Physical Evidence Chiropractic
7035 Beracasa Way, Suite 103 Boca Raton Florida, 33433
Phone# (561)674-1217 Fax# (561)361-4999

Date_____ File #_____

PERSONAL HISTORY

Last Name _____ First Name _____ middle _____

Address_____ City _____State _____Zip_____

Date of Birth _____Age _____Social Security #_____

Circle one: Married Single Widowed Divorced Separated

Employer_____ Type of work _____

Home Phone ( ) _____Work ( ) _____cell ( ) _____

Spouse Name _____ Spouse phone# ( ) _____

Email Address _____

Name and Number of Emergency Contact _____

Relationship _____

Who Is Responsible for your bill? _____

HEALTH CONDITION

What is your major complaint? _____

When/How did this begin? _____

Quality (what does it feel like) _____

If stress is involved, what is the severity [on a scale 0-10, 0 being no stress] _____

If pain is involved what is the severity [on a scale 0-10, 0 being no pain] _____

What are you unable to do as a result of your discomfort/ pain/ challenge? _____

_____

What makes it better

_____

What makes it worse _____

Does the pain travel ____yes ____no numbness or tingling ____yes ___no?

Where is the pain located_____ Constant ___yes ____no only during certain activities _____

Other Doctors seen for this condition? ___Y___N who? _____

Is Condition: ___Job Related ___Auto Accident ___Home Injury____ Slip & Fall_____

Other: _____

Date of Accident? _____Time Of Accident _____AM/PM

Have you reported this accident? ____ Yes____ no. To Whom? _____

Have you had any surgery? ____Yes ___NO if yes please describe _____

_____

Previous Chiropractic care ____yes___ no Dr. Name and for what_____

Any other alternative treatments? _____

Currently under other care ___yes ___no. Any recent diagnostics? ___yes ___no X-ray MRI Cat etc...
What / how recent _____

Any allergies? _____ Infections (incl HIV, hep c) ____yes ___No

Immunizations_____

Are you experiencing any work Restrictions as a result of your present condition?

Yes___ No ___ if yes please explain_____

How Many Hours per day are you at a computer (on Average)? _____

How do you get to work? _____ how long does it take? _____

Do you have difficulty sitting for long periods? _____yes _____no, walking ___yes ___no, standing ___yes ____No

Do you wear arch supports in your shoes _____yes _____no?

Do you take any over the counter medications ___yes ___No, what and how often _____
_____

Do you take any prescriptions ___yes ___no, what and how often _____

_____

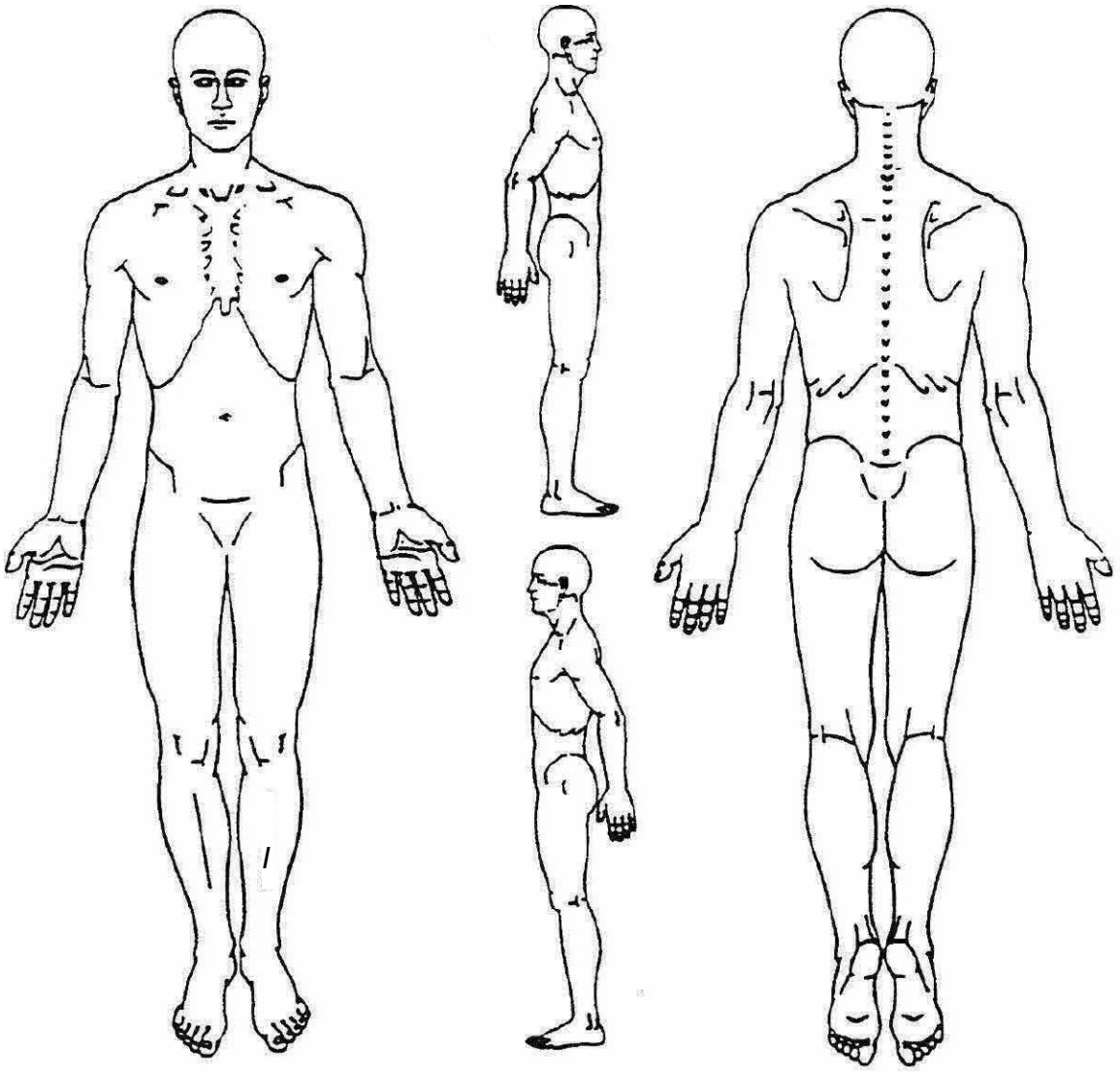
Have you had recent significant weight changes? ___ yes ___no. Explain_____

_____

PAIN DRAWING

Please mark the figure below with the letters and best describe the sensation or pain you are feeling. Please mark areas where pain radiates or spreads with a **T, ⁻, X** or to indicate the direction of radiating pain.

A = Ache	D= Dull Pain	**P** = Pins & Needles	SH = Shallow
B = Burning	N = Numbness	I = Throbbing	C = Cold



R = Radiating Pain	**S** = Stabbing	**DP** = Deep	0 = Other

Please circle *how you* would rate your pain RIGHT NOW:

Please circle how you would rate your worst possible pain

(no pain) O 1 2 3 4 *5* *6* *7* 8 9 10 (worst possible pain)

Please circle *how you* would rate your AVERAGE pain:

(no pain) O 1 2 3 4 *5* *6* *7* 8 9 10 (worst possible pain)

Please circle both the pain level at its BEST and at its WORST: (circle two numbers)

(no pain) O 1 2 3 4 *5* *6* *7* *8* 9 10 (worst possible pain)

I UNDERSTAND AND AGREE THAT HEALTH AND ACCIDENT INSURANCE POLICIES ARE AN ARRANGEMENT BETWEEN AN INSURANCE CARRIER AND MYSELF. I UNDERSTAND THE DOCTOR'S OFFICE WILL PREPARE ANY NECESSARY FORMS TO ASSIST ME IN MAKING COLLECTIONS FROM THE INSURANCE COMPANY AND THAT ANY AMOUNT AUTHORIZED TO BE PAID DIRECTLY TO THE DOCTOR'S OFFICE WILL BE CREDITED TO MY ACCOUNT ON RECEIPT. I THE UNDERSIGNED AGREE THAT I AM RESPONSIBLE FOR ANY AND ALL COSTS ASSOCIATED WITH THE TREATMENT RENDERED TO ME BY THE DOCTOR EVEN IF MY INSURANCE COMPANY FAILS TO PAY, OR PAYS A PORTION THEREOF IF I BECOME DELINQUENT IN PAYMENT OF SUCH FEES DUE THE DOCTOR (30 DAYS PAST DUE FROM THE DATE OF THE ORIGINAL INVOICE) I AM RESPONSIBLE FOR ANY AND ALL COLLECTION COSTS ATTORNEY FEES AT THE MAXIMUM LEGAL RATE WITH THE REGARDS TO THE RECOVERY OF SUCH DELINQUENT ACCOUNT I ALSO UNDERSTAND THAT IF I SUSPEND TREATMENT OR INSURANCE ACCOUNT IS IMMEDIATELY DUE AND PAYABLE TO DOCTOR .

I HEREBY AUTHORIZE THE DOCTOR TO TREAT MY CONDITION AS HE OR SHE DEEMS APPROPRIATE THROUGH THE USE OF MANIPULATION THROUGHOUT MY SPINE. IT IS UNDERSTOOD AND AGREED THAT THE AMOUNT PAID TO THE DOCTOR IS FOR EXAM AND X-RAYS, ONLY THE X-RAY NEGATIVES WILL REMAIN PROPERTY OF THIS OFFICE BEING ON FILE WHERE THEY MAY BE SEEN AT ANY TIME WHILE A PATIENT IS AT THIS OFFICE PATIENT ALSO AGREES THAT HE/SHE IS RESPONSIBLE FOR ALL BILLS INCURRED AT THIS OFFICE THE DOCTOR WILL NOT BE HELD RESPONSIBLE FOR ANY PRE-EXISTING CONDITIONS NOR FOR ANY MEDICAL DIAGNOSIS.

PATIENT'S SIGNATURE: _____ DATE:

GUARDIAN OR SPOUSE'S SIGNATURE AUTHORIZING CARE:

_____ DATE : _____

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Informed Consent for Chiropractic care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understands both the objective and the method that will be used to obtain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and, alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as the relationship may effect the restoration and preservation of health. **Health** is a state of physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called **vertebral Subluxation**. This occurs when one or more of the 24 vertebra in the spinal column becomes misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an **adjustment**. An adjustment is the specific application of forces to correct and/or reduce vertebral Subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually performed by hand but maybe performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

All health care procedures carry some risk. Risks associated with chiropractic care may include, but are not limited to, muscle or ligament injuries, nerve injuries, vascular injuries, and fractures. Alternatives to chiropractic care may include medications, surgery and other alternative treatments.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

Print Name_____ Signature _____ Date _____

Consent to evaluate and adjust a minor child:

I, _____being the patient or legal guardian of_____

Have read and fully understand the above consent and hereby grant permission for my child to receive chiropractic care.

Pregnancy release: This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle. _____

Signature_____ Date: _____

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Informed Consent for Active Release Technique

What is Active Release Technique?

It is a hands-on touch and case-management system that allows a practitioner to diagnose and treat soft-tissue injuries. Soft tissue refers primarily to muscle, tendons, fascia and nerves. Specific injuries that apply are repetitive strains, traumas, adhesions, tissue hypoxia and joint dysfunction.

What do you expect from an Active Release Technique treatment?

Every session is actually a combination of examination and treatment. Dr. Lipman uses his hands to evaluate the texture, tension, movement and function of muscles, fascia, tendons, ligaments and nerves. Abnormal tissues are treated by combining precisely directed tension and pressure with very specific patient movements.

How Long Are Treatments?

Treatments take about 8-15 minutes for each area being treated. A condition may require two to ten Visits before full functionality is restored. Manipulation of the spine and extremity joints is almost always carried out in conjunction with Active Release Therapy to increase treatment effectiveness. Whenever possible we have our patients perform active movements during the treatment process. Active motions stimulate neurological pathways in the spinal cord that help to reduce pain during treatment. Motion also helps to reproduce the stresses the patient will actually be under during normal active motion.

Is it safe?

Yes it is.

Are there any side effects?

Active Release Therapy is a non-invasive, safe and virtually no side effects and comes with a record of very good results. In a small percentage of patients, symptoms can become worse before improving. This is generally a sign that healing has begun. In some cases Active Release Therapy can cause bruising and tenderness in the region that is being treated. If during the treatment session you find it to be too uncomfortable, please bring it to Dr. Lipman's attention immediately so the treatment can be modified. If worsening of symptoms or the bruising that may ensue is concerning you or lasts more than a few days, contact Dr. Lipman to discuss.

I _____ (Full name) Have read and understood the above Information. I consent to receive Active Release Technique treatment within this practice. I agree to

This consent remaining valid until such time as I withdraw that consent.

Signed _____Date_____

Physical Evidence Chiropractic
Dr. David Lipman

HIPAA FORM

Consent for purposes of treatment, Payment & health care operations (3/03)

In this document, "I" and "my" refers to the patient.
And "chiropractor" refers to Dr. David Lipman DC.

I consent to the use or disclosure of my protected health information by the chiropractor for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of chiropractor. I understand that analysis, diagnosis or treatment of me by chiropractor may be conditioned upon my consent as evidenced by my signature below

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment of health care operations of the practice. Chiropractor is not required to agree to the restrictions that I may request. However, if chiropractor agrees to a restriction that I request, the restriction is binding on chiropractor.

I have the right to revoke this consent, in writing, at any time, except to the extent that chiropractor has taken action in reliance on this consent.

My "protected health information" means health information, including me demographic information, collected form me and created or received by my physician, another health care provider, a health plan, my employer or health care clearing house. This protected health information relates to my past, present of future physical or mental health or condition and identifies or there is a reasonable basis to believe the information my identify me.

I have been provided with a copy of the Notice of Privacy Practices of Chiropractor and understand that I have a right to review the Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of chiropractor. The notice of privacy practices for chiropractor is also posted in the office of Dr. David Lipman's office. The notice of privacy practices also describes my rights and duties of the chiropractor with respect to my protected health information.

Chiropractor reserves the right to change the privacy practices that are described in the notice of privacy practices. I may obtain a revised notice of privacy practices by calling the office of chiropractor and requesting a revised copy to be sent in the mail or asking for one at the time of my next appointment.

Name: _____ Signature: _____

Date: _____ Witness Signature: _____