Health & Wellness Center PSL
433 NW Prima Vista Blvd., Port St. Lucie, FL 34983
Phone: (772) 336-1770 Fax: (772) 336-1160

CONFIDENTIAL HEALTH INFORMATION

Please allow our staff to photocopy your driver's license and insurance details.
All information you supply is confidential. We comply with all federal privacy standards.

_____ **Today's Date**

Release of Medical Information: Who do you give consent to release your information to?
○ spouse ○ family members ○ insurance company ○ physician ○ Other _____

Who may we thank for referring you?

_____ **Gender ○Male ○Female Social Security number** _____

_____ **Preferred Language:** _____
Your Last Name

_____ _____ _____
Your First Name **Your Middle Name (or initial)** **Birth Date**

_____ **Marital Status**
○Single ○Married ○Divorced
_____ **○Widowed ○Separated ○Partnered**
Address

_____ _____ _____ _____ _____
City **State** **ZIP/Postal Code** **Home Phone** **Cell Phone**

_____ _____
Email Address **Spouse's Name**

_____ _____
Emergency Contact **Phone**

_____ **I give permission to be contacted by:**
Phone **○ Phone ○ Mail ○ Email**

_____ **Race/Ethnicity:** **○Caucasian**
Your Occupation **○Black/African American ○ Asian**
○Hispanic ○ I choose not to specify
○Other _____

_____ _____
Your Employer **Work Phone**

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Health & Wellness Center/Dr. Lare Ziemba all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether paid by insurance or not. I authorize the use of my signature on all insurance submissions. This office may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will continue as long as I remain a patient of this office, unless revoked in writing. A copy of our office HIPPA form is available at your request.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

DATE: _____ **Relationship to Patient:** _____

Patient Name:_____ **Date**_____

1. The symptoms that have prompted me to seek care today include: _____

_____

2. And are the result of ○ **An accident** ○ **Work** ○ **Auto** ○ **Other** _____

○ **A worsening long-term problem EXPLAIN:** _____

3. When did you first notice your current symptoms? _____

4. Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

5. Duration and Timing (When did it start and how often to you feel it?) ○ **Constant** ○ **Comes and goes** ○ **Occasional**

Explain? _____

6. Quality of symptoms (What does it feel like?) ○ **Numbness** ○ **Tingling** ○ **Stiffness** ○ **Dull** ○ **Aching** ○ **Cramps** ○ **Nagging** ○ **Sharp** ○ **Burning** ○ **Shooting** ○ **Throbbing** ○ **Stabbing** ○ **Other** _____

7. Radiation (Does it affect other areas of your body? (To what areas does the pain radiate, shoot or travel? Arm, leg, hand, etc.)

_____

8. Aggravating factors (What worsens the problem?) (Mark *all that apply*) ○ **Sitting** ○ **walking** ○ **bending** ○ **sleeping** ○ **lifting** ○ **movement** ○ **household chores** ○ **exercise** ○ **driving** ○ **shopping** ○ **dressing** ○ **reaching** ○ **yard work** ○ **other:**

_____

9. Relieving factors (What tends to lessen the problem) (Mark *all that apply*) ○ **Sitting** ○ **standing** ○**lying down** ○ **rest** ○ **no movement** ○ **stretching** ○ **ice** ○ **heat** ○ **medication** ○ **massage** ○ **topical ointment** ○ **other:**_____

10. Prior interventions (What have you done to relieve the symptoms?) ○ **Prescription medication** ○ **Surgery** ○ **Ice** ○ **Heat** ○ **Over the counter drugs** ○ **Homeopathic remedies** ○ **Physical therapy** ○ **Acupuncture** ○ **Massage** ○ **Chiropractic** ○ **Other :**_____

11. Have you had an x-ray, MRI, CT Scan on your back or neck ○ **No** ○ **Yes** **When ?**_____

12. Does your current condition interfere with : ○ **Work** ○ **Recreational Activities** ○ **Household responsibilities** ○ **Personal relationships** ○**Sports/ golf** ○ **Other:** _____

Review of Systems: **Chiropractic care focuses on the integrity of your nervous system, which controls your entire body. Please darken the circle beside any condition that you've *Had* or currently *Have*.**

Neurological	**Cardiovascular**	**Respiratory**	**Musculoskeletal**	
○Anxiety	○High blood pressure	○Asthma	○ Osteoporosis	○Arthritis
○Depression	○Low blood pressure	○Apnea	○Knee pain	○Scoliosis
○Headache	○High cholesterol	○Emphysema/COPD	○Hip pain	○TMJ issues
○Dizziness/vertigo	○Poor circulation	○Allergies	○Foot/Ankle Pain	○Elbow/wrist
○Pins & Needles	○Angina	○Shortness of breath	○Neck pain	○Poor Posture
○Numbness	○Swelling ankles/feet	○Air hunger	○Shoulder problems	
○Seizures	○Anemia	○Cough	○Back pain	level
○Tremors	○Murmur		○Herniated/Bulged discs_____	
Sensory	**Integumentary**	**Digestive**	**Ears/ Nose/ Throat**	
○Blurred Vision	○Skin cancer	○Anorexia/Bulimia	○Bleeding gums	
○Ringing in ears	○Psoriasis	○Ulcer/stomach pain	○Sinuses	
○Hearing loss	○Eczema	○Nausea/ vomiting	○Frequent sore throat	
○Chronic ear infection	○Acne	○Heartburn/reflux	○Swollen glands	
○Loss of smell	○Hair loss	○Constipation	○Earaches/ hearing loss	
○Loss of taste	○Rash/itching	○Diarrhea	○Mouth sores	

Patient Name:_____ **Date**_____

Please darken the circle beside any condition that you've *Had* or currently *Have.*

Endocrine	**Genitourinary**	**Constitutional**	**Women only**
○Thyroid __hypo/ __ hyper	○ Kidney stones	○Fainting	○Irregular periods
○Diabetes	○Infertility	○Low libido	○Painful periods
○Hypoglycemia	○Bladder incontinence	○Poor appetite	○Vaginal discharge
○Fibromyalgia	○Prostate Issues	○Fatigue	○Pregnancy
○Swollen glands	○Erectile dysfunction	○Insomnia	○Breast pain/ lump
○Systemic Lupus	○Frequent urination	○ Sudden weight change __ loss__gain	

Please identify **your** past health history, including accidents, injuries, illnesses and treatments. ***Please complete each section fully.***

Illnesses

Check the illnesses you have ***Had*** in the past or ***Have*** now.

○ HIV	○Epilepsy	○Malaria	○Rheumatoid arthritis	Other_____
○Alcoholism	○Glaucoma	○Measles	○Scarlet or rheumatic Fever	○
○Allergies	○Goiter	○Multiple Sclerosis	○Sexually transmitted disease type_____	
○Arteriosclerosis	○Gout	○Mumps	○Stroke	
○Tuberculosis	○Heart Disease	○Parkinson's	○**Cancer- Type**_____	
○Chicken Pox	○Hepatitis	○Polio	○**DIABETES –is A1C checked - Yes___ No ___ AIC-Number**_____	

Accident/ falls/ injuries- describe (Past or recent)_____

_____

Operations

Surgical interventions, which may or may not have included hospitalization.

○ Appendix removal	○ Hysterectomy	○ **Joint Replacement** _____
○ Heart Bypass surgery	○ **Pacemaker**	○ **Spine** _____
○ Gallbladder removed	○ Tonsillectomy	○ **Cancer- Type**_____
○ Elective	○ Vasectomy	○ **Arthroscopic**_____
○ Eye cataracts	○ **Other**_____	

Family History - Some health issues are hereditary. **List any conditions or diseases of your immediate family members.**
(Examples- diabetes, thyroid, arthritis, depression, cancer, hypertension, stroke, heart disease, liver disease, autoimmune, asthma, anemia etc.)

Mother: _____
Father: _____
Siblings: _____
Grandparents: _____

Social History - Tell Dr. Ziemba about your health habits and stress levels. *Please check if appropriate.*

○Alcohol Use _____ drinks per day / week / month
○Caffeine Use _____ drinks per day/ week/ month
○Exercising _____ times per week/ month
○Recreational drug use _____ times per week/ month

TOBACCO USE___ **NEVER** Smoked____ Ex-smoker ____ Smoke
If you smoke, are you interested in quitting? _____**YES** _____**NO**
How many packs per day_____ pack/ or _____Occasional smoker
Chew Tobacco_____ YES _____NO

MEDICATIONS: **(Prescriptions and over-the-counter)**

Drug name	**Strength/ MG**	**frequency (times per day)**

ALLERGIES TO MEDICATIONS: ___Yes ___No **List:** _____

Previous / other Health Care Providers you have seen in last 5 years:

Name	Type of Physician	Problem cared for	still seeing
			Yes / No
			Yes / No
			Yes / No

VAS
DC

Patient Name _____ Date ____/____/____

How long have you had your symptoms? _____days _____ weeks _____ months _____years

On the diagram below, please indicate where, and what type of symptoms that you are experiencing, right now. Write the appropriate abbreviations (see the key below) over the area of the body where those symptoms are occurring.

A = ACHE

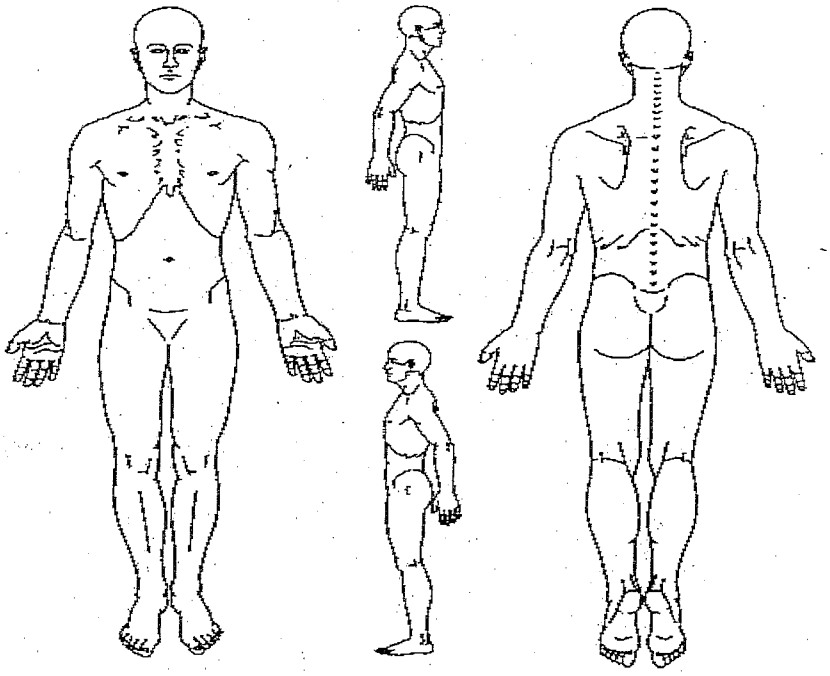
B = BURNING

N = NUMBNESS

P = PINS & NEEDLES

S = STABBING

O = OTHER_____



Instructions: Please fill in the bubble that corresponds to the pain level that you are experiencing.

Note: If you have more than one complaint, please indicate your pain levels for each complaint. Please indicate your pain level for ① your pain at its worst, ② your pain right now and ③ your average pain level.

Example:

No Pain ⓪①②③④●⑥⑦⑧⑨⑩ **Worst Possible**

① My pain when it is at its worst is:

No Pain ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ **Worst Possible**

②My pain right now is:

No Pain ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ **Worst Possible**

③ My average pain level is:

No Pain ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ **Worst Possible**

Patient/Other Signature _____ Relationship to Patient_____

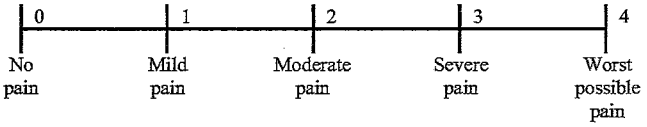
Practitioner Signature _____ Date_____

Functional Rating Index

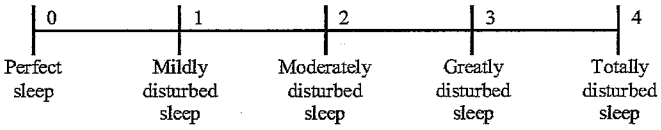
For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** has affected your ability to manage everyday activities. For each item below, **please circle the number which most closely describes your condition right now.**

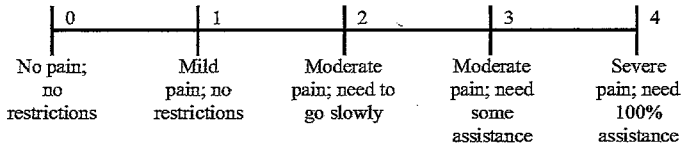
1. Pain Intensity



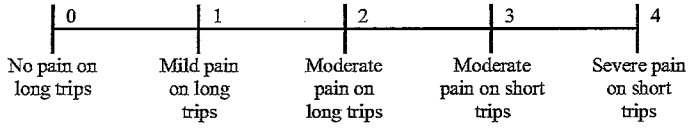
2. Sleeping



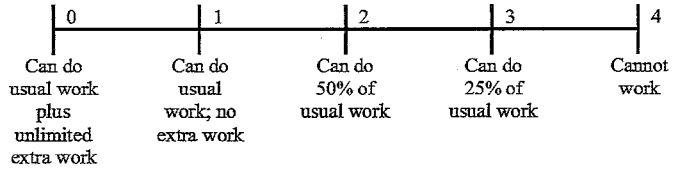
3. Personal Care (washing, dressing, etc.)



4. Travelling (driving, etc.)

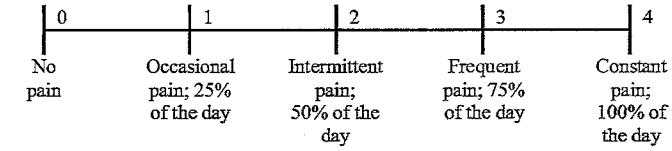


5. Work

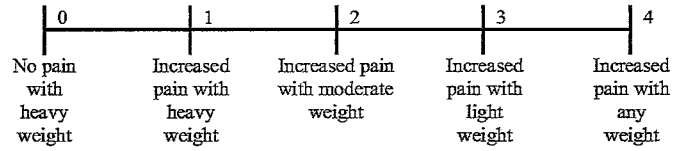


6. Recreation

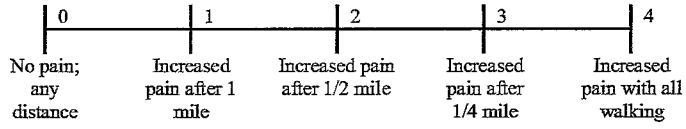
7. Frequency of Pain



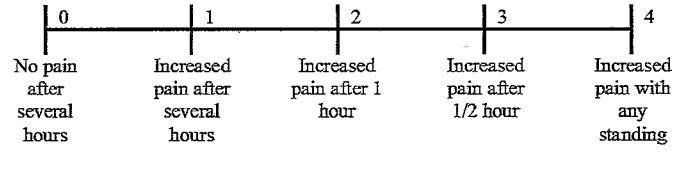
8. Lifting



9. Walking



10. Standing



_____ _____

Patient's Signature **Date**

For Office Use Only:

Practitioner ID#: _____

Total Score _____ **/ 40**

Clinical Diagnosis Codes:

Patient ID#: _____

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Notice of Privacy Practices

Health & Wellness Center of PSL

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED; AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our Pledge Regarding Your Medical Information:

The privacy of your medical information is important to us. We understand that your- medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our office. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will explain to you the ways we may use and share medical information about you. It will also describe your rights and our duties regarding disclosure of medical information.

OUR LEGAL DUTY:

Law requires us to:
1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of this notice that is now in effect.

We have the right to:
1. Change our privacy practices and the terms of this notice at any time, providing that the changes are permitted by law.
2. Make those changes effective for all medical information that we keep, including information previously created or received before changes.
3. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes different ways in which we use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing that request to us.

For Treatment: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, therapists, or other staff members who are partaking in your care, as well as other physicians who may be treating you. For instance, if we are treating you for lower back pain, we may send your records to your orthopedic surgeon for review in coordinating your care.

For Payment: We may use and disclose your medical information for payment purposes. For example, your health insurance company may request your medical records to show the type of treatment you received at our office. This information may also be shared with your insurance company's adjuster, nurses, or doctors who review claims, or authorize treatment.

For Health Care Operations: We may need to use or disclose your medical information for our health care operations. This might include, improving quality, performance of employees, and conducting training programs, as well as, for getting certification, licenses, or credentials which are required by our State law.

OFFICE PROCEDURES:
The following ordinary office procedures are routinely performed at our office. If you object to any of these procedures, please notify us of your privacy wishes.

Appointment Reminders:
Our office may from time to time contact you regarding appointments at this office in the form of a telephone call, a written postcard, or may leave a message on your answering machine, or with your household member. We also may send you a birthday card, or flyer to notify you of a special event in our office, or some new nutritional research.

Sign In Sheet:
Our office requires the patients to sign in upon arrival on a sign in sheet. This sheet is utilized by all the patients and is accessible for viewing by the staff and patients. If you do not want to sign in on this universal sheet, please advise the staff and you will be asked to sign in on a separate paper.

Family/Friends:
We send thank you cards to the person who may have referred you to our office. We may also be in contact with a family member or friend regarding your care, and PHI if this person is necessary for payment purposes, or helping with your needs regarding your care.

NO CONSENT REQUIRED:

Notification for Emergency: In case of an emergency we may need to contact your family, or other person responsible for your care. We will only share the health information that is directly necessary for your immediate care, according to our professional judgment. We will only allow others to pick up your medical supplies, information, x-rays, or reports with a signed release from you regarding the authorization of the said person.

Victims of Abuse, Neglect, or Domestic Violence: We may disclose medical information to appropriate authorities if we have reason to believe you are a victim of abuse, neglect, or domestic violence, or a victim of other crimes. We may share medical information if it is necessary to prevent a serious threat to your health or safety. We may share your

medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.

Business Associate: We may disclose your PHI to a business associate with proper written assurance, in accordance with applicable law, that the business associate will appropriately safeguard your PHI. A business associate is an entity that assists us in undertaking some essential function, such as, a billing company which helps us transmit insurance claims.

Law Enforcement and/or Judicial Proceedings: In certain instances we may be required to disclose your PHI to a law enforcement official, or court of law if required by a lawfully issued subpoena, or court order.

Worker's Compensation: We may disclose medical and health information when authorized and necessary to comply with our State laws governing Worker's Compensation.

Personal Injury Cases: We may disclose or share your medical and health information with your attorney, or insurance company's attorney with a written release of information signed by yourself.

Military and Veterans: If you are a member of the armed forces, we may disclose your PHI as required by the military command authorities.

Health Oversight Activities: We may disclose medical information to an agency providing health oversight activities as authorized by law, including audits, administrative, or criminal investigations, inspections, licensure, or disciplinary actions.

YOUR INDIVIDUAL RIGHTS

You have the right to:

1. Look at or get copies of your medical records, provided you make the request in writing. We can provide you these records in the form of photocopies, or other format provided it is practical for us. (such as completing a form you wish us to submit). If you request copies we will charge $1.00 for each page, and postage if you want the copies mailed to you.
2. Receive a list of all the times we shared your medical information for purposes other than treatment, payment, and insurance billing operations.
3. Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by that agreement.
4. Request that we communicate with you about your medical information by different means or to different locations. Your request must be made in writing.
5. Request that we change your medical information. We may deny this request, provided we give you a written explanation. You may respond with a statement

of disagreement, which will become part of your records as well. If we accept your request to change your medical information, we will make reasonable efforts to share your amended record with people and/or companies you request.

6. Revoke any authorization and/or consent. You must request a revocation in writing to this office. You must inform us of what (PHI) information you want to limit, and to whom or what you want it limited. We are not required to agree to all restrictions, only those required by law. Other requests for restriction of disclosure of your PHI will be discussed with you about our policies.

QUESTIONS AND COMPLAINTS

If you have any question about this notice, please contact:

HEALTH & WELLNESS CENTER
OF PORT ST. LUCIE
433 N.W. Prima Vista Blvd.
Port St. Lucie, FL 34983
(772) 337-3141

If you think we may have violated your privacy rights, contact the person named above in writing. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint, if needed. We will not retaliate in any way if you choose to file a complaint.

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name:_____ Date:_____

Signature:_____

Informed Consent for Chiropractic Treatment and Diagnosis

Chiropractic treatment has been the subject of many government and multi-disciplinary studies, and has been demonstrated to be effective in the treatment of many neck and back condition, including pain, numbness/tingling, muscle spasms, loss of motion, headaches and more. Like most health care procedures, the chiropractic adjustment carries with it some risks. Unlike many other procedures / or use of medications, the serious risks associated with chiropractic are extremely rare. Below are listed the following known risks.

Temporary soreness, or increased symptoms of pain, usually associated with muscular strain/ and or inflammation. It is not uncommon for patients to experience temporary soreness after the first few treatments. If you experience this, please apply ice/cold therapy or ice/ followed by moist heat to the sore area for 15 minute intervals 2-3 times a day as needed to reduce symptoms.

Dizziness, nausea, flushing. These symptoms are relatively rare. It is important to notify the chiropractor if you experience any of these symptoms after care.

Fractures. When patients have underlying conditions that weaken bones, such as, osteoporosis, they may be susceptible to fracture, rib fracture is the most common complication. Please notify your chiropractor if you have any bone weakening disease so that your treatment plan will be modified to minimize any risk of fracture.

Disc herniation. There have been rare reports of worsening of disc herniation/bulge following chiropractic manipulation, however, no scientific study has ever demonstrated such injuries are caused by the adjustment and/ or chiropractic treatment.

A certain rare type of stroke has been associated with chiropractic manipulation of the neck, however, there has also been an association of this type of stroke and primary care medical visits. The occurrence of this type of stroke being associated with chiropractic and or medical care may be a coincidental finding, that people suffering neck pain or headache caused by this condition seek care for their pain with a doctor at the time the stroke is ensuing or beginning. This type of stroke has been found to occur with common neck motion and no present scientific evidence establishes a definite cause and effect relationship from cervical adjustment. The risk for this complication is extremely rare and has been estimated at 1 in 1 to 2 million occurrences.

Other minor risks, include minor skin irritation from allergy/ sensitivity or burns from physiotherapy devices that produce heat.

I understand that the practice of chiropractic, like all of the healing arts, is not an exact science, and I acknowledge that no guarantee can be given to the results or outcomes of my care.

Patient Name: _____ Date: _____

It has been explained to me that there are several forms of chiropractic adjustments which can be used to correct vertebra subluxations/ misalignments; these consist of manual manipulation, instrument adjusting, stretching tables/ techniques, low force drop table techniques, mobilization, myofascial release and massage/ pressure point techniques. The doctor will utilize the adjustment techniques best suited for your condition, and specific anatomy.

I have read or have had read to me the above consent. I have also been given opportunity to discuss or ask questions about any of the content above.

My signature below indicates I am giving consent to partake in evaluation, and treatment with Dr. Ziemba, of Health & Wellness Center. I intend this consent form to cover the entire course of treatment for my present condition, and for any future condition for which I seek treatment at this office.

Patient Name_____ Date_____

Guardian Name if minor_____

Signature Patient/Guardian_____

Based on personal observation/ patient's history and physical exam, I conclude that throughout the informed consent process the patient was:

[ ] of legal age [ ] consent given by guardian [ ] oriented x3

[ ] fluent in English [ ] assisted by a translator [ ] appears unimpaired

Signature of Chiropractor_____ Date_____

Signature of Translator if applicable_____

Name of Translator_____