Intake Questionnaire

Patient Name: _____ ***Date of Birth:*** _____

Parent/Guardian*:* _____

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

Email: _____ ***(Cell/Home):*** _____

Sex: *Male or Female* ***Today's Date:*** _____

How did you hear about us? _____

What is the reason for your visit today? (circle):

Auto Accident Slip and Fall Pregnancy Pediatric Wellness

Have you been to a chiropractor before? *Yes or No*

Are you: *Employed / Unemployed / Retired / Student*

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

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

_____

****FEMALES**** *Are you pregnant? Y / N If yes, how many weeks?* _____

Last Menstrual Cycle: _____

When was your last spinal evaluation, including X-rays? _____

Poor posture leads to poor health and often indicates a spinal problem.

How would you rate your posture? (1 being poor - 10 being excellent) ____

Medication/ Supplements: _____

What brings you to the chiropractor: _____

When did the condition first occur? _____

Was the condition (Sudden, gradual, post injury)? _____

Is the condition getting (worse, improving, constant, intermittent): _____

What makes the condition worse? _____

What makes the condition better? _____

How long have you experienced this complaint? _____

Type of Pain: (Circle)

Sharp Dull Ache Stiffness Shooting Burning Throbbing Numb Stabbing

Is your pain worse? *AM PM Both*

What would you like to gain from chiropractic? (Circle) *Resolve existing Overall Wellness Both*

Have you had any major surgery/operations we should know about? _____

_____

Trauma History:

*Slip and falls*_____*Work/Sports*_____*Other*_____

Who is your Primary Care? _____

How is your quality of sleep? *Poor / Average / Good / Great*

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

How would you rate your energy? _____

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

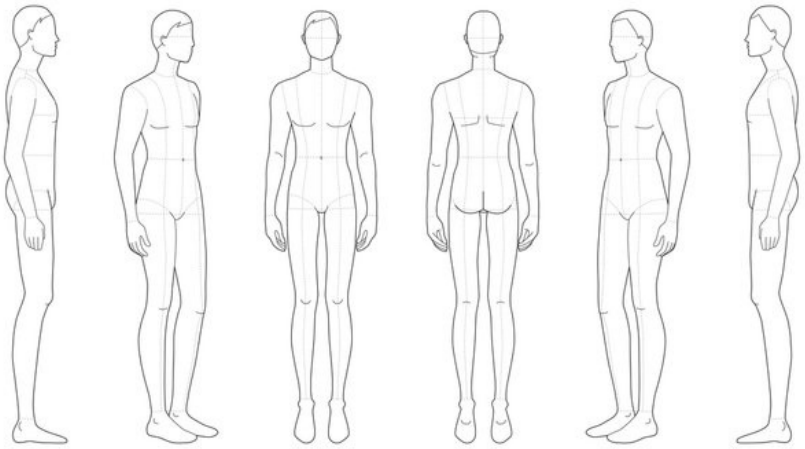
_____

_____ _____

Patient or Parent/ Guardian Signature ***Date***

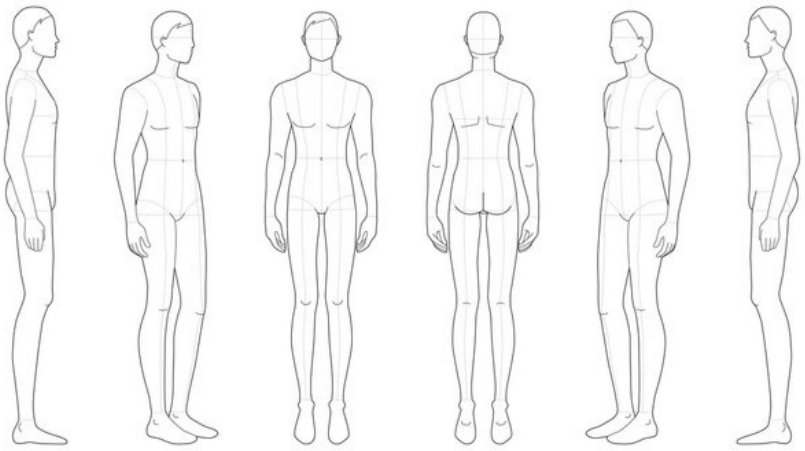
Pain Diagram:

Place an "X" on any areas where there is pain:



Right Side Right Front Front Back Left Front Left Side

Circle areas that are experiencing numbness and tingling:



Right Side Right Front Front Back Left Front Left Side

_____ _____

Patient or Parent/ Guardian Signature Date

Pediatric:

Is your child receiving care from any other health professionals? _____
If yes, please name them and specialty: _____
What health concerns bring your child to be evaluated and treated by a chiropractor? _____
What are your top three goals for your child:
1._____
2._____
3._____
Please tell us about your pregnancy:
Any fertility issues? *Yes or No* ***If yes, please explain:*** _____
Did mother smoke? *Yes or No* ***If yes, how many per week?*** _____
Did mother exercise? *Yes or No.* ***If yes, please explain:*** _____
Was mother ill? *Yes or No* ***If yes, please explain:*** _____
Any ultrasounds? *Yes or No* ***If yes, please explain:*** _____
Please explain any notable episodes of mental or physical stress during pregnancy:
_____
Please explain any other concerns or notable remarks about your child's conception or pregnancy:
_____
Child's birth was? (Circle) *At Home Birthing Center Hospital Other* ***Doctor's Name:*** _____
Please indicate any applicable interventions or complications: (Circle)
Breech Induction Pain Meds Epidural Episiotomy Vacuum Extraction Forceps Other
Child's Birth Wt: _____ ***Child's Birth Ht:*** _____ ***APGAR Score at birth:*** _____ ***APGAR Score after birth:*** _____
Was your child breastfed? _____ ***How long?*** _____ ***Difficulty?*** _____
Did child ever use formula? _____***What age?*** _____ ***What type?*** _____
Did/Does your child suffer from colic, reflux, or constipation? _____
If yes, please explain: _____
Did/Does your child frequently arch their neck/back, feel stiff, or bang their head? *Yes or No*
If yes, please explain: _____
What age did your child:
Respond to sound? _____ ***Follow an object?*** _____ ***Hold their head up?*** _____
Vocalize? _____***Teethe?*** _____ ***Sit Alone?*** _____***Crawl?*** _____ ***Walk?*** _____
Begin cow's milk_____ ***Begin solid foods***_____
Food intolerance or allergies, when did they start? _____
_____
Major hospitalizations/injuries/surgery history: _____
_____
Has your child received antibiotics? *Yes or No* ***If yes how many times and reason:*** _____
_____
Behavioral/ social issues? _____
How would you describe your child's diet? *Average / Mostly whole, organic foods / processed foods*

_____ _____
Patient or Parent/ Guardian Signature ***Date***

Pregnancy:

Is this your first pregnancy? *Yes or No* ***How many weeks are you?*** _____
If not, please tell us about your previous pregnancy/birth experience(s). (Durations, intervention, etc.):
_____
Do you plan to follow the same plan as your pervious delivery? *Yes or No*
If no, what would you change? _____
When is your expected due date? _____ ***Did you have trouble conceiving?*** *Yes or No*
If yes, please explain: _____
Have you used any forms of hormonal or oral contraceptive? *Yes or No* ***If yes, which and how long?***
_____
Last menstrual cycle: _____ ***Pre-pregnancy weight?*** _____ ***Current weight?*** _____
Have you experienced morning sickness? *Yes or No* ***If yes, please explain:*** _____
_____
What type of exercise are you currently performing? _____
Please tell us about your current diet and any dietary restrictions: _____
_____
Have you taken any medication or supplements during your pregnancy? *Yes or No*
If yes, please explain: _____
Have you had any slips, falls, or other physical traumas during the pregnancy? *Yes or No*
If yes, please explain: _____
Have you had any major emotional stressors during your pregnancy? *Yes or No*
If yes, please explain: _____
Your Birth Plan:
What are your top three goals for this pregnancy
*1.*_____
*2.*_____
*3.*_____
Do you currently have a birth plan? *Yes or No*
If yes, please explain: _____
Are you taking prenatal or birthing classes? *Yes or No*
If yes, please explain: _____
Who is your OBGYN/ Midwife? _____
Will they be present for the delivery? *Yes or No*
Who is your birth provider? _____
Do you intend to have a doula or birth coach present? *Yes or No*
If yes, please explain: _____
Do you wish to have a natural birth? *Yes or No*
If no, please explain: _____
Post Birth Plan:
Do you plan on breastfeeding? *Yes or No* ***What do you intend to do for vaccines?***
_____
Is there anything else you would like to tell us about your birth plan? _____
_____

_____ _____
Patient Signature ***Date***

Auto Accident/ Slip and Fall:

Have you been involved in an auto accident in the last 14 days? *Yes or No*
Adjuster's Name: _____ Adjuster's #: _____
Medical Claim #: _____ Auto Insurance Carrier: _____
***Slip/Fall (If not applicable please skip) ***
Where did the accident take place? _____
Have you retained an attorney? *Yes or No*
Attorney Name: _____ Attorney #: _____

Please describe accident:

_____

_____
Date of and time of accident: _____

Were you the (circle one): *Driver Front Passenger Rear Passenger*
Was this result of a slip and fall? *Yes or No*

Was there a traffic violation, who was at fault? _____
How many people were in the car at the time? _____
Did the police come to the accident site? *Yes or No* ***Was a police report filed?*** *Yes or No*
Were there any witnesses? *Yes or No* ***Were you wearing your seat belt?*** *Yes or No*
Was this vehicle equipped with airbags? *Yes or No* ***If YES, did it/they inflate?*** *Yes or No*
In relation to the base of your skull, where was the headrest?
__ Above __ Below __ At Base of Skull
In relation to the base of your skull, where was the headrest?
___ Above ___ Below ___ At Base of Skull

What did your vehicle impact? ___*Another Vehicle* ***___****Other*
If Other Explain: _____
Did any part of your body strike anything in the vehicle? ___*YES* ***___****NO*
If yes, please describe: _____
Make & Model of the vehicle you were occupying? _____
Name of the location/street on which you were traveling?
_____
In which direction were you heading? ___*N* ***___****S* ***___****E* ***___****W***
What was the approx. speed of your vehicle? _____

Did you lose consciousness? *Yes or No* ***If so, how long: _____***
How did you feel immediately after the accident/slip and fall? _____
_____
Did you go to the hospital/urgent care: *Yes or No* ***Name of Facility: _____***
Name of Physician: _____ Was he/she a (circle): *D.C. M.D. D.D.S.*
When did you go? (circle): *After Accident Next Day Two Days or More*
How did you get there? _____
Describe Treatment, if any: _____
Were X-Rays taken? *Yes or No* ***Was medication prescribed?*** *Yes or No*
Have you been able to work since the injury occurred? *Yes or No*
Are your activities restricted at work/home since the accident? *Yes or No*

Please indicate any symptoms that are a result of the incident:

__Dizziness __Difficulty Sleeping __Jaw Problems __Nausea
__Memory Loss __Irritability __Arms/Shoulder Pain __Back Pain
__Headache(s) __Fatigue __Numb Hands/Fingers __Lower Back Pain
__Blurred Vision __Tension __Chest Pain __Back Stiffness
__Buzzing in Ear __Neck Pain __Shortness of Breath __Leg Pain
__Ears Ringing __Neck Stiffness __Stomach Upset __Numb Feet/Toes
__Other_____

Is your condition getting worse? *_ Yes _No _ Constant _Comes and Goes*

To evaluate the effect that continuing work will have on your recovery please complete the following:
How many hours are in your normal weekday? _____

Indicate your daily job duties/activities which you are occasionally asked to perform:
__Standing __Driving __Operating equipment
__Sitting __Twisting __Working with arms above head
__Walking __Crawling __Typing
__Lifting __Bending __Stooping
__Other _____

What positions can you work in with minimum physical effort and for how long?
_____
Prior to the injury were you capable of working on an equal basis with others your age?
__YES __NO __N/A
Do you work with others who can help you with any heavy lifting? __*Yes __No __N/A*
While in recovery, is there any light duty wok you could request? __*Yes __No __N/A*

If any of your medical or account information has changed, please inform our front desk personnel. Please remember you are ultimately responsible for your account

_____ _____
Patient or Parent/ Guardian Signature ***Date***

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: _____Parent/Guardian: _____

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

Medical Records Authorization

To: _____
_____
P: _____
F: _____

I _____ hereby authorize and request you to release a complete copy of my medical records to:

Erica Lopez, DC
730 S. Sterling Ave, Suite 214
Tampa, FL 33609-4542
P: (813)280-9696
F: (813) 492-2695

Patient Name: _____
DOB: _____

Notes:

_____
_____
_____

Patient Signature: _____ Date: _____

HIPPA Release of Information
Media Release of Authorization Form

I, _____, hereby authorize Dr. Erica Lopez and authorized employees to publish my personal health information/story (e.g my patient testimonial or information relating to the diagnosis, treatment, and health care services provided to me. I authorize this information to be used in the form of images or videos on the following social media platforms: Instagram, Facebook, or www.drericalopez.com.
I understand that I have a right to revoke this authorization by providing written notice to Dr. Erica Lopez. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for care as a patient.

___I decline at this time. Should I change my mind I will notify staff and complete a new form.

Print Name of Patient: _____
Signature of Patient: _____
Date: _____