747 Fawn Ridge Drive Suite 100, Orange City, FL 32763
Office: (386) 259-9051 Fax: (386) 259-4243

Patient Information Record

☐ Auto ☐ Slip and Fall ☐ Self Pay

PATIENT INFORMATION

Name: _____
Last First MI
Address: _____
City State Zip Code
Phone #: _____ **Cell #:** _____
Date of Birth: _____ **SS#:** _____ **Sex:** M F
Marital Status _____ **Email:** _____
Emergency Contact
First Name: _____ Last Name: _____
Relationship: ☐Spouse ☐ Relative ☐ Friend ☐ Other: _____ Phone: _____

INSURANCE INFORMATION

Insured Name _____ **Relationship to insured:** _____
Insured Address: _____
City State Zip Code
Date of Accident _____ **1st Date of Visit:** _____
Insurance Company _____
Address _____
City State Zip Code
Adjuster _____ **Phone** _____ **Fax:** _____
Policy #: _____ **Claim #:** _____
Policy limit _____ **Deductible** _____ **Med Pay** _____

ATTORNEY INFORMATION

Attorney: _____ **Case Manager:** _____
Address _____
City State Zip Code
Phone #: _____ **Fax#:** _____
Email: _____

Restore
Injury Health Center

747 Fawn Ridge Drive Suite 100, Orange City, FL 32763
Office: (386) 259-9051 Fax: (386) 259-4243

INFORMED CONSENT

Restore Injury Health Center, LLC maintains equipment, personnel, and facilities to assist in the delivery of chiropractic adjustments, therapeutic procedures, and recommendations of whole food nutritional supplements with the goal of regaining and maintaining health. As with any comparable intervention, there is always a calculated risk of complication, injury, or even death, and no guarantee has been made as to treating, curing, or preventing the occurrence of disease. Chiropractic adjustments and associated procedures are therefore not performed on patients unless and until a patient has been examined and thus had an opportunity to discuss his or her concerns with the doctor. Each patient reserves the right to receive or refuse any proposed procedure or therapy based upon the prescription or explanation received.

INITIATION OF TREATMENT FOR PERSONAL INJURY

By your signature below, you consent to the initiation of treatment at our office. If requested, we require you supply our office with the following information regarding your case: your personal car insurance information, the other driver's insurance information, your commercial health insurance, the accident report, and your attorney's name and contact information if one has been retained (if you have not retained an attorney, please let us know so we can make the appropriate referral for you.) Also, please note that using your Medpay or PIP to cover the cost of treatment at our office does not cause your insurance rates to go up. If your rates increase, it is most likely because: (a) the accident was determined by the insurance company to be your fault, (b) you received a police citation or ticket, or (c) you have been involved in numerous reported auto accidents within a brief period of time and are therefore considered "high risk." Additionally, filing your Medpay or PIP does not relieve the "at fault" party from having to pay in full for your loss. If the "at fault" driver's liability insurance refuses to make payment on your medical bills for whatever reason, filing your Medpay or PIP will help ensure that you are not left to pay these expenses out of pocket.

PAYMENT OF BILLS/OFFICE POLICY

You are responsible for payment of services and there is no guarantee your insurance company will reimburse you for services or products sold at our office. As a courtesy, and at our discretion, our office will submit insurance claims to your auto insurance company if you have been involved in a car accident. If you are a Florida resident with auto insurance, this may be a great benefit to you. However, please keep in mind that insurance is an agreement between you and your insurance company and not between you and our office. As long as our office is filing your Medpay or PIP and your insurance company is continuing to cover the charges accrued, collection of payment at time of service will be waived.

If you are unable to make a scheduled appointment, we respectfully request that you let our office know a minimum of 24 hours in advance and that you reschedule the missed appointment within the same week. This permits you to stay on the treatment schedule that has been prescribed to you by the doctor. Our office staff are not permitted to change or alter your prescription, only the doctor.

CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

In addition to the above treatment and office policies, your signature constitutes your acknowledgement that: (1) You have read a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and have been advised that a full copy of this office's HIPAA Compliance Manual is available upon request; (2) You understand that this office reserves the right to revise its Notice of Privacy Practices at any time and it will be available to patients upon request; (3) You consent to the use of your protected health information in a manner consistent with State and Federal Law, this office's Notice of Privacy Practices, and the HIPAA Compliance Manual. Upon final or discharge of care, any medical records requested will only be provided to another doctor or attorney with a signed medical release form.

I have read and understand the foregoing. This permission form applies to subsequent visits.

_____ _____

Patient's Signature Date

Restore
Injury Health Center

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LETTER OF PROTECTION, POWER OF ATTORNEY AND CONTRACTUAL LIEN

PATIENT'S NAME: _____ DATE OF BIRTH: _____

DATE OF ACCIDENT: _____

By my signature below, I authorize Restore Injury Health Center, LLC to release any information pertinent to my case to any insurance company or attorney to facilitate collection under this assignment, lien and authorization. I agree that this office be given power of attorney to endorse my name on any and all checks for payment of my subsequent bill.

I hereby authorize and direct you, my attorney, to pay directly to the doctor such sums as may be due and owing him for reasonable and necessary medical services rendered to me for evaluation or treatment for conditions related to this accident. I instruct my attorney to pay in full any outstanding monies due to Restore Injury Health Center, LLC at the time of settlement with any liability claim that may result from this case. ***I instruct my attorney to pay my doctor immediately upon settlement, by way of issuance of a separate draft made payable to*** **Restore Injury Health Center, LLC**. I hereby further give a lien on my case to the doctor against any and all proceeds of my settlement, judgment or verdict which may be paid to you by my attorney or myself as a result of the injuries of which I have been treated or injuries in connection therewith.

I instruct any third party individual or insurance carrier that may be liable, to pay Restore Injury Health Center, LLC directly for any outstanding medical bills which are the result of this accident. If payment is not made until the time of settlement, ***I instruct the third party to issue a separate draft to be payable to*** **Restore Injury Health Center, LLC** ***for the medical bills.***

I understand and acknowledge that all charges incurred by me are my responsibility regardless of any settlement made by a third party. I am instructing and agreeing to the above conditions as a safeguard to Restore Injury Health Center, LLC and the entity's right to collect payment. If a settlement does not occur within a reasonable amount of time, I agree to make other arrangements to pay my account in full. I understand and agree that if this office must take any action to collect an outstanding balance on my account, I will be responsible for payment of and reimburse this office for all costs of such collection efforts including but not limited to all court costs and attorney fees.

I understand that this agreement is made for the doctor's protection in consideration of his awaiting payment. I understand and agree that my directions to you, as my attorney, are irrevocable until either the satisfaction of my financial account with Restore Injury Health Center, LLC occurs or Restore Injury Health Center, LLC releases such Letter of Protection.

I agree to promptly notify the doctor of any change or addition of attorney(s) used by me in connection of the accident and I instruct my attorney to do the same and to promptly deliver a copy of this lien to any such substituted or added attorney.

Please acknowledge this letter by signing below and returning it to the doctor's office.

_____ _____
Patient's Signature Date

I, being the attorney of record for the above patient, do hereby agree to observe all the terms of the above and agree to withhold such sums for any settlement, judgment or verdict as may be necessary to adequately protect and fully compensate the doctor named above in payment of his fees.

_____ _____
Attorney's Signature Date

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Injury Health Center

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ASSIGNMENT OF BENEFITS, AUTHORIZATION TO SETTLE CLAIM AND DIRECTION TO PAY MEDICAL PROVIDER DIRECTLY

By my signature below, for good and valuable consideration (including but not limited to the extension of credit to me), I hereby assign, transfer and convey to **Restore Injury Health Center, LLC** (hereinafter "the Provider") all of my rights, title and interest in and to medical expense reimbursement in whatever form, including but not limited to any automobile liability medical expense payments or other health benefits indemnification and/or agreement otherwise payable to me. This payment shall not exceed my indebtedness to the above named assignee and I acknowledge that I will timely pay any indebtedness owed by me to the assignee that is not otherwise satisfied by the above-mentioned assigned proceeds. I also acknowledge that any medical expenses not covered under my insurance policy will be my responsibility.

I further authorize the Provider to negotiate, collect and settle any claim with any insurance carrier or other third party payor with regard to these services, which authorization shall include authority to:
(1) request and receive from any insurer or any other party any and all documentation and records that I am empowered to request regarding this claim, including, without limitation, a statement of coverage, policy declarations page and insurance policy pursuant to Section 627.4137. In addition, the provider has the authority to request and receive any Independent Medical Examination Reports, notices sent to me regarding appointments for Independent Medical Examinations and Examinations Under Oath (including proof of mail), Records Review Reports, coverage denial letters, Explanations of Benefits, and Benefit Payment Sheets or Logs (P.I.P. Payout Sheets), without regard as to whether such documentation has already been provided to me and,
(2) to endorse in my name any check issued for payment where benefits were assigned. By way of this assignment and notice, I further instruct you, the insurer, to furnish to Provider copies of all future notices affecting Provider's interest in this claim, including, without limitation, any notices of requested medical examinations or statements.

The Provider hereby objects to any reductions or partial payments. Any partial or reduced payment, regardless of the accompanying language, issued by the insurer and deposited by the provider shall be done so under protest, at the risk of the insurer, and the deposit *shall not* be deemed a waiver, *accord, satisfaction*, discharge, settlement or agreement by the provider to accept a reduced amount as payment in full.

I further direct my insurer to direct all payments for services rendered by the Provider directly to Provider at the billing address contained on Provider's medical bills.

THIS IS A DIRECT AND IRREVOCABLE ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER MY POLICY OF INSURANCE.

A photocopy of this form shall be considered as effective and valid as the original.

I have read the foregoing and understand and agree to each of the above provisions:

_____ _____

Patient's Signature Date

APPLICATION FOR FLORIDA "NO FAULT" BENEFITS

NAME OF INSURANCE COMPANY

DATE	OUR POLICY HOLDER	DATE OF ACCIDENT	FILE NUMBER

TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER THE FLORIDA PERSONAL INJURY PROTECTION LAW, PLEASE COMPLETE THIS FORM AND RETURN IT PROMPTLY.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURANCE COMPANY MAKES A STATEMENT OF CLAIM CONTAINING ANY FALSE INCOMPLETE OR MISLEADING INFORMATION, IS GUILTY OF A FELONY OF THE THIRD DEGREE.

YOUR NAME	PHONE NO.	HOME	BUSINESS

YOUR ADDRESS (NO, STREET, CITY OR TOWN, STATE AND ZIP CODE)	DATE OF BIRTH	SOCIAL SECURITY NO.

PERMANENT ADDRESS, IF DIFFERENT	HOW LONG HAVE YOU LIVED IN FLORIDA?

DATE AND TIME OF ACCIDENT	PLACE OF ACCIDENT (STREET, CITY OR TOWN AND STATE)

BRIEF DESCRIPTION OF ACCIDENT AND VEHICLES INVOLVED:

DESCRIBE MOTOR VEHICLE YOU OWN -	DESCRIBE MOTOR VEHICLE OWNED BY ANY MEMBER OF YOUR FAMILY-

AS A RESULT OF THIS ACCIDENT, WERE YOU INJURED? Y IF YOUR ANSWER IS YES, COMPLETE THE REST OF THIS FORM. IF NO, SIGN HERE AND RETURN THIS FORM TO US.

SIGNATURE: _____ **DATE:** _____

DESCRIBE YOUR INJURY

WERE YOU TREATED BY A DOCTOR? Y		DOCTOR'S NAME AND ADDRESS
IF YOU WERE TREATED IN A HOSPITAL, WERE YOU AN IN PATIENT ____ OUT PATIENT ____		HOSPITAL'S NAME AND ADDRESS

AMOUNT OF MEDICAL BILLS TO DATE	WILL YOU HAVE MORE MEDICAL EXPENSE? Y	AT THE TIME OF YOUR ACCIDENT, WERE YOU IN THE COURSE OF YOUR EMPLOYMENT? N

DID YOU LOSE WAGES OR SALARY AS A RESULT OF YOUR INJURY?	IF YES, AMOUNT OF LOSS TO DATE	WHAT IS YOUR AVERAGE WEEKLY WAGE OR SALARY?

IF YOU LOST WAGES:	DATE DISABILITY FROM WORK BEGAN	DATE YOU RETURNED TO WORK

HAVE YOU RECEIVED, OR ARE YOU ELIGIBLE FOR, PAYMENTS UNDER ANY WORKMEN'S COMPENSATION OR EMPLOYMENT LAW? N	IF YES, AMOUNT PER WEEK PER MONTH

LIST NAMES AND ADDRESSES OF YOUR PRESENT EMPLOYER(S) AND GIVE YOUR OCCUPATION AND DATES OF EMPLOYMENT FOR EACH

EMPLOYER AND ADDRESS	YOUR OCCUPATION	FROM	TO
EMPLOYER AND ADDRESS	YOUR OCCUPATION	FROM	TO
EMPLOYER AND ADDRESS	YOUR OCCUPATION	FROM	TO

AS A RESULT OF YOUR INJURY HAVE YOU HAD ANY OTHER EXPENSES?	IF YES, EXPLAIN ON REVERSE SIDE
SIGNATURE: DATE:	

IMPORTANT: 1. TO BE ELIGIBLE FOR BENEFITS COMPLETE AND SIGN THIS APPLICATION
2. SIGN AND ATTACH AUTHORIZATION(S)
3. RETURN PROMPTLY WITH ANY MEDICAL BILLS YOU HAVE RECEIVED TO DATE

OFFICE OF INSURANCE REGULATION
Bureau of Property & Casualty Forms and Rates

Standard Disclosure and Acknowledgement Form
Personal Injury Protection - Initial Treatment or Service Provided

The undersigned insured person (or guardian of such person) affirms:

1. The services or treatment set forth below were **actually rendered.** This means that those services have **already been provided.**

_____

_____

2. I have the right and the **duty to confirm** that the services have already been provided.
3. I was **not solicited** by any person to seek any services from the medical provider of the services described above.
4. The medical provider has **explained** the services to me for which payment is being claimed.
5. If I notify the insurer in writing of a billing error, I may be entitled to a portion of any reduction in the amounts paid by my motor vehicle insurer. If entitled, my share would be at least 20% of the amount of the reduction, up to $500.

Insured Person (patient receiving treatment or services) or Guardian of Insured Person:

Name *(PRINT or TYPE)*	Signature	Date

The undersigned licensed medical professional or medical director, if applicable, affirms the statement numbered 1 above and also:

A. I have **not solicited** or caused the insured person, who was involved in a motor vehicle accident, to be solicited to make a claim for Personal Injury Protection benefits.

B. The treatment or services rendered were explained to the insured person, or his or her guardian, **sufficiently** for that person to sign this form with informed consent.

C. The accompanying statement or bill is **properly completed** in all material provisions and all relevant information has been provided therein. This means that each request for information has been responded to **truthfully, accurately**, and in a **substantially complete** manner.

D. The coding of procedures on the accompanying statement or bill is proper. This means that **no service has been upcoded, unbundled**, or constitutes an invalid **or not medically necessary diagnostic test** as defined by Section 627.732 (15) and (16), Florida Statutes or Section 627.736(5)(b)6, Florida Statutes.

Licensed Medical Professional Rendering Treatment/Services or Medical Director, if applicable *(Signature by his/ her own hand):*

Name *(PRINT or TYPE)*	Signature	Date

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of Claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree per Section 817.234(1)(b), Florida Statutes.

Note: The **original** of this form must be furnished to the insurer pursuant to Section 627.736(4)(b), Florida Statutes and may **not** be electronically furnished. Failure to furnish this form may result in non-payment of the claim.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you, or to family and friends you approve.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. You also have the right to request restrictions on disclosure of PHI (Personal Health Information),or alternative means of communication to ensure privacy.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law or national security activities.

Abuse or Neglect: We may disclose your health information to appropriate authorities when we suspect abuse or neglect.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (Such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information with limited exceptions. If you request copies, we will charge you a reasonable fee to locate and copy your information, and postage if you want the copies mailed to you.

Amendment: You have the right to request that we amend your health information.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may 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 with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us with the U.S. Department of Health and Human Services. A Privacy/Contact Officer has been designated for this office. The Privacy Officer can be contacted by simply contacting the office and asking to speak to the Office Manager who serves as the Privacy Officer.

PATIENT ACKNOWLEDGEMENT OF THE NOTICE OF PRIVACY PRACTICES AND CONSENT FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

I,_____, acknowledge that I
(Patient Name)

have either received a copy of **Restore Injury Health Center, LLC** NOTICE OF PRIVACY PRACTICES or that this NOTICE OF PRIVACY PRACTICES was made available to me to receive and hereby consent to the use and disclosure of my personal health information by **Restore Injury Health Center, LLC** for treatment, billing/payment, and health care operations as outlined in the NOTICE OF PRIVACY PRACTICES.

Signature of Patient or Parent or Legal Guardian: _____

Date: _____

Restore
Injury Health Center

First Name: _____ **Last Name:** _____

DATE OF ACCIDENT: _____ **Hour:** _____ ☐ **AM** ☐ **PM**

Please describe the accident in detail:

_____

_____

_____

_____

Location of Accident: Street: _____ City: _____

Type of vehicle you were in: _____ Speed: _____

Type of other vehicle involved: _____ Speed: _____

Visibility at the time of accident: ☐ Poor ☐ Fair ☐ Good

Road conditions at time of accident: ☐ Wet ☐ Dry ☐ Dark

Were you: ☐ Driver ☐ Passenger ☐ Front seat ☐ Back seat ☐ Pedestrian

Were you struck from: ☐ Behind ☐ Front ☐ Left Side ☐ Right Side

Did your vehicle strike another vehicle? ☐ Yes ☐ No Did their vehicle strike your vehicle? ☐ Yes ☐ No

Did the driver of your vehicle get a ticket? ☐ Yes ☐ No Did the driver of the other vehicle? ☐ Yes ☐ No

Did you strike any objects in the car? ☐ Yes ☐ No

☐ Steering Column ☐ Rearview Mirror ☐ Dashboard ☐ Back seat

☐ Door Frame ☐ Headrest ☐ Can't Remember ☐ Other

What portion of your body did you strike?

☐ Head ☐ Chest ☐ Face ☐ Knees ☐ Arms ☐ Other

Were you rendered unconscious, cut or bleeding? ☐ Yes ☐ No

If cut, please explain where: _____

Wearing seat belts? ☐ Yes ☐ No What kind? ☐ Lap ☐ Shoulder ☐ Lap/Shoulder

Did airbags deploy? ☐ Yes ☐ No Were police notified? ☐ Yes ☐ No

Did you see the accident coming? ☐ Yes ☐ No If yes, did you brace for impact? ☐ Yes ☐ No

Where did you go after the accident? ☐ Home ☐ Hospital ☐ Work ☐ Doctor

Were you admitted to the hospital? ☐ Yes ☐ No Name of the hospital: _____

What was done in the hospital? ☐ Exam ☐ X-Rays ☐ MRI ☐ CT Scan ☐ Other_____

Have you lost any days from work due to this accident? ☐ Yes ☐ No Number of day(s) missed: _____

GENERAL SYMPTOMS

Check symptoms you have noticed since the accident:

☐ Headache	☐ Dizziness	☐ Numbness in toes	☐ Face flushed	☐ Feet cold
☐ Neck pain/stiff	☐ Irritability	☐ Depression	☐ Buzzing in ears	☐ Hands cold
☐ Mid back pain	☐ Chest pain	☐ Fatigue	☐ Loss of balance	☐ Stomach upset
☐ Low back pain	☐ Head seems to heavy	☐ Shortness of breath	☐ Fainting	☐ Constipation
☐ Nervousness	☐ Pins & needles in arms	☐ Lights bother eyes	☐ Loss of smell	☐ Cold sweats
☐ Tension	☐ Pins & needles in legs	☐ Loss of memory	☐ Loss of taste	☐ Fever
☐ Sleeping problems	☐ Numbness in fingers	☐ Ringing in ears	☐ Diarrhea	☐ _____

Symptoms other than above: _____

Complaint began when: ☐ Less than 24 hours after accident ☐ 1-7 days after accident

Is the condition: ☐ Improving ☐ Worsening ☐ Staying the Same

Is the frequency of the pain: ☐ Constant ☐ Comes and goes

Circle the Quality of the pain: dull / aching / sharp / shooting / burning / throbbing / tight/stiff / other: _____

Does any pain radiate or travel to any areas of your body: _____

Do you have any numbness or tingling in your body: _____

Grade pain Intensity/Severity: (0 = No pain) 0 1 2 3 4 5 6 7 8 9 10 (10 = Worst possible pain)

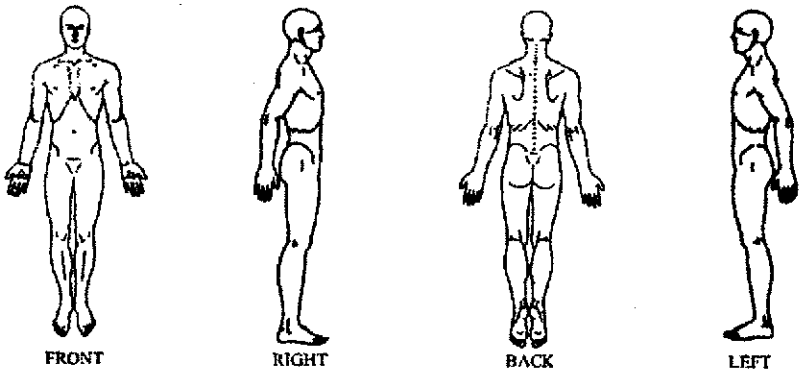
What worsens it? ☐ General activity ☐ Moving wrong ☐ Bending ☐ Lifting ☐ Walking ☐ Standing ☐ Sitting

☐ Using a computer/desk work ☐ Other _____

What makes it better? ☐ Rest ☐ Ice pack ☐ Heating pad ☐ OTC Meds ☐ Rx Meds ☐ Massage ☐ Nothing

Previous doctors, treatments, medications, or surgery you've sought for your complaint: _____

Place an **X** on the areas where you are currently experiencing pain/discomfort.



PAST HEALTH HISTORY:

A. **Previous illnesses you've had in your life:** _____

_____

B. **Previous injury or trauma:** _____

_____

C. **Allergies:** _____

D. **Medications:**

Medication you are now taking	Reason for taking
_____	_____
_____	_____

E. **Surgeries:**

Date	Type of Surgery
_____	_____
_____	_____

F. **Females:**

Are you pregnant: ☐ Yes ☐ No Date of the beginning of your last menstrual period: _____

FAMILY HEALTH HISTORY:

Do you have a family history of:

☐ Cancer ☐ Heart problems/Stroke ☐ Diabetes ☐ Rheumatoid Arthritis ☐ High Blood Pressure

SOCIAL AND OCCUPATIONAL HISTORY:

A. **Level of Education:** ☐ high school ☐ some college ☐ college graduate ☐ post graduate studies

B. **Job description:** _____

C. **Level of activity:** ☐ sedentary ☐ moderate ☐ active ☐ very active

Please check all conditions you currently have or have had

General Questions
- ☐ Weight loss
- ☐ Weight gain
- ☐ Change in sleep patterns
- ☐ Change in activity capacity

Neurologic and Psychiatric
- ☐ Anxiety
- ☐ Headaches
- ☐ Depression
- ☐ Meningitis
- ☐ Paralysis
- ☐ Seizure
- ☐ Stroke
- ☐ Tingling
- ☐ Tremors
- ☐ Memory Loss
- ☐ Dizziness
- ☐ Head injuries
- ☐ Blackouts or near blackouts
- ☐ Change in sensation anywhere on your body
- ☐ Localized weakness or numbness

Ears, Eyes, Nose & Throat
- ☐ Glaucoma
- ☐ Allergy
- ☐ Cataracts
- ☐ Goiter
- ☐ Double vision
- ☐ Gum problems
- ☐ Eye problems
- ☐ Ear infections
- ☐ Hearing Loss
- ☐ Glasses/contacts
- ☐ Ringing in your ears
- ☐ Sinus infections
- ☐ Swollen glands

Cardiovascular
- ☐ Chest Pain
- ☐ Leg cramps
- ☐ Ankle swelling
- ☐ Cardiac catheterization
- ☐ Cold hands or feet
- ☐ Congenital heart defects
- ☐ Dizziness when standing quickly
- ☐ Heart attacks
- ☐ Heart failure
- ☐ High or low blood pressure
- ☐ Irregular heart rate
- ☐ Heart palpitations
- ☐ Murmurs

Respiratory
- ☐ Wheezing
- ☐ Asthma
- ☐ Breathlessness when lying flat
- ☐ Prolonged cough
- ☐ Pneumonia
- ☐ Emphysema
- ☐ Tuberculosis
- ☐ Shortness of breath
- ☐ Frequent infections (bronchitis)

Skin
- ☐ Acne
- ☐ Rashes
- ☐ Hives
- ☐ Lumps
- ☐ Jaundice
- ☐ Psoriasis

Kidneys & Urinary Tract
- ☐ Painful urination
- ☐ Excessive thirst
- ☐ Involuntary urination/incontinence
- ☐ Urinating frequently
- ☐ Frequent bladder infections
- ☐ Kidney disease
- ☐ Kidney stone

Endocrine
- ☐ Abnormal body hair
- ☐ Changes in skin texture
- ☐ Cold intolerance
- ☐ Heat intolerance
- ☐ Increased loss of hair
- ☐ Rheumatism
- ☐ Thyroid disease

Male & Female
- ☐ Painful sexual intercourse
- ☐ Loss of sexual interest
- ☐ Sexually transmitted diseases

Males Only
- ☐ Hernia
- ☐ Prostate disease
- ☐ Testicular pain

Females Only
- ☐ Hernia
- ☐ Endometriosis
- ☐ Hot flashes
- ☐ Fibroids
- ☐ PMS
- ☐ Complications with pregnancy

Musculoskeletal
- ☐ Anemia
- ☐ Back pain
- ☐ Gout
- ☐ Neck pain
- ☐ Easy Bleeding
- ☐ Easy bruising
- ☐ Joint swelling
- ☐ Morning stiffness
- ☐ Muscle aches
- ☐ Arthritis
- ☐ Bursitis
- ☐ Joint aches
- ☐ Tendonitis

Gastrointestinal
- ☐ Diarrhea
- ☐ Reflux
- ☐ Ulcers
- ☐ Vomiting
- ☐ Heartburn
- ☐ Hepatitis
- ☐ Abdominal pain
- ☐ Constipation
- ☐ Nausea
- ☐ Problems swallowing
- ☐ Liver disease

- ☐ Ovarian cysts
- ☐ Heavy bleeding during cycles
- ☐ Pelvic Inflammatory Disease
- ☐ Postmenopausal symptoms

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize Restore Injury Health Center to provide me with chiropractic care, in accordance with this state's statutes.

Patient or Guardian Signature: _____ Date: _____

Doctors Signature: _____ Date: _____