DR. ERICA LOPEZ, LLC
730 S. Sterling Ave, Suite 214
TAMPA, FL 33609
(813)280-9696

First Name: _____ **Last Name:** _____ **DOB:** _____ **Age:** _____

☐ **Male** ☐ **Female** **Ethnicity** _____ **SS#**_____

Phone# (Cell)_____**(Home)**_____**(Work)** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Email: _____ **Can we email appointment reminders? YES NO**

Circle One: Employed / Unemployed / Retired / Student **Employer:** _____

Circle One: Single / Married / Divorced / Separated / Widowed **Spouse Name:** _____

How many children? _____ **Names & Ages:** _____

FEMALES: Are you pregnant? Y / N **Last Menstrual Cycle:** _____ **If Yes, how many weeks?** _____

Most patients are referred to our office. What made you decide to visit our office?

☐ **Friend/Family** _____ ☐ **Telephone Call** ☐ **Website/Internet** ☐ **Other** _____

When was your last spinal evaluation, including X-rays? _____ ☐ **Never**

Who is responsible for your bill? **You** ☐ **I have been in an accident.** ☐ **Auto** ☐ **Other**_____

Poor posture leads to poor health and often indicates a spinal problem. How would you rate your posture?

Poor 1-----2-----3-----4-----5-----6-----7-----8-----9-----10 Excellent

MAJOR (Primary) COMPLAINT: _____ **Date symptoms first appeared:** _____

Have you had this condition before? Y / N **How long have you been experiencing your complaint? Days Weeks Months Years**

Type of pain: Sharp Dull Ache Stiff Shooting Burning Throbbing Tingling Numb Stabbing

Is your condition getting… Same / Better / Worse Pain worse in: AM / PM Does the pain radiate? Y / N If so, Where? _____

What makes the condition worse? Sitting / Standing / Lying / Walking / Activity / Other _____

What treatments have you tried that have NOT worked? _____

Circle the severity of your complaint when at its worst: Mild 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10 Severe

Circle the percentage of time daily you experience your complaint: 10%----20%----30%----40%----50%----60%----70%----80%----90%----100%

OTHER COMPLAINT(S): _____ **Date symptoms first appeared:** _____

Have you had this condition before? Y / N **How long have you been experiencing your complaint? Days Weeks Months Years**

Type of pain: Sharp Dull Ache Stiff Shooting Burning Throbbing Tingling Numb Stabbing

Is your condition getting… Same / Better / Worse Pain worse in: AM / PM Does the pain radiate? Y / N If so, Where? _____

What makes the condition worse? Sitting / Standing / Lying / Walking / Activity / Other _____

What treatments have you tried that have NOT worked? _____

Circle the severity of your complaint when at its worst: Mild 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10 Severe

Circle the percentage of time daily you experience your complaint: 10%----20%----30%----40%----50%----60%----70%----80%----90%----100%

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HEALTH HISTORY:
Patient Name:_____

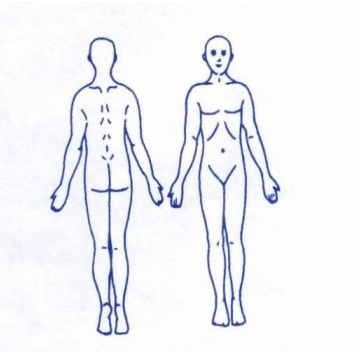
Major Surgery / Operations _____

Medications you currently are taking: _____

Trauma History: Auto Accidents _____
Slips / Falls_____
Work / Sports _____
Other _____

Who is your Primary Care Doctor? _____ **Phone #:** _____

CERVICAL:	**Neck Pain or Tension**	**Sinus Infections**	**Tinnitus (Ringing in Ears)**
	Pain / Tension across shoulders	**Headaches / Migraines**	**Allergies / Asthma**
	Numbness / Tingling down arm(s)	**Depression / Anxiety**	**Ear Infections**
	Vertigo / Dizziness	**Difficulty Sleeping**	**Fatigue**
THORACIC:	**Mid Back Pain or Tension**	**Acid Reflux / Heartburn**	**High / Low Blood Pressure**
	Difficulty Breathing	**Indigestion / Gas**	**Stress**
	Chest Pains	**Carpal Tunnel Syndrome**	**Lowered Immunity**
LUMBAR:	**Low Back Pain or Tension**	**Loss of Appetite**	**Frequent Urination**
	Sciatica	**Prostate Problems**	**Kidney / Bladder problems**
	Numbness / Tingling down leg(s)	**Menstrual Irregularities**	**Plantar Fasciitis**
	Constipation / Diarrhea	**Sexual Dysfunction**	**Joint Pain / Stiffness**



PAIN DIAGRAM

Place an 'X' on the drawing where you experience pain. Please be sure to mark ALL areas of discomfort.

Are you currently taking nutritional supplements? YES / NO

Please list all Supplements:
_____
_____

How would you rate your quality of sleep: Poor / Average / Good / Great?

Regarding your sleep quality: Difficulty falling asleep / Wake up more than 1 time per night

How often do you exercise: None / Daily / Moderate / Heavy?

Type of Exercise: _____

Do you consume: Coffee / Cigarettes / Alcohol / Over the Counter Meds / Sugar

How would you rate your daily energy level on a scale of 1 – 10? _____

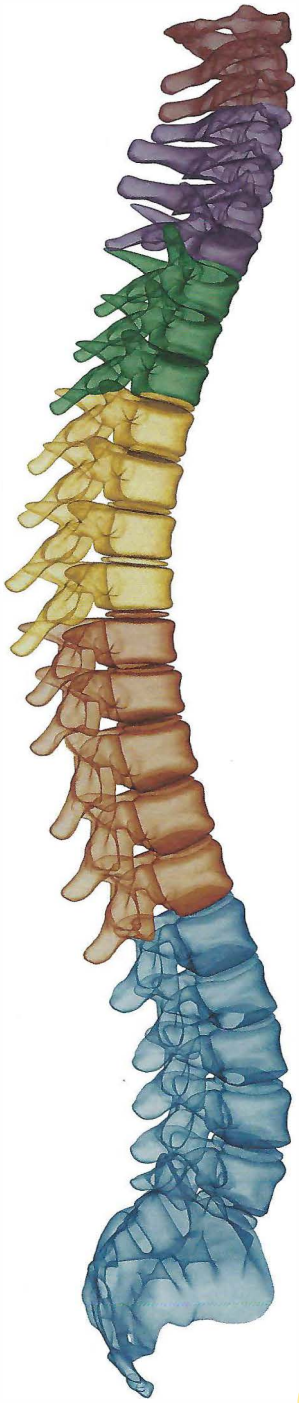
Are there any health concerns you would like to discuss today?
_____
_____

Patient Review of Systems

THE NERVOUS SYSTEM CONTROLS AND COORDINATES ALL ORGANS AND STRUCTURES OF THE HUMAN BODY

Please check the corresponding boxes for each symptom or condition you have experienced – including both past and present.

Dr. Erica LOPEZ
CHIROPRACTOR



REGIONS	FUNCTIONS	SYMPTOMS			
		PAST	PRESENT		
Cervical	• Autonomic Nervous System • ENT System • Vision, Balance & Coordination • Speech • Immune System • Digestive System • Nerve Supply to Shoulders, Arms & Hands • Sympathetic Nucleus • Metabolism	☐	☐	Colic & Excessive Crying	
		☐	☐	Ear & Sinus Infections	
		☐	☐	Allergies & Congestion	
		☐	☐	Immune Deficiency	
		☐	☐	Headaches & Migraines	
		☐	☐	Vertigo & Dizziness	
		☐	☐	Sore Throat & Strep	
		☐	☐	Swollen Tonsils & Adenoids	
		☐	☐	Vision & Hearing Issues	
		☐	☐	Low Energy & Fatigue	
		☐	☐	Difficulty Sleeping	
		☐	☐	Pain, Numbness & Tingling in Arms to Hands	
		☐	☐	Epilepsy & Seizures	
		☐	☐	Sensory & Spectrum	
		☐	☐	ADD / ADHD	
		☐	☐	Focus & Memory Issues	
		☐	☐	Anxiety & Stress	
		☐	☐	Balance & Coordination	
		☐	☐	Speech Issues	
		☐	☐	TMJ / Jaw Pain	
		☐	☐	Stiff Neck & Shoulders	
		☐	☐	Depression	
		☐	☐	High Blood Pressure	
		☐	☐	Poor Metabolism & Weight Control	
Upper Thoracic	• Upper G.I. • Respiratory System • Cardiac Function	☐	☐	Reflux / GERD	
		☐	☐	Chronic Colds & Cough	
		☐	☐	Asthma	
		☐	☐	Bronchitis & Pneumonia	
		☐	☐	Functional Heart Conditions	
Mid Thoracic	• Major Digestive Center • Detox & Immunity	☐	☐	Gallbladder Pain / Issues	
		☐	☐	Jaundice	
		☐	☐	Fever	
		☐	☐	Indigestion & Heartburn	
		☐	☐	Stomach Pains & Ulcers	
		☐	☐	Blood Sugar Problems	
Lower Thoracic	• Stress Response • Filtration & Elimination • Gut & Digestion • Hormonal Control	☐	☐	Behavior Issues	
		☐	☐	Hyperactivity	
		☐	☐	Chronic Fatigue	
		☐	☐	Chronic Stress	
		☐	☐	Allergies & Eczema	
		☐	☐	Skin Conditions / Rash	
		☐	☐	Kidney Problems	
		☐	☐	Gas Pain & Bloating	
Lumbar, Sacrum & Pelvis	• Lower G.I. (Absorption & Motility) • Gut-Immune System • Major Hormonal Control	☐	☐	Constipation	
		☐	☐	Crohn's, Colitis & IBS	
		☐	☐	Diarrhea	
		☐	☐	Bed-wetting	
		☐	☐	Bladder & Urination Issues	
		☐	☐	Cramps & Menstrual Issues	
		☐	☐	Cysts & Endometriosis	
		☐	☐	Infertility	
		☐	☐	Impotency	
		☐	☐	Hemorrhoids	
		☐	☐	Sciatica & Radiating Pain	
		☐	☐	Lumbopelvic / SI Joint Pain	
		☐	☐	Hamstring Tightness	
		☐	☐	Disc Degeneration	
		☐	☐	Leg Weakness & Cramps	
		☐	☐	Poor Circulation & Cold Feet	
		☐	☐	Knee, Ankle & Foot Pain	
		☐	☐	Weak Ankles & Arches	
		☐	☐	Lower Back Pain	
		☐	☐	Gluten & Casein Intolerance	

Patient Name: _____ Date: __/__/__

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Patient Consent for Use and Disclosure of Protected Health Information

Dr. Erica Lopez, LLC

I hereby give my consent for Dr. Erica Lopez, LLC to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

Dr. Erica Lopez, LLC Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Dr. Erica Lopez, LLC reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Dr. Erica Lopez, LLC Privacy officer at:

730 S Sterling Ave, Suite 214, Tampa, FL 33609

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

With this consent, Dr. Erica Lopez, LLC may mail to my home or other alternative locations any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With this consent, Dr. Erica Lopez, LLC may email to my home or other alternative locations 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 Dr. Erica Lopez, LLC restricts 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 Dr. Erica Lopez, LLC's use and disclosure of my PHI to carry out TPO.

I may 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 Dr. Erica Lopez, LLC may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____ _____
Patient's Name **Date**

_____
Print Name of Patient or Legal Guardian

INFORMED CONSENT FOR TREATMENT

PATIENT NAME:

Physicians and other health care providers are required to obtain your informed consent before starting treatment.

I _____ do hereby give my consent to the performance of chiropractic treatment that may consist of manipulations/adjustments, physical medicine and exercises. I understand that the manipulations/adjustments will involve movement of the joints and soft tissues that is considered to be one of the safest and most effective form of therapy for musculoskeletal problems.

I am aware that there are possible risks/complications associated with my treatment. Tests have been performed to minimize these risks. I freely assume the risks of treatment after having been informed of the possible risks/complications associated with my treatment as follows:

***Soreness**: It is common to experience muscle soreness during treatment.*
***Uncomfortableness**: Temporary symptoms (dizziness, nausea) can occur, but are rare.*
***Fractures/Joint Injury**: Underlying physical defects, deformities or pathologies (osteoporosis) may cause susceptibility to injury.*
***Stroke**: Strokes from chiropractic adjustments are rare.*
***Burns**: Some therapies used generate heat and may, in rare cases, cause burns.*

Treatment results: I understand there are benefits associated w/treatment including decreased pain, improved mobility and function, and reduced muscle spasms. However, I also understand there is no guarantee that I will achieve these benefits during my care, as the practice of medicine, including chiropractic, is not an exact science.

Alternative Treatments Available: Reasonable alternatives to treatment have been explained to me including rest, home therapy, exercises, medication and possible surgery.

I agree to treatment by my doctor and such persons of the doctor's choosing and provide my informed consent for treatment.

I HAVE READ OR HAVE HAD READ TO ME THE ABOVE EXPLANATION OF CHIROPRACTIC TREATMENT. ANY QUESTIONS REGARDING TREATMENT HAVE BEEN ANSWERED TO MY SATISFACTION.

_____
Patient's Signature

_____
Witness Signature

_____
Date

PATIENT STATUS AT TIME OF CONSENT:

( ) OF LEGAL AGE
( ) ORIENTED x3
( ) COHERENT/LUCID
( ) PROFICIENT ENGLISH
( ) ASSISTED BY INTERPRETER

_____

( ) MEDICATED, BUT UNIMPAIRED
( ) DENIES USE OFALCOHOL OR RECREATIONAL DRUGS PRIOR TO CONSENT
( ) UNABLE TO GIVE LEGAL CONSENT
( ) CONSENT VIA LEGAL GUARDIAN

_____

Patient's questions (if any) and responses are as follows:

Comments:

I certify that this form accurately reflects the patient's status during the informed consent process.

_____
Doctor Signature

_____
Date