



# ORLANDO SPORTS CHIROPRACTIC

7513 West Sand Lake Road ♦ Orlando, FL 32819

PHONE 407-345-8686 FAX 407-345-8626

www.orlandosportschiropractic.com

Chiropractic · Massage · Acupuncture · Nutrition · Chinese Medicine · Exercise Therapy

## PERSONAL INFORMATION

Full Name \_\_\_\_\_ Nickname \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ ext. \_\_\_\_\_

Cell Phone \_\_\_\_\_ Email \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Sex  M  F Age \_\_\_\_\_ Birthday \_\_\_\_/\_\_\_\_/\_\_\_\_

Marital Status  Single  Married  Partnered  Divorced  Widowed Children: #: \_\_\_\_\_ Ages: \_\_\_\_\_

Hand Dominance  Right  Left Race  Caucasian  African-American  Hispanic  Asian  Other \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Level of Education: \_\_\_\_\_

F/T  P/T  Seasonal  F/T student  P/T student

Have you been to a Chiropractic Office before?  Yes  No If yes, how long ago? \_\_\_\_\_

How did you hear about our office?

Referring Physician: \_\_\_\_\_  Another patient: \_\_\_\_\_  Online: \_\_\_\_\_

Health Fair/Sports Event: \_\_\_\_\_  Other \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_ Phone \_\_\_\_\_

Has any family member been seen in this office?  Yes  No Family member name: \_\_\_\_\_

## REASON FOR VISIT

New Injury:  
\_\_\_\_\_  
\_\_\_\_\_

Chronic Condition:  
(Please fill-out next page)

Wellness Check-up  
(Please skip next page and  
continue with medical history)

## GOAL OF TREATMENT

- Relief from pain
- Get back to normal day-to-day
- Be able to work
- Get back to exercising
- Get back to sport
- Improve Posture
- Improve Sports Performance
- Wellness
- Other: \_\_\_\_\_

## ACCOUNT INFORMATION

### PERSON RESPONSIBLE FOR THIS ACCOUNT

Name: \_\_\_\_\_ Relationship:  Self  Spouse  Child  Other \_\_\_\_\_

Payment Method:  Cash  Check  Credit Card  Care Credit

FEES ARE PAYABLE WHEN SERVICES ARE RENDERED UNLESS OTHER ARRANGEMENTS ARE MADE. WE ARE REQUIRED TO MAINTAIN ORIGINAL X-RAYS AND RECORDS AS PROPERTY OF THIS CLINIC. X-RAY COPIES ARE AVAILABLE (\$25 per disc).

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

What is your main complaint(s)? \_\_\_\_\_

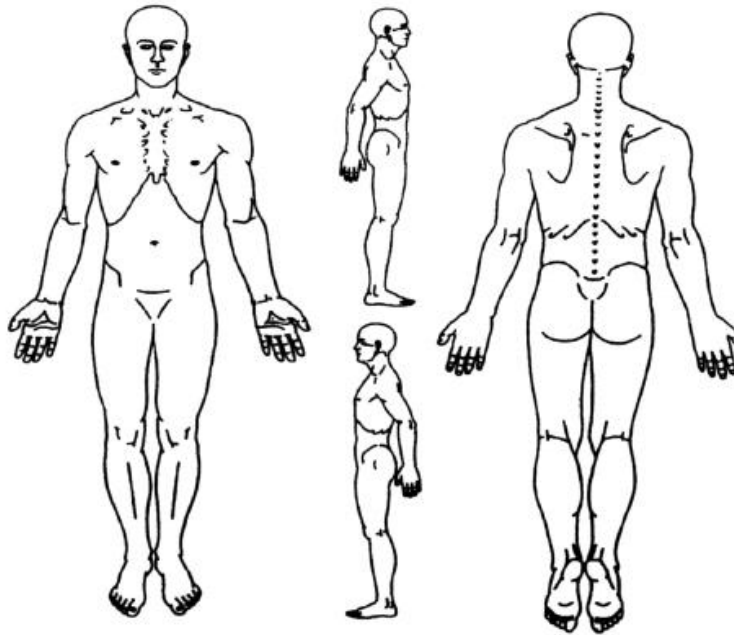
When did it begin? \_\_\_\_\_ Have you had this same or similar pain before? Yes No

Is it getting worse staying the same getting better?

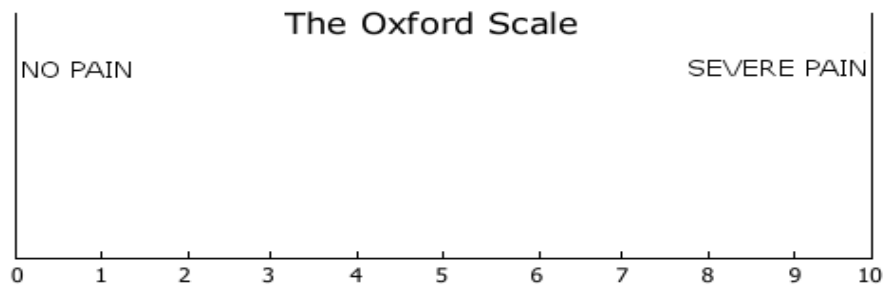
Briefly explain what happened: \_\_\_\_\_

On the diagram below, please show where you are experiencing all of your present complaints using the following letters:

A: ache B: burning C: cramping D: dull R: throbbing N: numbness T: tingling S: stiffness



Please mark on this scale, the severity of your pain:



What treatment have you already received for your current condition?

- None
- Medications
- Surgery
- Physical Therapy
- Chiropractic
- Acupuncture
- Injections
- Massage
- Other: \_\_\_\_\_ Please explain briefly: \_\_\_\_\_

What makes it better? \_\_\_\_\_ What makes it feel worse? \_\_\_\_\_

I understand the above information and guarantee this form was completed to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## CURRENT SYMPTOM LIST

Name: \_\_\_\_\_

Date: \_\_\_\_\_

**HEAD:**

- Headaches  
 a. migraine in nature  
 b. back of Head  
 c. sinus (allergy)  
 d. temples  
 e. entire head  
 Frequency \_\_\_\_\_ x's per \_\_\_\_\_  
 Head feels heavy  
 Lightheadedness  
 Fainting  
 Loss of memory  
 Eye Strain  
 Light bothers eyes  
 Blurred vision  
 Double vision  
 Loss of vision  
 Loss of balance  
 Dizziness  
 Loss of hearing  
 Pain in the ears  
 Ringing/buzzing in the ear/s  
 Loss of taste  
 Loss of smell  
 Sinus trouble  
 Jaw pain

**NECK:**

- Neck pain and stiffness  
 Neck pain  
 Neck stiffness  
 Neck pain with movement  
      forward  
      backward  
      turning to the left  
      turning to the right  
      bending to the left  
      bending to the right  
 Muscle spasms in neck  
 Grinding sounds in the neck  
 Arthritis in the neck

**SHOULDERS:**

- Pain in the joint  L  R  
 Pain across the shoulders  
 Pain between shoulder blades  
 Stiffness in shoulder  L  R  
 Tension in the shoulders  
 Muscle spasms  L  R  
 Unable to raise arm over head/over shoulder level

**ARMS & HANDS:**

- Pain in the upper arm  L  R  
 Pain in the elbow  L  R  
 Tennis elbow  L  R  
 Pain in forearm  L  R  
 Pain in hands  L  R  
 Pain in fingers  L  R  
 Sensation of pins and needles in  
     Arms  L  R  
 Sensation of pins and needles in  
     fingers  L  R  
 Numbness in arms  L  R  
 Numbness in hands  L  R  
 Fingers go to sleep  L  R  
 Stiffness in fingers  L  R  
 Hands get cold  L  R  
 Swollen joints in fingers  
 Loss of grip strength  L  R

**MID-BACK:**

- Mid-back pain and stiffness  
 Mid-back pain  
 Mid-back stiffness  
 Muscle spasms in mid-back  
 Pain in kidney area

**CHEST:**

- Chest pain  
 Shortness of breath  
 Pain around the ribs  
 Breast pain  
 Irregular heartbeat

**ABDOMEN:**

- Nervous stomach  
 Nausea  
 Gas  
 Constipation  
 Diarrhea  
 Hemorrhoids

**Women Only:**

- Menstrual pain \_\_\_\_\_  
 Menstrual cramping  
 Irregular periods

**Men Only:**

- Urinary frequency  
 Difficulty in starting urination  
 Night urination  
 Prostate swelling/pain

**LOW BACK:**

- Low back pain and stiffness  
 Low back pain  
 Low back stiffness  
 Muscle spasms in low back

**HIPS, LEGS & FEET**

- Pain in the buttocks  L  R  
 Pain in the hip joint  L  R  
 Pain down both leg  
 Pain down one leg  L  R  
 Leg cramps  L  R  
 Knee pain  L  R  
      \_\_\_\_\_ inside  L  R  
      \_\_\_\_\_ outside  L  R  
 Pins & needles in legs  L  R  
 Numbness in legs  L  R  
 Numbness in feet  L  R  
 Numbness in toes  L  R  
 Swollen ankles  L  R  
 Swollen feet  L  R  
 Feet feel cold

**GENERAL**

- Anxiety  
 Nervousness  
 Irritable  
 Depression  
 Fatigue  
 Generally feel run down  
 Loss of weight \_\_\_\_\_ lbs  
 Gain weight \_\_\_\_\_ lbs  
 Excessive perspiration  
 Tremors  
 Other \_\_\_\_\_

**Activities of Daily Living: Check all the activities that you are unable to do or have difficulty with because of this problem.**

- Sitting  Standing  Lifting  
 Moving Arms  Moving legs  
 Bending at waist  Carrying  
 Lying/sleeping  Pulling  
 Pushing  Kneeling  Twisting or turning back  Twisting or turning neck  
 Turning over  Reaching  Grooming  
 Dressing  Bathing  Going to the bathroom  Recreational activities  
 Golfing  Sexual relations  
 Going up/down stairs  Laundry  Household chores/Housework  Cough/sneeze  Riding in car

# Your Medical History

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

## Medical Conditions

- Arthritis
- Allergies/Hay Fever
- Asthma
- Alcoholism
- Alzheimer's
- Autoimmune Disease
- Blood Pressure Problems
- Bronchitis
- Cancer
- Chronic Fatigue Syndrome
- Cholesterol Problems
- Circulatory Problems
- Colitis
- Dental Problems
- Depression
- Diabetes
- Diverticular Disease
- Drug Addiction
- Eating Disorder
- Epilepsy
- Emphysema
- Eyes, Ears, Nose, Throat Problems
- Environmental Sensitivities
- Fibromyalgia
- Food Intolerance
- Genetic Disorder
- Glaucoma
- Gout
- Heat Disease
- Chronic Infection
- Inflammatory Bowel Disease
- Irritable Bowel Syndrome
- Kidney or Bladder Disease
- Learning Disabilities
- Liver or Gallbladder Disease (ex. Stones)
- Mental Illness
- Mental Retardation
- Migraine Headaches
- Neurological Problems (ex. Parkinson's, Paralysis)
- Sinus Problems
- Stroke
- Thyroid Trouble
- Obesity

- Osteoporosis
- Pneumonia
- Skin Problems
- Stomach Reflux
- Tuberculosis
- Ulcer
- Urinary Tract Infection
- Varicose Veins
- Others: \_\_\_\_\_

Explain: \_\_\_\_\_

- No known problems

## Traumas

- Head
- Neck/Back
- Organ
- Dislocations
- Bone fracture(s)
- Joint Sprain(s)
- Muscle Strain(s)
- Scar(s)
- Other \_\_\_\_\_

Explain \_\_\_\_\_

- None

## Surgeries/Hospitalizations

- Appendectomy
- Tonsillectomy
- Ear Tubes
- C-Section
- Heart
- Colonoscopy
- Shoulder
- Knee
- Other Joint/Bone: \_\_\_\_\_
- None
- Others: \_\_\_\_\_

Explain: \_\_\_\_\_

## Lab & Diagnostics (dates and outcomes)

- Blood: \_\_\_\_\_
- Urine: \_\_\_\_\_
- X-RAY: \_\_\_\_\_
- MRI: \_\_\_\_\_
- CAT Scan: \_\_\_\_\_
- Bone Density: \_\_\_\_\_
- Colonoscopy/Endoscopy: \_\_\_\_\_
- Others: \_\_\_\_\_

## Other Doctors/Providers

- OB/GYN: \_\_\_\_\_
- NEURO: \_\_\_\_\_
- ORTHO: \_\_\_\_\_
- GP: \_\_\_\_\_
- ENDO: \_\_\_\_\_
- PT: \_\_\_\_\_
- Other: \_\_\_\_\_
- No Other Doctors

## Allergies

- Medications
- Food
- Latex
- Environmental
- Pollen
- Cats
- Other \_\_\_\_\_

- None (no known allergies)

## Family Health History

(Parents & Siblings)

- Arthritis
- Asthma
- Alcoholism
- Alzheimer's
- Cancer
- Depression
- Diabetes
- Drug Addiction
- Eating Disorder
- Genetic Disorder
- Glaucoma
- Heart Disease
- Infertility
- Learning Disabilities
- Mental Illness
- Mental Retardation
- Migraine Headaches
- Neurological Disorders (ex. Parkinson's, Paralysis)
- Obesity
- Osteoporosis
- Stroke
- Suicide
- Other \_\_\_\_\_

If more room is needed,  
please feel free to use the  
back of this form.

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

**Health Habits**

Social

- Tobacco
  - o Cigarettes: #/day \_\_\_\_\_
  - o Cigars: amt \_\_\_\_\_
  - o Chew: amt \_\_\_\_\_
  - o Quit: \_\_\_\_\_
  - o None
- Alcohol
  - o Wine: #glasses/d or wk \_\_\_\_\_
  - o Liquor: #oz/d or wk \_\_\_\_\_
  - o Beer: #glasses/d or wk \_\_\_\_\_
  - o None
- Caffeine
  - o Coffee: #6oz cups/d \_\_\_\_\_
  - o Tea: #6oz cups/d \_\_\_\_\_
  - o Soda: #cans/d \_\_\_\_\_
  - o Other Sources: \_\_\_\_\_
  - o None
- Recreational Drug Use
  - o Occasionally
  - o Regularly
  - o Explain: \_\_\_\_\_
  - o None

Exercise

- 5-7 Days per week
- 3-4 Days per week
- 1-2 Days per week
- 45 Minutes or more duration
- 30-45 Minutes duration
- Less than 30 minutes
- Walk - #days/wk \_\_\_\_\_
- Run, Jog, Other Aerobic - #days/wk \_\_\_\_\_
- Weight Lift - #days/wk \_\_\_\_\_
- Stretch - #days/wk \_\_\_\_\_

Other \_\_\_\_\_

- None

Sports

- Swimming
- Cycling
- Mountain Biking
- Hiking
- Baseball/Softball
- Soccer
- Football
- Basketball
- Golf
- Tennis
- Volleyball
- Lacrosse
- Gymnastics
- Skiing
- Dance/Cheer
- Marathon/Triathlon
- Other \_\_\_\_\_

Nutrition & Diet

- Mixed Food Diet (Animal and Vegetable)
- Vegetarian
- Vegan
- Salt Restriction
- Fat Restriction
- Starch/Carbohydrate Restriction
- Total Calorie Restriction
- Specific Diet Plan: \_\_\_\_\_  
(ex Weight Watchers, Atkins)

Specific food restrictions:

- Dairy
- Corn
- All Gluten
- Soy
- Wheat
- Eggs
- Other \_\_\_\_\_

Food Frequency (often, sometimes, or never)

- Fruit: \_\_\_\_\_
- Dark Vegetable: \_\_\_\_\_
- Grains: \_\_\_\_\_
- Beans, Peas, Legumes: \_\_\_\_\_
- Dairy, Eggs: \_\_\_\_\_
- Meat, Poultry, Fish: \_\_\_\_\_
- Water: #oz/d \_\_\_\_\_

Eating Habits

- Skip Meals - \_\_\_\_\_ (which)
- One Meal/Day
- Two Meals/Day
- Three Meals/Day
- Graze (Small Frequent Meals)
- Generally Eat on the Run
- Eat Constantly Whether Hungry or Not

Current Supplements

- Multivitamin/Mineral
- Vitamin C
- Vitamin D
- Vitamin E
- EPA/DHA
- Calcium, Source \_\_\_\_\_
- Magnesium
- Zinc
- Minerals; Describe \_\_\_\_\_
- Acidophilus
- Digestive Enzymes
- Amino Acids
- CoQ10
- Antioxidants
- Herbs
- Homeopathy
- Protein Shakes
- Superfoods (bee pollen/phytonutrients)
- Liquid Meals
- Others \_\_\_\_\_

Sleep

- 8-10 hr/night
- 5-7 hr/night
- Less than 5 hr/night
- Heavy Sleeper
- Restless
- Sleep Apnea/Snoring
- Difficulty Falling Asleep
- Wake Easily
- Vivid Dreams
- Wake Rested
- Wake Fatigued

Current Medications

*Rx & OTC*

- None
- Blood Pressure
- \_\_\_\_\_
- Cholesterol
- \_\_\_\_\_
- Hormonal Replacement
- \_\_\_\_\_
- Thyroid
- \_\_\_\_\_
- Diabetes
- \_\_\_\_\_
- Anti-inflammatory
- \_\_\_\_\_
- Pain
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

If more room is needed, please feel free to use the back of this form.

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

**Health Goals**

Energy

- Feel More Vital
- Have More Energy
- More Endurance
- Less Tired After Lunch
- Sleep Better
- Be Free of Pain
- Less Colds/Flu
- Get Rid of Allergies
- Not Be Dependent Upon OTC Meds
- Stop Using Laxatives
- Improve Sex Drive

Body Composition

- Lose Weight
- Burn More Fat
- Be Stronger
- Better Muscle Tone
- More Flexibility

Stress/Mental/Emotional

- Reduce Stress
- Be More Focused
- Improve Memory
- Be Less Depressed
- Be Less Moody
- Be More Decisive
- Feel More Motivated

Life Enrichment

- Reduce Risk of Degenerative Disease
- Slow Down Accelerated Aging
- Maintain Healthier Life Longer
- Change from "Treating Illness"  
Orientation to "Creating Wellness"  
Lifestyle.

**What therapies have you tried for your problems/conditions OR to improve your health over-all?**

- None
- Diet Modification
- Fasting
- Vitamins/Minerals
- Herbs
- Homeopathy
- Chiropractic
- Acupuncture
- Massage
- Exercise Therapy
- Physical Therapy
- Conventional Drugs
- Surgery
- Other \_\_\_\_\_

**What therapies offered at Orlando Sports Chiropractic are you interested in to treat your problems/conditions AND/OR to improve your health over-all?**

- Diet Modification
- Fasting
- Vitamins/minerals
- Herbs
- Homeopathy
- Chiropractic
- Acupuncture
- Massage
- Exercise Rx
- Physical Therapy
- Trigger Point Injections
- B12 Injections
- Other \_\_\_\_\_

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The information provided in these health history forms is true and accurate to the best of my knowledge and I freely give my permission for treatment at Orlando Sports Chiropractic.

I agree to inform the doctors and/or therapists of any experience of pain during any treatment. I understand that seeking treatment at Orlando Sports Chiropractic does not deter me from seeking medical treatment for other medical conditions. I agree to update the doctors and/or therapists in regard to changes in my health and understand that there shall be no liability on the doctor's or therapist's part should I forget to do so. I agree to hold harmless the establishment, all management, including volunteers, from and against any and all claims. I agree to handle suit at its sole expense and agree to bear all costs related even if claims, etc., are groundless, false, and fraudulent.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_





**Patient Consent to the Use and Disclosure of Health Information  
for Treatment, Payment, and/or Healthcare Operations**

I understand that, as a part of my healthcare, this practice originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and plans for future care or treatment.

**I understand that this information serves as:**

- A basis for planning my care and treatment.
- A means of communication among the health professionals who contribute to my care; i.e.: consultations and referrals
- A source of information for applying my diagnosis and treatment information to my bill for payment purposes
- A survey for routine healthcare operations, such as assessing quality and reviewing the competence of staff

I have been provided the opportunity to review the “Patient Privacy Practices” that provides a more complete description of information, uses and disclosures. I understand that I have the following rights:

- The right to review the “Patient Privacy Practices” prior to acknowledging this consent
- The right to restrict or revoke the use or disclosure of my health information for purposes other than treatment or payment
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations

**Restrictions:**

I request the following restrictions to the use or disclosure of my health information: \_\_\_\_\_

Is there anyone you want us to be able to discuss your healthcare information with?

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

**Messages or Appointment Reminders:**

If you do not want us to leave a message on your answering machine, or with someone at your home, reminding you of an appointment, which may also include non-sensitive healthcare information, please check the box below:

Do not leave a message on my answering machine or with anyone at my home

I understand that as a part of my treatment, payment, or healthcare operations, it may become necessary to disclose health information to another entity; i.e.: referrals to other healthcare providers, labs, and/or other individuals or agencies as permitted or required by state or federal law.

I fully understand the information provided by this consent.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Printed name of person signing

\_\_\_\_\_  
Date

\*If other than patient is signing, are you the parent, legal guardian, custodian or have Power of Attorney for this patient, for treatment, payment or healthcare operations. Yes [ ] No [ ]

---

**FOR OFFICE USE ONLY**

Patient refused to sign the consent form.

Reason for patient refusal to sign \_\_\_\_\_

Restrictions were added by the patient (see restrictions listed above)

“Consent form” received and reviewed by \_\_\_\_\_ on (date) \_\_\_\_\_

## ***Informed Consent to Chiropractic Treatment***

**The nature of chiropractic treatment:** The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound, or dry hydrotherapy may also be used.

**Possible Risks:** As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns, or minor complications.

**Probability of risks occurring:** The risks of complications due to chiropractic treatment have been described as "rare", occurring about as often as complications from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

**Other treatment options offered here which could be considered** may include the following:

- **Massage Therapy:** This option involves very low risks with little to no side-effects; including, but not limited to, soreness and bruising.
- **Chinese Medicine Modalities:** These options involve very low risks with little to no side-effects. Please ask for informed consent of Chinese Medicine if you would like to consider this option.

**Other treatment options not offered here which could be considered** may include the following:

- ***Over-the-counter analgesics:*** The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- ***Medical care:*** typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- ***Hospitalization*** in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- ***Surgery,*** in conjunction with medical care, adds the risks of adverse reaction to anesthesia; as well as an extended convalescent period in a significant number of cases.

**Risks of remaining untreated:** Delay of treatment allows formation of adhesions, scar tissue, and other degenerative changes. These changes can further reduce skeletal mobility and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

**Unusual risks: I understand that I will have any unusual risks of my case explained to me.**

We do not offer to diagnose or treat any disease or condition beyond the scope of Chiropractic medicine in the state of Florida. However, if during the course of examination, we encounter non-chiropractic or unusual findings, we will so advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of the health care provider who specializes in that area. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others.

\_\_\_\_\_ I authorize the taking of photographs and x-rays to be used for treatment purposes.

\_\_\_\_\_ I authorize the performance of other diagnostic and therapeutic procedures for treatment purposes. These may include, but are not limited to massage therapy, acupuncture, homeopathic injections, Graston Technique, electrical stimulation, ultrasound, cryotherapy, and heat therapy.

\_\_\_\_\_ I hereby give consent to have chiropractic adjustments performed in a semi-open room setting. I understand that a semi-open room setting does not ensure complete privacy and will inform the staff if I need to discuss any confidential information in private.

**I have read the explanations the above of treatment options. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment and hereby give my full consent to treatment.**

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Witness: \_\_\_\_\_



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## AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

(HIPPA Compliant: 45 CRF s.164.508 & 456.057)

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

- 1. I authorize the use of disclosure of the above named individual's health information as described below.
- 2. The following individual(s) or organization(s) is/are authorized to make the disclosure:

\_\_\_\_\_

- 3. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

- |   |  |
|---|--|
| <input type="checkbox"/> Most recent history and physical | <input type="checkbox"/> Medication list           |
| <input type="checkbox"/> Laboratory results               | <input type="checkbox"/> X-ray and imaging reports |
| <input type="checkbox"/> Consultation results             | <input type="checkbox"/> Entire record             |
|   | <input type="checkbox"/> Other _____               |

- 4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
- 5. This information may be disclosed to and used by the following individual or organization: Orlando Sports Chiropractic. I authorize the release of records to Orlando Sports Chiropractic by facsimile, email and/or by U.S. Mail. The purpose of the disclosure is to provide Orlando Sports Chiropractic with necessary medical records.
- 6. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: \_\_\_\_\_. If I fail to specify an expiration date, event or condition, this authorization will expire in six months.
- 7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.
- 8. I understand that Florida Statute 456.057(10) makes it clear that any third party to whom records are disclosed is prohibited from further disclosing any information in the medical record without the expressed written consent of the patient or the patient's legal representative.

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
If Signed by Legal Representative, Relationship to Patient

\_\_\_\_\_  
Signature of Witness

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**X-RAY CONSENT/WAIVER**

Please choose one:

**Consent:** I understand that the doctor may need x-rays in order to administer my treatment and I give my permission for such tests.

**Waiver of X-Rays:** I do not feel that my present problem (or illness) is serious enough to warrant the use of x-rays. Therefore, you are hereby authorized and directed to treat my present problem (or illness) to the best of your ability without making a complete study and analysis of my present problem (or illness). Should any unforeseen effects or any further illness or injury develop, directly or indirectly, as a result of such treatment, I shall assume full responsibility. In consideration of you treating me at my request without benefit of a complete study and analysis, I do hereby release you from all causes of action, damages, and liabilities arising by reason of said treatment, whether heretofore or hereafter occurring, and whether now known or unknown by the parties hereto.

**FEMALES ONLY:**

I understand that if I am pregnant and have x-rays that it is possible to injure the fetus.

I have been advised that the ten (10) days following the onset of a menstrual period are generally considered safe for x-ray exams.

With the above factors in mind I am advising the doctor that:

My last menstrual period began: \_\_\_\_\_

- |  |  |
|--|--|
| <input type="checkbox"/> I am pregnant               | <input type="checkbox"/> I have had a tubal ligation |
| <input type="checkbox"/> I could be pregnant         | <input type="checkbox"/> I have had a hysterectomy   |
| <input type="checkbox"/> My menstrual period is late | <input type="checkbox"/> My periods are irregular    |
| <input type="checkbox"/> I have an IUD               | <input type="checkbox"/> I have begun menopause      |

Please choose one:

**Consent:** With full understanding of the above, I believe that I am not currently at risk and wish to have any necessary x-rays taken in order for the doctor to fully evaluate my condition.

**Waiver of X-Rays:** I acknowledge that I am \_\_\_\_\_ months pregnant and am not able to allow x-rays to be taken of me at this time. I fully understand and agree to the terms set forth above on the matter "waiver of x-ray" form.

\_\_\_\_\_  
Signature\_\_\_\_\_  
Date