



4347 S. U.S HWY 27  
CLERMONT, FL 34711  
PH. (352)243-7300  
FAX (352)243-7355

# NEW PATIENT QUESTIONNAIRE

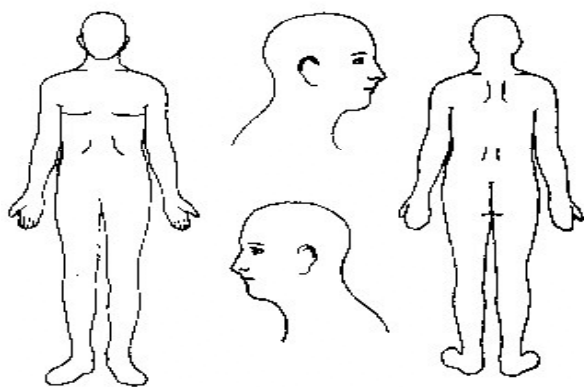
Family Chiropractic

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ How did you hear about our office? \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Age: \_\_\_\_\_ S.S. # \_\_\_\_\_  
 Address \_\_\_\_\_ Apt # \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
 Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_ E-mail \_\_\_\_\_  
 Contact in case of an emergency \_\_\_\_\_ Phone # \_\_\_\_\_ Relationship \_\_\_\_\_  
 Your Occupation \_\_\_\_\_ Employer \_\_\_\_\_

FEMALES: Are you pregnant? \_\_\_ No \_\_\_ Yes If yes, How many weeks? \_\_\_ Date of last menstrual cycle? \_\_\_  
 Chief complain for today's visit? \_\_\_\_\_  
 How long have you had this condition? \_\_\_\_\_ Date when symptoms first appeared: \_\_\_\_\_  
 Have you had this condition before? Y N If Yes, When? \_\_\_\_\_  
 Is this condition related to : ↑ Work ↑ Auto Date of accident: \_\_\_\_\_ Have you lost days from work? Y N  
 What doctors have you seen for this condition? \_\_\_\_\_  
 What did they do? \_\_\_\_\_  
 When was your last visit to the Chiropractor? \_\_\_\_\_ Were you helped? \_\_\_\_\_  
 What spinal correction program were you given? \_\_\_\_\_  
 Did you follow it? If not, why? \_\_\_\_\_ How did the post-x-rays look? \_\_\_\_\_  
 What surgeries have you had? \_\_\_\_\_  
 List drugs you now take (prescription 7 non-prescription) \_\_\_\_\_  
 Are you currently wearing: Heel Lifts \_\_\_\_\_ Arch supports \_\_\_\_\_ Back Brace \_\_\_\_\_

*Please mark X for present conditions, O for past conditions*

<input type="checkbox"/> Fractured bones	<input type="checkbox"/> Sinus Problems	<input type="checkbox"/> Fainting	<input type="checkbox"/> Varicose Veins
<input type="checkbox"/> Auto Accidents	<input type="checkbox"/> Eating Disorders	<input type="checkbox"/> Loss of Balance	<input type="checkbox"/> Liver Trouble
<input type="checkbox"/> 0-1 year ago	<input type="checkbox"/> Trouble Sleeping	<input type="checkbox"/> Blurred vision R L	<input type="checkbox"/> Gall Bladder Trouble
<input type="checkbox"/> 1-5 years ago	<input type="checkbox"/> Trouble Concentrating	<input type="checkbox"/> Double Vision R L	<input type="checkbox"/> Digestive Problems
<input type="checkbox"/> more that 5 years ago	<input type="checkbox"/> Learning Disability	<input type="checkbox"/> Upper Back Pain/Stiffness	<input type="checkbox"/> Heartburn
<input type="checkbox"/> Other accidents/ Falls	<input type="checkbox"/> Mood changes	<input type="checkbox"/> Mid back Pain/Stiffness	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Back curvature	<input type="checkbox"/> Headache	<input type="checkbox"/> Low BackPain/Stiffness	<input type="checkbox"/> Diarrhea/Constipation
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Pain/Stiff Neck R L	<input type="checkbox"/> Numbness, Tingling or Pain	<input type="checkbox"/> Colon Trouble
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Numbness/Tingling/Pain	<input type="checkbox"/> in buttocks, thighs, legs, feet, toes.	<input type="checkbox"/> Hemorrhoids
<input type="checkbox"/> Swollen/Painfull joints	<input type="checkbox"/> Arms/Hands/Fingers	<input type="checkbox"/> Pain with cough, sneeze	<input type="checkbox"/> Prostate Problems
<input type="checkbox"/> Convulsions/Epilepsy	<input type="checkbox"/> R or L	<input type="checkbox"/> Hip Pain	<input type="checkbox"/> Impotence
<input type="checkbox"/> Skin Problems	<input type="checkbox"/> Jaw Pain/ TMJ R L	<input type="checkbox"/> Foot Trouble R L	<input type="checkbox"/> Kidney Trouble
<input type="checkbox"/> Cancer	<input type="checkbox"/> Head/Shoulders Feel Tired	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Menstrual Problems
<input type="checkbox"/> Frequent Colds/Flu	<input type="checkbox"/> Difficulty in Excessive	<input type="checkbox"/> Asthma	<input type="checkbox"/> Menopausal Problems
<input type="checkbox"/> Depressed	<input type="checkbox"/> Standing Lifting	<input type="checkbox"/> Lung Problems	<input type="checkbox"/> Pregnant (Now)
<input type="checkbox"/> Irritable	<input type="checkbox"/> Walking Household duties	<input type="checkbox"/> Difficulty breathing	<input type="checkbox"/> Bed Wetting
<input type="checkbox"/> Anemia	<input type="checkbox"/> Bending Twisting	<input type="checkbox"/> Heart Problem	<input type="checkbox"/> Ear Infection
<input type="checkbox"/> Tremors	<input type="checkbox"/> Riding	<input type="checkbox"/> Stroke	<input type="checkbox"/> AIDS/HIV
<input type="checkbox"/> Allergies	<input type="checkbox"/> Shoulder Pain R L	<input type="checkbox"/> High/Low Blood Pressure	<input type="checkbox"/> Last Menstrual Period



Place an "X" on the drawing on areas causing you pain and a letter describing it

**S = STABBING**  
**N = NUMBNESS**  
**B = BURNING**  
**A = ACHING**  
**P = PINS & NEEDLES**

### PAIN INTENSITY

Please circle the number that best describes your pain

0 1 2 3 4 5 6 7 8 9 10  
 NONE LITTLE MEDIUM SEVERE

Patient Signature \_\_\_\_\_



---

**PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED  
HEALTH INFORMATION**

I hereby give my consent for Michaux Family Chiropractic (hereinafter referred to as the “Practice”) to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). The Practice’s Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy prior to signing this consent. The practice reserves the right to revise its Notice of Privacy Practice any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to:

**Dr. Kurtis Michaux, our Privacy Officer, at the following address:  
4347 South U.S. Hwy 27 Clermont, FL 34711**

With this consent, the practice may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and calls pertaining to my clinical care, including laboratory result among others.

With this consent, the Practice may mail to my home or other alternative location any items that assists the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they marked Personal and Confidential.

With this consent, The Practice may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that the Practice restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to the Practice’s use and disclosure of my PHI to carry out TPO. I make revoke my consent in writing except to the extent that the Practice has already made disclosures in reliance upon my prior consent.

If I do not sign this consent, or later revoke it, the Practice may decline to provide treatment to me.

---

Signature of Patient or Legal Guardian

---

Patient’s Name

---

Print Name of legal Guardian (If patient is a minor)

---

(Date)



---

**TERMS OF ACCEPTANCE AND CONSENT FOR CARE**  
**THIS DOCUMENT CONSTITUTES INFORMED CONSENT FOR CHIROPRACTIC CARE**

Our office has one goal, to aid the patient in achieving optimal health as quickly and safely as possible, through the removal of interference in their body. We do this through safe and gentle chiropractic care.

We will attempt to identify and diagnose any ailments you may have that may be corrected through chiropractic care, massage therapy and/or active/passive rehabilitation. If any condition or disease appears to be present out of our scope of practice, we will refer you to an appropriate physician to diagnose and/or treat that condition.

Our primary focus is the detection and correction of vertebral subluxation. This is the misalignment of one spinal bone or multiple bones with interference to the nervous system. Any interference to the nervous system may or may not cause various different symptoms. Again, our focus is to correct the cause, not the symptom.

Vertebral subluxations come on from physical, chemical, and/or emotional stress or trauma. Through specific chiropractic adjustments, we reduce and/or correct these subluxations. It is also important to note that the sooner we are able to treat your subluxations and the degenerative processes that are involved the faster and more completely your body will heal. It may be necessary to examine an individual each time a new injury occurs and often x-rays are necessary to maintain the utmost safety when dealing with your body. The risks of chiropractic care or massage therapy are minimal when dealing with a licensed professional; however, if you have concerns about these risks, please discuss them with the doctor prior to the examination.

I have read and I accept the terms above and understand them fully. I hereby give consent to the MICHAUX FAMILY CHIROPRACTIC to evaluate me to determine my condition and treat me for such conditions. I also understand that I may at anytime discontinue with the exam and/or x-rays or any treatment if I so choose.

I, \_\_\_\_\_ have read and fully understand the above statements.  
(PRINT NAME)

\_\_\_\_\_  
(SIGNATURE)

\_\_\_\_\_  
(DATE)

Complete if patient is a minor child. \_\_\_\_\_  
(PRINT CHILD'S NAME)

I, \_\_\_\_\_ being the parent or legal guardian of the aforementioned child, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive treatment.

\_\_\_\_\_  
(SIGNATURE)

\_\_\_\_\_  
(DATE)



---

## OFFICE POLICIES

1. It is our office policy that any patient and /or insurance company that pays up-front or in advance is entitled to an administrative discount.
2. The fee paid for treatment x-rays is for analysis only. The film itself is the property of this office. Once films are used for treatment purposes, they cannot be released.
3. If you have a co- insurance or any out of pocket responsibility what will be your method of payment?

Cash       Check       Visa/Master Card

I understand and agree that health and accident insurance policies are an agreement between and insurance carrier and myself. Furthermore, I understand Michaux Family Chiropractic will prepare any necessary any necessary reports, and forms to assist in making collections from my insurance company and that any amount authorized to be paid directly to Michaux Family Chiropractic will be credited to my account upon receipt. *However*, I clearly understand and agree that all services rendered to me, are charged directly to me and that I am personally responsible for payment.

I also understand that if I suspend or terminate my care at this office ,any outstanding charges for professional services rendered to me will be immediately due and payable. I agree that I will be responsible for all attorney and legal fees if legal action becomes necessary to collect this amount.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian Signature authorizing care: \_\_\_\_\_ Date: \_\_\_\_\_

In case of emergency notify: \_\_\_\_\_

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

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

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_