Dr. Archana Mehta
Chiropractic Physician

Dr. Susan Yi
Chiropractic Physician

Dr. Ashley Sooklal
Chiropractic Physician

5537 Sheldon Rd. Suite T Tampa FL 33615
Tel: 813-885-5786

13301 Orange Grove Dr. Suite A Tampa FL 33618
Tel: 813-963-3055

Fax: 813-886-0559

Chiropractic Case History / Patient Information

Date: ______________

Name:__________________________ Social Security #:_____-_____-_____ Home Phone:(___)______-_______

Address:______________________________ City:________________ State:______ Zip:______________

E-mail address:____ Cell Phone:(___)______-_______

Age:________________ Birth Date:_____/_______/_______ Marital Status: ☐M ☐S ☐W ☐D

Occupation:____________________________Employer:____

Employer's Address:____ Office Phone:(___)______-_______

Spouse:____________________________ Occupation:______________ Employer:_________________

How many children?________ Names and Ages of Children:_______________________________________

Name of nearest relative:______________________ Address:________________ Phone:(___)______-_______

How were you referred to our office?____

Family Medical Doctor:____ Phone:(___)______-_______

When doctors work together it benefits you.

May we have your permission to update your medical doctor regarding your care at this office? ☐Yes ☐No

HISTORY OF PRESENT ILLNESS:

Chief Complaint: Purpose of this appointment:____

Date symptoms appeared or accident happened:____

Is this due to: ☐Auto ☐Work Other____

Have you ever had the same or a similar condition? ☐Yes ☐No

If yes, when and describe:____

Days lost from work, if any:______________ Date of last physical examination:_____________________

PAST MEDICAL HISTORY:

Have you ever been diagnosed as having or have suffered from: (place a check by conditions that apply to you)

☐ Broken or Fractured Bones	☐ Osteoarthritis	☐ Eating Disorder
☐ Circulatory Problems	☐ Epilepsy	☐ Alcoholism
☐ Rheumatoid Arthritis	☐ Pace Maker	☐ Drug Addiction
☐ Seizures/Convulsions	☐ Strokes	☐ HIV Positive
☐ A Congenital Disease	☐ Cancer	☐ Gall Bladder
☐ Excessive Bleeding	☐ Ruptures	☐ Depression
☐ High/Low Blood Pressure	☐ Coughing Blood	☐ Ulcers

Have you had any major illness, injuries, falls, auto accidents, or surgeries? Females, include childbirth (Please include dates):____

Have you been treated for any health condition by a physician in the last year? ☐Yes ☐No

If yes, describe:____

What medications or drugs are you taking? ____

Do you have any allergies to any medications? ☐Yes ☐No If yes, describe:____________________

Do you have any allergies of any kind? ☐Yes ☐No If yes, describe:____________________

Please list any other health problems you have, no matter how insignificant they may be:____________________

____

SOCIAL HISTORY:

Do you drink alcoholic beverages? ☐Yes ☐No If so, how much per week?____________________

Do you use any tobacco products? ☐Yes ☐No Do you smoke? ☐Yes ☐No If so, how many packs per day?______

Do you take any vitamin supplements? ☐Yes ☐No If so, please list:____________________

Do you consume caffeine? ☐Yes ☐No If so, how much per day? ____________________

Do you exercise? ☐Yes ☐No If yes, what is the frequency and type of exercise?____________________

What are your hobbies?____

What percentage of time during the day (at home or at your job away from home) do you spend:

Lifting____________ Sitting____________ Bending____________ Working at a Computer____________

FAMILY DISEASES:

Check if applicable and indicate whether family member is **F**ather, **M**other, **S**ister, **B**rother:

Tuberculosis	☐F ☐M ☐S ☐B	Cancer	☐F ☐M ☐S ☐B	Mental Illness	☐F ☐M ☐S ☐B
Diabetes	☐F ☐M ☐S ☐B	Asthma	☐F ☐M ☐S ☐B	Heart Disease	☐F ☐M ☐S ☐B
Stroke	☐F ☐M ☐S ☐B	Kidney Disease	☐F ☐M ☐S ☐B	Lung Disease	☐F ☐M ☐S ☐B
Arthritis	☐F ☐M ☐S ☐B	Liver Disease	☐F ☐M ☐S ☐B	Other ____________	

Please check any and all insurance coverage that may be applicable in this case: ☐Major Medical ☐Auto Accident ☐Worker's Compensation ☐Medicaid ☐Medicare ☐Medical Savings Account & Flex Plans ☐Other

Name of Primary Insurance Company: ____

Name of Secondary Insurance Company (if any):____

AUTHORIZATION AND RELEASE: I authorize any payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

Patient Signature:____ Date:____________

Guardian's Signature Authorizing Care:________________________________ Date:____________

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PAIN DRAWING

Name:______________________________ Date:______________________________

Date of Birth:______________________________ Examiner:______________________________

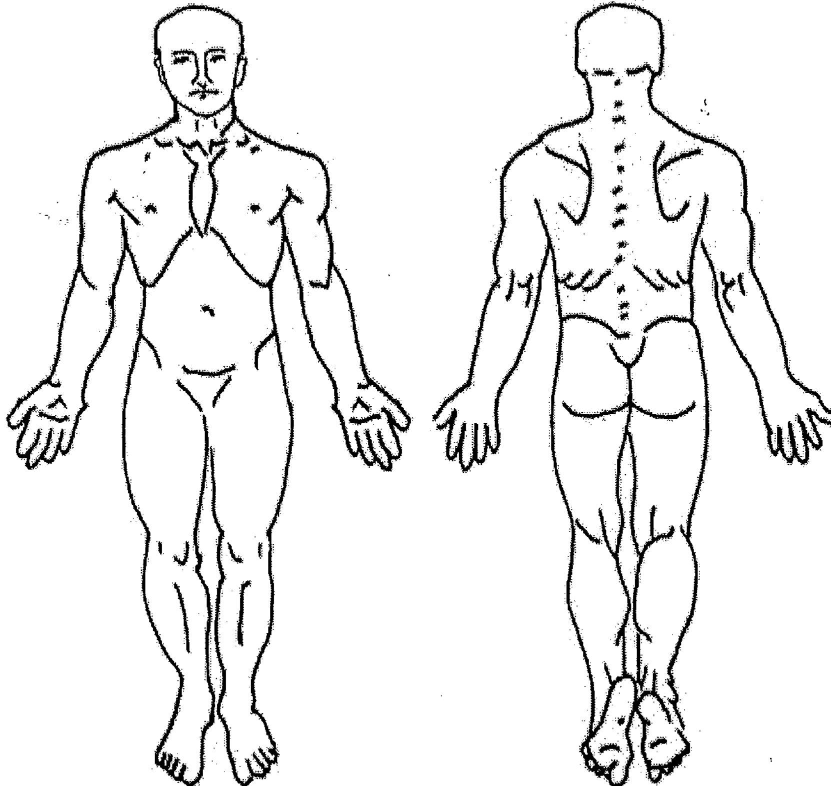
TELL US WHERE YOU HURT

Please read carefully:

Mark the areas on your body where you feel pain. Include all affected areas. Mark areas of radiation. If you pain radiates, draw an arrow from where it starts to where it stops. Please extend the arrow as far as the pain travels. Use appropriate symbol(s) listed below.

Ache >>>>>>>>>>>> Numbness ============= Pins & Needles ooooooooo

Burning xxxxxxxxxxx Stabbing ///////////////// Throbbing ~~~~~~~~~~~~~



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Assignment and Instruction for Direct Payment for Private/Group Insurance

I hereby instruct ______________________________ Insurance Company to pay by check made out and mailed directly to:

Chiropractic Naturally
Archana Mehta, DC
5537 Sheldon Rd
Suite T
Tampa, FL 33615

If my current policy prohibits direct payment to the doctor, then I hereby also instruct and direct you to make out the check to me and mail as follows:

c/o Chiropractic Naturally
Archana Mehta, DC
5537 Sheldon Rd
Suite T
Tampa, FL 33615

The professional or medical expense benefits allowable and otherwise payable to me under my, current insurance policy as payment toward the total charge for professional services rendered. THERE IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentioned assignee and I have agreed to pay, in the current manner, any balance of said professional service charges over and above this insurance polic.

A photocopy of this assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in this case.

Dated on this ______________________________ day of ____________________ 20___

______________________________ Signature of Policyholder

______________________________ Witness

______________________________ Print name

______________________________ Signature of Claimant, if other than policyholder

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INFORMED CONSENT FORM

I hereby request and consent to the performances of chiropractic treatments and other chiropractic/medical procedures, including various forms of physical therapy and diagnostic x-rays by ______________________________. This consent is extended to other licensed chiropractic physicians, chiropractic assistants and licensed massage therapists, who nor or in the future are employed by, working with or associated with this office.

I certify that I have had the opportunity to discuss with the doctor of chiropractic and/or other office personnel, the nature and purpose of the care that is being provided. I understand that, as in the practice of any of the healing arts, in the practice of chiropractic, there are some risks to treatment including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I also understand that the doctor, who has explained all of these things to me, is not expected to be able to anticipate and explain all the risks and complications. I will rely on the doctor to exercise appropriate judgment during the course of care based on the facts known at this time and in my best interest.

My signature below certifies that I have read or have had read to me the above consent. I also certify that I have had the opportunity to ask questions and options to care have been explained. By signing this consent form, I agree to the care being provided to me for the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment.

______________________________ Patient's name (please print)	______________________________ Witness' name
______________________________ Patient's signature	______________________________ Witness' signature
______________________________ Date	______________________________ Date
______________________________ Patient's representative	______________________________ Patient's representative
______________________________ Representative's relationship to patient *(If patient is a minor or if physically or mentally impaired)*	______________________________ Translated by
______________________________ Doctor's name	______________________________ Doctor's signature

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NOTICE OF PRIVACY PRACTICE ACKNOWLEDGMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1998 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.

I acknowledge that I have received your Notice of Privacy Practice containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I authorize disclosure of my protected health information for the named individual(s) listed below:

______________________	______________________
Name	Relationship:
______________________	______________________
Name	Relationship:

Patient Name: ______________________

Relationship to Patient: ______________________

Signature: ______________________

Date: ______________________

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AUTHORIZATION TO TREAT A MINOR

I hereby authorize ____ and whoever they may designate as their representative to administer medical care, as they may deem necessary, to my daughter/son ______________________________.

____
Patient / Legal Guardian Print Name

____
Witness Print Name

____
Parent / Legal Guardian Signature

____
Witness Signature

____
Date

____
Date

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Patient Name: ______________________________

Health Care Authorization Form

The Patient identified above authorizes Chiropractic Naturally to use and/or disclose protected health information in accordance with the following:

. I give permission to Chiropractic Naturally to use my address, phone number, and clinical records to contact me with birthday cards, holiday related cards, recall cards, testimonials, appointment reminders, telephone calls and information about treatment alternatives or other health related information.

. I give permission to Chiropractic Naturally to treat in an open door room. I am aware that the other persons in the office may over hear some of my protected health information during the course of the care. Should I need to speak with the doctor at any time in private, the doctor will provide a room for these conversations.

. By signing this form you are giving Chiropractic Naturally permission to use and disclose your protected health information in accordance with the directives listed above.

EXPIRATION

The authorization shall expire on the following date: ___________________

RIGHT TO REVOKE AUTHORIZATION

You have the right to revoke this authorization, in writing, at any time. However, your written request to revoke authorization is not effective to the extent that we have provided services or taken action in reliance on your authorization.
You make revoke this authorization by mailing or hand delivering a written notice to the Privacy Official of Chiropractic Naturally. The written notice must contain the following: you name, date of birth, a clear statement of your intent to revoke the authorization, the date of your request and your signature.
This revocation is not effective until it is received by the Privacy Official.
This authorization is requested by Chiropractic Naturally for its own use/disclosure of PHI. (Minimum necessary standards apply.)
You have the right to sign this authorization. If you refuse to sign this authorization, Chiropractic Naturally will not refuse to provide treatment.

___________________________________ ___________________

Patient Signature Date

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ACUPUNCTURE CONSENT

I hereby voluntarily agree to and accept the terms of my acupuncture treatment and/or acupuncture point injection therapy. I understand that there is a possibility of bruising and/or swelling at the site of the needle insertion and that I may experience dizziness after treatment. I also understand that there is no implied or guaranteed statement of effectiveness of a specific treatment or series of treatments.

Patients are advised to eat and drink water prior to treatment. Please refrain from alcohol, caffeine or other stimulants or medications that affect the nervous system prior to treatment as this may negate the effects of acupuncture treatments.

NAME________________________________ DATE__________________

ADDRESS____

PHONE______________________________ ALT. PHONE________________________