ray views taken of your spine to determine a misalignment/subluxation of your vertebrae. These can also be used to indicate progress after period of care. Cost is subject to insurance rate, otherwise $50 per view (per cervical, thoracic, lumbar) under compliance coupon.

Release of Authorization/Assignment of benefits

I authorize and request payment of insurance benefits directly to Andres Julia, D.C. I agree that this authorization will cover all services rendered until I revoke the authorization. I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the patient. It is customary to pay for services when rendered unless other arrangements have been made in advance. I understand that I am financially responsible for charges not covered by insurance.

Signature_____**Date**_____

UNITED HEALTH CARE PATIENTS ONLY (THIS SECTION)

Date Symptoms began_____**How did symptoms start?**_____

Describe symptoms_____

Average Pain Intensity: the last 24 hours (0-10=most severe)_____ **last Week (0-10=most severe)**_____

How often do experience symptoms? □Constantly □Occasionally □Frequently □Intermittently

Do symptoms interfere with your usual daily activities?□Not at all□A little Bit□Moderately□Quite a Bit□Extremely

How has your condition changed since beginning care at this facility? □N/A Initial Visit □Much Worse □Worse □Slightly Worse □No Change □A little better □Better □Much better

In general, how would you rate your overall health? □Excellent □Very good □Good □Fair □Poor

Please Read the Following Statements and Select the Appropriate Response	**Disagree**	**Agree**
My pain has spread at some time in the past 2 weeks		
In addition to my pain, I have had pain elsewhere in the last 2 weeks		
In the last 2 weeks, I have only walked a short distance because of my pain		
In the last 2 weeks, I have dressed more slowly than usual because of my pain		
It's really not safe for a person with a condition like mine to be physically active		
Worried thoughts have been going through my mind a lot in the last 2 weeks		
I feel that my pain is terrible and that it is never going to get better		
In general in the last 2 weeks, I have not enjoyed all the things I used to enjoy		

Over all, how bothersome has your back pain been in the last 2 weeks:

□ Not at all □ Slightly □ Moderately □ Very Much □ Extremely

UNITED HEALTH CARE PATIENTS ONLY (THIS SECTION)

BACK Index: Please Circle the correlating number

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

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 ½ 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.

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 my pain my normal sleep is reduced by 50%
4 Because of my pain my normal sleep is reduced by 75%
5 Pain prevents me from sleeping at all

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 ½ hour
4 Pain prevents me from sitting more than 10 minutes.
5 I avoid sitting because it increases pain immediately.

Walking
0 I have no pain while walking.
1 I have some pain while walking but it does not increase with distance
2 I cannot walk more than 1 mile without increasing pain.
3 I can't walk more than ½ mile without increasing pain.
4 I cannot walk more than ¼ mile without increasing pain.
5 I cannot walk at all without increasing pain

Lifting
0 I can lift 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

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 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

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 form of travel.
4 Pain restricts all forms of travel except that done while lying down.
5 Pain restricts all forms for travel

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 effect 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.

For Office Use Only:
Back Index Score= [Sum of all statements/ (# of sections w/ a statement selected x 5)] x 100= _____

UNITED HEALTH CARE PATIENTS ONLY (THIS SECTION)

NECK Index: Please Circle the correlating number

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 extremely disturbed (5-7 hours sleepless).

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

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.

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 ready 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.

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 but no more
4 I can hardly do any work at all.
5 I cannot do any work 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.

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.

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

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

For Office Use Only:
Back Index Score= [Sum of all statements/ (# of sections w/ a statement selected x 5)] x 100= _____

ABUNDANCE CHIROPRACTIC NOTICE OF PRIVACY PRACTICE AGREEMENT

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your Personal Health Information. In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as dictated by our office policy, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled 'HIPAA' on tables in the reception. Once you have read this notice, please sign the last page, and return only the signature page to our front desk receptionist. Keep this page for your records.

PERMITTED DISCLOSURES:

1. Treatment purposes- discussion with other health care providers involved in your care
2. Inadvertent disclosures- open treating area mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes- to process a claim or aid in investigation
5. Emergency- in the event of a medical emergency we may notify a family member
6. For Public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement – to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons –discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders -we may call your home and leave messages regarding a missed appointment or apprize you of changes in practice hours or upcoming events.
11. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

YOUR RIGHTS:

1. To receive an accounting of disclosures
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice
3. To request mailings to an address different than residence
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain one copy of your records at no charge, when timely notice is provided (72 hours). X-rays are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call Dr. Andres Julia at (727) 201-2271 if he is unavailable, you may make an appointment with our receptionist to see him within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights 200 Independence Ave. SW Room 509F HHH Building Washington DC 20201

I have received a copy of Chiropractic's Patient Privacy Notice. I understand my rights as well as the practices duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this 'Notice of Privacy Practice" at an time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

Patient Name_____ DOB_____

Patient Signature_____Date_____

Witness_____Date_____

JDD,DC 5/2011

INFORMED CONSENT FOR CHIROPRACTIC CARE

CHIROPRACTIC CARE, WHILE OFFERING CONSIDERABLE BENEFITS, MAY ALSO PROVIDE SOME LEVEL OF RISK. IN EXTREMELY RARE CASES, INJURY HAS BEEN ASSOCIATED WITH CHIROPRACTIC CARE. THESE CASES INCLUDE: STRAIN/SPRAIN INJURIES, IRRITATION OF EXISTING DISC CONDITION, AND FRACTURES, ETC. ONE OF THE RAREST COMPLICATIONS ASSOCIATED WITH CHIROPRACTIC WHICH OCCURS AT A RATE BETWEEN ONE INSTANCE PER ONE MILLION TO TWO MILLION CERVICAL SPINE ADJUSTMENTS MAY BE A VERTEBRAL INJURY THAT COULD LEAD TO A STROKE.

PRIOR TO RECEIVING CHIROPRACTIC CARE IN THE OFFICE, A HEALTH HISTORY AND PHYSICAL EXAMINATION WILL BE COMPLETED TO ASSESS YOUR SPECIFIC HEALTH AND SPINAL NEEDS. THESE PROCEDURES WILL ASSIST US IN DETERMINING IF CHIROPRACTIC CARE IS NECESSARY OR IF FURTHER EXAMINATION IS NEEDED. IN ADDITION, THEY WILL HELP US DETERMINE IF THERE IS ANY REASON TO MODIFY YOUR CARE OR PROVIDE YOU WITH A REFERRAL TO ANOTHER HEALTH CARE PROVIDER. ALL RELEVANT FINDINGS WILL BE REPORTED TO ALONG WITH A CARE PLAN PRIOR TO BEGINNING CARE.

I UNDERSTAND THERE ARE RISKS ASSOCIATED WITH CHIROPRACTIC CARE AND GIVE CONSENT TO THE EXAMINATION THE DOCTOR DEEMS NECESSARY AND CHIROPRACTIC CARE, INCLUDING SPINAL ADJUSTMENTS, AS REPORTED FOLLOWING MY ASSESSMENT

Name_____**Signature**_____**Date**_____

Guardian Signature (For Minor)_____**Office Staff Signature**_____

TERMS OF ACCEPTANCE

TO PROMOTE THE MOST EFFECTIVE APPLICATION OF CHIROPRACTIC PROCEDURES AND THE STRONGEST POSSIBLE DOCTOR-PATIENT RELATIONSHIP, WE STATE THE FOLLOWING TO FACILITATE THE GOAL OF OPTIMUM HEALTH THROUGH CHIROPRACTIC.

TO THAT END, WE ASK THAT YOU ACKNOWLEDGE THE FOLLOWING POINTS REGARDING SERVICES WE PROVIDE:

1. CHIROPRACTIC IS A SPECIFIC, SEPARATE, AND DISTINCT PRACTICE AUTHORIZED BY LAW TO ADDRESS SPINAL HEALTH
2. CHIROPRACTIC SEEKS TO RESTORE NORMAL NERVE FUNCTIONING THROUGH THE ADJUSTMENT OF SPINAL SUBLUXATIONS TO MAXIMIZE THE INHERENT HEALING POWER OF THE BODY. SUBLUXATIONS ARE DEVIATIONS FROM NORMAL SPINAL STRUCTURES THAT INTERFERE WITH NORMAL NERVE PROCESSES.
3. THE CHIROPRACTIC ADJUSTMENT PROCESS, AS DEFINED IN THE LAW OF THIS JURISDICTION, INVOLVES THE APPLICATION OF A SPECIFIC DIRECTIONAL THRUST TO A REGION(S) OF THE SPINE WITH THE SPECIFIC INTENT OF REPOSITIONING MISALIGNED SPINAL SEGMENTS. THIS IS A SAFE, EFFECTIVE PROCEDURE APPLIED OVER ONE MILLION TIMES EACH DAY BY DOCTORS OF CHIROPRACTIC IN THE UNITED STATES ALONE
4. CHIROPRACTIC DOES NOT SEEK TO REPLACE OR COMPETE WITH OTHER SPECIFIC HEALTH CARE PROFESSIONALS. THEY RETAIN RESPONSIBILITY FOR CARE AND MANAGEMENT OF MEDICAL CONDITIONS. WE DO NOT OFFER ADVICE REGARDING TREATMENT PRESCRIBED BY OTHERS.
5. YOUR COMPLIANCE WITH THE DOCTOR'S RECOMMENDATIONS IS ESSENTIAL TO ACHIEVING THE MAXIMUM HEALTH BENEFITS
6. WE INVITE YOU TO SPEAK FRANKLY TO THE DOCTOR ON ANY MATTER RELATED TO YOUR CARE AT THIS FACILITY, ITS NATURE, DURATION, OR COST, WHAT WE WORK TO MAINTAIN AS A SUPPORTING, OPEN ENVIRONMENT

BY SIGNING BELOW, I AM STATING THAT I HAVE FULLY READ AND UNDERSTAND THE ABOVE STATEMENTS

Signature_____Date_____

X-RAY AUTHORIZATION

AS YOUR HEALTHCARE PROVIDER, WE ARE LEGALLY RESPONSIBLE FOR YOUR CHIROPRACTIC RECORDS. WE MUST MAINTAIN A RECORD OF YOUR X-RAYS IN OUR FILES

X-RAYS ARE UTILIZED IN THIS OFFICE TO HELP LOCATE AND ANALYZE VERTEBRAL SUBLUXATIONS. HEALTH HISTORY AND EXAMS WILL ALLOW THE DOCTOR TO DETERMINE IF X-RAYS ARE NECESSARY FOR YOUR CASE. THESE X-RAYS ARE NOT USED TO INVESTIGATE FOR MEDICAL PATHOLOGY. THE DOCTOR(S) OF ABUNDANCE CHIROPRACTIC DO NOT DIAGNOSE OR TREAT MEDICAL CONDITIONS. HOWEVER, IF ANY ABNORMALITIES ARE FOUND, WE WILL BRING IT TO YOUR ATTENTION SO THAT YOU CAN SEEK PROPER MEDICAL ADVICE.

AT YOUR REQUEST, WE WILL PROVIDE YOU WITH A COPY OF YOUR X-RAYS

THE FEE FOR COPYING YOUR X-RAYS ON A DISC IS $15.00 WHICH MUST BE PAID IN ADVANCE.

BY SIGNING BELOW I AM AGREEING TO THE ABOVE TERMS AND CONDITIONS

Signature_____**Date**_____

FEMALE PATIENTS ONLY: TO THE BEST OF MY KNOWLEDGE, I BELIEVE I AM NOT PREGNANT AT THE TIME X-RAYS ARE TAKEN AT ABUNDANCE CHIROPRACTIC

Signature_____**Date**_____