

# W E L C O M E

We look forward to meeting with you at our Fort Myers office.  
We are located in Kenwood Park complex.

12734 Kenwood Lane, Suite 32 Fort Myers FL 33907

When you drive into Kenwood Park, we will be the third building on your right. Our front door is on the west side of the building, around the corner to your right.

Please bring the following forms completely filled out. We look forward to meeting you!





# Patient Information

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

*(Your email will not be shared with any 3<sup>rd</sup> parties and is used for general office announcements, promotions and communication)*

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Cell: \_\_\_\_\_ WK: \_\_\_\_\_ Hm: \_\_\_\_\_

Secondary address (for seasonal patients only) \_\_\_\_\_

City: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Social Security #: \_\_\_\_\_ Birth date \_\_\_\_\_ Marital Status:  M  S  other

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship \_\_\_\_\_

Your Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Who may we thank for referring you to our office? \_\_\_\_\_

**Insurance Information** *you are considered self-pay patient until we qualify and accept your insurance coverage.*

Payment for Services:  Cash  Check  Credit Card  Health Insurance  Automobile Insurance

Insured's Employer: \_\_\_\_\_ Insured's Social Security: \_\_\_\_\_ DOB \_\_\_\_\_

Does more than one insurance company cover you?  Yes  No

Name: \_\_\_\_\_ Policy \_\_\_\_\_ Phone \_\_\_\_\_

Have you ever been under chiropractic care?  Yes  No

DC name \_\_\_\_\_

Who is your primary care physician? \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

By signing below, I authorize Southwest Spine & Sport, Inc. to release any healthcare information regarding treatment to my primary care provider.

**Signature:** \_\_\_\_\_ **Date** \_\_\_\_\_

## Health History

**Please check to indicate if you are currently experiencing any of the following conditions:**

- |  |  |   |  |                                     |
|--|--|---|--|-------------------------------------|
| <input type="checkbox"/> Neck Pain/Stiffness | <input type="checkbox"/> Pins/Needles in Arms  | <input type="checkbox"/> Light Bothers Eyes | <input type="checkbox"/> Sudden Weight Loss    | <input type="checkbox"/> Nausea     |
| <input type="checkbox"/> Back Pain/Stiffness | <input type="checkbox"/> Pins/Needles in Legs  | <input type="checkbox"/> Depression         | <input type="checkbox"/> Loss of Taste         | <input type="checkbox"/> Cold Feet  |
| <input type="checkbox"/> Arm/Hand Pain       | <input type="checkbox"/> Fatigue               | <input type="checkbox"/> Nervousness        | <input type="checkbox"/> Loss of Memory        | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Leg/Knee Pain       | <input type="checkbox"/> Sleeping Difficulties | <input type="checkbox"/> Tension            | <input type="checkbox"/> Jaw Problems          | <input type="checkbox"/> Fever      |
| <input type="checkbox"/> Headaches           | <input type="checkbox"/> Loss of Smell         | <input type="checkbox"/> Cold Sweats        | <input type="checkbox"/> Constipation          | <input type="checkbox"/> Fainting   |
| <input type="checkbox"/> Dizziness           | <input type="checkbox"/> Allergies             | <input type="checkbox"/> Stomach Problems   | <input type="checkbox"/> Shortness of Breath   |                                     |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Blurred Vision        | <input type="checkbox"/> Night Pain         | <input type="checkbox"/> Bowel/Bladder Changes |                                     |

**Please check to indicate if you have ever had any of the following:**

- |   |  |   |   |   |
|---|--|---|---|---|
| <input type="checkbox"/> Aids/HIV           | <input type="checkbox"/> Cancer              | <input type="checkbox"/> Hepatitis          | <input type="checkbox"/> Osteoporosis         | <input type="checkbox"/> Stroke             |
| <input type="checkbox"/> Alcoholism         | <input type="checkbox"/> Cataracts           | <input type="checkbox"/> Hernia             | <input type="checkbox"/> Pacemaker            | <input type="checkbox"/> Suicide Attempt    |
| <input type="checkbox"/> Allergy Shots      | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Herniated Disc     | <input type="checkbox"/> Parkinson's Disease  | <input type="checkbox"/> Thyroid Problems   |
| <input type="checkbox"/> Anemia             | <input type="checkbox"/> Chicken Pox         | <input type="checkbox"/> Herpes             | <input type="checkbox"/> Pinched Nerve        | <input type="checkbox"/> Tonsillitis        |
| <input type="checkbox"/> Anorexia           | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> High Cholesterol   | <input type="checkbox"/> Pneumonia            | <input type="checkbox"/> Tuberculosis       |
| <input type="checkbox"/> Appendicitis       | <input type="checkbox"/> Emphysema           | <input type="checkbox"/> Kidney Disease     | <input type="checkbox"/> Polio                | <input type="checkbox"/> Tumors/Growths     |
| <input type="checkbox"/> Arthritis          | <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Liver Disease      | <input type="checkbox"/> Prostate Problems    | <input type="checkbox"/> Typhoid Fever      |
| <input type="checkbox"/> Asthma             | <input type="checkbox"/> Fractures           | <input type="checkbox"/> Measles            | <input type="checkbox"/> Prosthesis           | <input type="checkbox"/> Ulcers             |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Glaucoma            | <input type="checkbox"/> Migraines          | <input type="checkbox"/> Psychiatric Care     | <input type="checkbox"/> Vaginal Infections |
| <input type="checkbox"/> Breast Lump        | <input type="checkbox"/> Goiter              | <input type="checkbox"/> Miscarriage        | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Venereal Disease   |
| <input type="checkbox"/> Bronchitis         | <input type="checkbox"/> Gonorrhea           | <input type="checkbox"/> Mononucleosis      | <input type="checkbox"/> Rheumatic Fever      | <input type="checkbox"/> Whooping Cough     |
| <input type="checkbox"/> Bulimia            | <input type="checkbox"/> Gout                | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Scarlet Fever        |   |
|   | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Mumps              | <input type="checkbox"/> Other _____          |   |

Are you currently under drug and/or medical care?  Yes  No If yes, explain \_\_\_\_\_

Please list any medications you are currently taking: \_\_\_\_\_

Please list any surgeries and/or hospitalizations you have had (type & date): \_\_\_\_\_

Please list dates of **any automobile accidents** you have been involved in: \_\_\_\_\_

Please list any allergies: \_\_\_\_\_

Please list any supplements you are currently taking (vitamins/herbs/minerals): \_\_\_\_\_

Is there a family history of any of the following conditions? (indicate family member including parents, grandparents & siblings)

- |  |  |
|--|--|
| <input type="checkbox"/> Heart Disease _____ | <input type="checkbox"/> Diabetes _____  |
| <input type="checkbox"/> Cancer _____        | <input type="checkbox"/> Arthritis _____ |
|  | <input type="checkbox"/> Other _____     |

Do you exercise:  Frequently  Moderately  Occasionally  None

Do your work activities mostly involve:  Sitting  Standing  Light Labor  Heavy Labor

Do you sleep on your:  Back  Side  Stomach Do you use a cervical pillow?  Yes  No

What is your daily/weekly intake of the following:

Caffeine \_\_\_\_\_ cups/day Alcohol \_\_\_\_\_ drinks/week Cigarettes \_\_\_\_\_ packs/day

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

**Signature:** \_\_\_\_\_ **Date** \_\_\_\_\_



**Consent for Treatment:**

A patient coming to the doctor gives him/ her permission and authority to care for them in accordance with appropriate test, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases underlying physical defects, deformities or pathologies, may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/ she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/ she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the physician.

I agree to settle any claim or dispute I may have against or with any of these persons or entities, whether related to the prescribed care or otherwise, will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

I have read, or have had read to me, the above consent. I have also had the opportunity to ask questions regarding its content, and by signing below I agree to the above named procedures. I intend this consent form to cover treatment for my present condition, as well as all future conditions for which I seek treatment.

**Signature:** \_\_\_\_\_ **Date** \_\_\_\_\_

**Massage Therapy PATIENT MISSED APPOINTMENT POLICY**

We have to insist on a \$60 service charge for any NO CALL / NO SHOW appointments made with our LMTs. Thank you for your understanding.

*I have read, understand, and agree to follow the above policy.*

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

**Signature:** \_\_\_\_\_ **Date** \_\_\_\_\_



**PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our Notice before signing this form. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy by phoning our office at 239-274-8005. Or downloading it off our website at [www.southwestspine.com](http://www.southwestspine.com).

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations as described in our Notice. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I acknowledge that I have reviewed the Notice of Privacy Practices of Southwest Spine and Sport, Inc. (Please initial one of the following options and sign below.)

I acknowledge that it is the policy of South to leave reminder messages on my answering machine or with another person in my home. I may make a request of an alternative means of communication (within reason) in writing.

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

**Signature:** \_\_\_\_\_ **Date** \_\_\_\_\_