

WELCOME

3 Locations to Serve You Better!

**PINES WEST
CHIROPRACTIC**
18501 Pines Blvd., Suite 104
Pembroke Pines, FL 33029

**EAST SIDE
CHIROPRACTIC**
8228 Biscayne Blvd.
Miami, FL 33138

**MARTINEZ
CHIROPRACTIC**
12821 S.W. 88 St.
Miami, FL 33186

PATIENT INFORMATION

Patient: _____ Date: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Sex: ☐ M ☐ F Age: _____ DOB: _____
☐ Single ☐ Married ☐ Widowed ☐ Divorced
Patient SS No. _____ Occupation: _____
Employer: _____ Employer Phone No. _____
Employer Address: _____
Spouse's Name: _____ Birthdate: _____
SS No. _____ Occupation: _____
Spouse's Employer: _____
Children (Names & Ages) _____
Whom may we thank for referring you: _____

PHONE NUMBERS

Home: _____
Work: _____
Ext: _____
Best time to call _____

Cell Phone: _____

EMAIL: _____

IN CASE OF EMERGENCY

Name: _____
Relationship: _____
Home #: _____
Work #: _____

INSURANCE

Who is responsible for this account? _____
Relationship to Patient _____
Insurance Co. Name _____
Group or Card No. _____
Is Patient covered by additional insurance? ☐ Yes ☐ No
Subscriber's Name _____
Birthdate _____ SS No. _____
Relationship to Patient _____
Insurance Co. Name _____
Insurance I.D. No. _____

ACCIDENT INFORMATION

Is condition due to an accident?
☐ Yes ☐ No Date _____

Type of Accident?

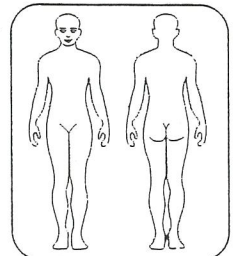
☐ Auto ☐ Work ☐ Home ☐ Other

Explain Other: _____

If yes, please tell our front office and fill out correct accident form in addition to this form.

PATIENT CONDITION

Reason for Visit: _____ Preventive health check up: ☐ Yes ☐ No
When did your symptoms appear? _____ Is condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown
Mark an X on the picture where you continue to have pain, numbness or tingling. _____
Rate the severity of your pain on a scale of 1 (least pain) to 10 (severe pain) _____
Type of Pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting ☐ Burning
☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other _____
How many days in the last week did you feel the pain? _____ ☐ Is it constant or ☐ Occasional
Does it interfere with your ☐ Work ☐ Family Life ☐ Sleep ☐ Recreation ☐ Exercise
Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down ☐ Driving
Do you suffer from any other health conditions? _____



PAST HEALTH HISTORY

Please Check and Describe:

Major Surgery/Operations: ☐ Appendectomy ☐ Tonsillectomy ☐ Gall Bladder ☐ Hernia ☐ Back Surgery
☐ Broken Bones ☐ Other _____

Car accidents, falls, injuries: _____

Hospitalization (Other Than Above): _____

Previous Chiropractic Care: ☐ None ☐ Doctor's Name & Approximate Date of Last Visit _____

Drugs You Now Take: ☐ Nerve Pills ☐ Pain Killers/Muscle Relaxers ☐ Blood Pressure Medicine ☐ Insulin

☐ Other _____

Below are a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of chiropractic care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD OR CURRENTLY HAVE:

- | | | | | |
|--|--|--------------------------------------|---|--|
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Mumps | <input type="checkbox"/> Asthma | <input type="checkbox"/> Lumbago | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Small Pox | <input type="checkbox"/> Aids/H.I.V. | <input type="checkbox"/> Eczema | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Influenza | <input type="checkbox"/> Stroke | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cancer | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Weak Immune System | <input type="checkbox"/> Carpal Tunnel Synd. |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Subluxations | <input type="checkbox"/> Repetitive Strain Synd. |
| <input type="checkbox"/> Chemical Dependency | | | | |

CHECK ANY OF THE FOLLOWING YOU HAVE HAD THE PAST SIX MONTHS:

MUSCULO-SKELETAL CODE

- ☐ Low Back Pain
- ☐ Pain Between Shoulders
- ☐ Neck Pain
- ☐ Arm Pain
- ☐ Joint Pain/Stiffness
- ☐ Difficult Chewing/Clicking Jaw
- ☐ General Stiffness
- ☐ Shoulder Pain
- ☐ Knee Pain
- ☐ Hip Pain
- ☐ Hand/Wrist Pain
- ☐ Foot/Ankle Pain

GENERAL CODE

- ☐ Fatigue
- ☐ Allergies
- ☐ Loss of Sleep
- ☐ Fever
- ☐ Headaches

C-V-R CODE

- ☐ Chest Pain
- ☐ Shortness of Breath
- ☐ Blood Pressure
- ☐ Irregular Heartbeat
- ☐ Heart Problems
- ☐ Lung Problems/Congestion
- ☐ Varicose Veins
- ☐ Ankle Swelling
- ☐ Stroke

GASTRO-INTESTINAL CODE

- ☐ Poor/Excessive Appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver Problems
- ☐ Gall Bladder Problems
- ☐ Weight Trouble
- ☐ Abdominal Cramps
- ☐ Gas/Bloating After Meals
- ☐ Heartburn
- ☐ Black/Bloody Stool
- ☐ Colitis

GENITO-URINARY CODE

- ☐ Bladder Trouble
- ☐ Painful/Excessive Urination
- ☐ Discolored Urine

MALE/FEMALE CODE

- ☐ Menstrual Irregularity
- ☐ Menstrual Cramps
- ☐ Vaginal Pain/Infection
- ☐ Breast Pain/Lumps
- ☐ Prostate/Sexual Dysfunction
- ☐ Venereal Disease
- ☐ Other Problems _____

NERVOUS SYSTEM CODE

- ☐ Nervous
- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Confusion/Depression
- ☐ Fainting
- ☐ Convulsions
- ☐ Cold/Tingling Extremities
- ☐ Stress

EENT CODE

- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Ear Aches
- ☐ Hearing Difficulty
- ☐ Stuffed Nose

FAMILY HISTORY

The following members have the same or similar problems as I do:

- ☐ Mother
- ☐ Father
- ☐ Brother
- ☐ Sister
- ☐ Spouse
- ☐ Child

FEMALES ONLY

When was your last menstrual cycle? _____ Are you pregnant? ☐ Yes ☐ No ☐ Not Sure

EXERCISE	WORK ACTIVITY	HABITS
<input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Daily <input type="checkbox"/> Heavy	<input type="checkbox"/> Sitting <input type="checkbox"/> Computers <input type="checkbox"/> Standing <input type="checkbox"/> Light Labor <input type="checkbox"/> Heavy Labor	<input type="checkbox"/> Smoking <input type="checkbox"/> Alcohol <input type="checkbox"/> Coffee/Caffeine Drinks <input type="checkbox"/> High Stress Level
		Packs/Day _____ Drinks/Week _____ Cups/Day _____

What is most important in your Doctor/Patient relationship? _____

What are your health goals? ☐ pain relief only ☐ correct my health problem

Signature _____

WELCOME



PINES WEST CHIROPRACTIC

"Live Healthy, Be Happy"

18501 Pines Blvd. Ste 104, Pembroke Pines, FL 33029

T: 954-432-3343 | F: 954-450-2565

INFORMED CONSENT FORM

I hereby request and consent to the performance of chiropractic treatments and other chiropractic/medical procedures, including various forms of physical therapy and diagnostic x-rays by Pines West Chiropractic Center. This consent is extended to other licensed chiropractic Physicians, Chiropractic assistants or licensed Massage Therapists, who now 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, that nature and purpose of the care that is being provided. I understand that the results are not guaranteed. Further, I have been informed and 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 these things to me, is not expecting to be able to anticipate 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 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 (please print)

Patient's Signature

Witness' Signature

Date Signed

Date Signed

Patient's Representative
(If patient is a minor or if physically
or mentally impaired)

Representative's relationship to Patient



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Release of Medical Records

Pines West Chiropractic Center
Dr. Joseph Buckley
18501 Pines Blvd
Suite 104
Pembroke Pines, FL 33029

To whom it may concern;

Please release all records, including but not limited to, progress notes, operative notes, laboratory test results, diagnostic tests and x-rays.

I, _____ (please print) HERBY AUTHORIZE THE
RELEASE OF MY MEDICAL RECORDS AS PROVIDED ABOVE.

Patients Signature

Date



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Authorization Form

Pines West Chiropractic Center

Patient Authorization for Use and Disclosure of Protected Health Information

By signing, I authorize Pines West Chiropractic to use and/or disclose certain protected health information (PHI) about me to _____.

This authorization permits Pines West Chiropractic to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.)

The information will be used or disclosed for the following purpose:

(If disclosure is requested by the patient, purpose may be listed as "at the request of the individual")

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire on _____.

The Practice will ____ will not ____ receive payment or other remuneration from third party in exchange for the using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from Pines West Chiropractic Center. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the privacy officer at.

**Pines West Chiropractic Center, 18501 Pines Blvd, Suite 104, Pembroke Pines, FL 33029
(954) 432-3343**

I have received a copy of the "Notice of Privacy Practices" and have read it.

Signature of Patient or Legal Guardian

Relationship to Patient

Print Patients Name

Date

Print Name of Legal Guardian

Date

Patient/Guardian must e provided with signed copy of the authorization form



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Massage Therapy Policy to ALL Patients

In fairness to our office, massage therapists, and other patients, we have made the following policy pertaining to Massage Therapy Appointments.

- ❖ A minimum **24 hour** notice of cancellation is **REQUIRED**.
- ❖ A **\$30 fee** will be charged directly to you for cancelling with a notice of less than 24 hours.
- ❖ This charge is your responsibility and **will not** be submitted to your insurance company.
- ❖ Children under age 16 cannot be left unattended while you are receiving a massage.

Patient Signature

Date

Optional Appointment Reminder via Text or Email

Please choose an option:

☐ Text Message: Phone Number: _____

☐ Email: Address _____

Chiropractic Newsletter

Receive our interesting, health improving monthly newsletter online

This monthly Chiropractic Newsletter delivers credible and current health information to help you and your family live healthier and happier. Please fill out the information below for your authorization.

- ☐ Yes, I would like to receive this monthly newsletter.
- ☐ No, I would not like to receive this monthly newsletter.

Email: _____

Signature: _____



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Patient Demographics

First Name: _____ Last Name _____

Language: check one
☐ English
☐ Spanish
☐ Other please Specify _____

Race: check one
☐ Decline to Specify
☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ White
☐ Other please specify _____

Ethnicity: check one
☐ Decline to Specify
☐ Not Hispanic or Latino
☐ Hispanic or Latino

Smoking: check one
☐ Current every day smoker
☐ Ex-smoker
☐ Never smoked

Religion: _____

Preferred Communication Type: check one
☐ Phone
☐ Email
☐ Mail/letter

Mother's Maiden Name: First _____ Last _____

Cognitive Status: check one
☐ Memory Impairment
☐ No Memory Impairment
Cognitive Status Start Date _____

Functional Status: check one
☐ Depends on Walking stick
☐ No Impairment
Functional Status Start Date _____

Next of Kin: First Name _____ Last Name _____

Relationship: _____

Address: _____



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PAIN DISABILITY QUESTIONNAIRE

Patient Name _____ Date _____

Instructions: These questions ask your views about how your pain now affects how you function in everyday activities. Please answer every question and mark the ONE number on EACH scale that best describes how you feel.

1. Does your pain interfere with your normal work inside and outside the home?
Work normally 0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10 Unable to work at all
2. Does your pain interfere with personal care (such as washing, dressing, etc.)?
Take care of myself completely 0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10 Need help with all my personal care
3. Does your pain interfere with your traveling?
Travel anywhere I like 0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10 Only travel to see doctors
4. Does your pain affect your ability to sit or stand?
No problems 0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10 Can not sit/stand at all
5. Does your pain affect your ability to lift overhead, grasp objects, or reach for things?
No problems 0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10 Can not do at all
6. Does your pain affect your ability to lift objects off the floor, bend, stoop, or squat?
No problems 0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10 Can not do at all
7. Does your pain affect your ability to walk or run?
No problems 0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10 Can not walk/run at all
8. Has your income declined since your pain began?
No decline 0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10 Lost all income
9. Do you have to take pain medication every day to control your pain?
No medication needed 0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10 On pain medication throughout the day
10. Does your pain force you to see doctors much more often than before your pain began?
Never see doctors 0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10 See doctors weekly
11. Does your pain interfere with your ability to see the people who are important to you as much as you would like?
No problem 0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10 Never see them
12. Does your pain interfere with recreational activities and hobbies that are important to you?
No interference 0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10 Total interference
13. Do you need the help of your family and friends to complete everyday tasks (including both work outside the home and housework) because of your pain?
Never need help 0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10 Need help all the time
14. Do you now feel more depressed, tense, or anxious than before your pain began?
No depression/tension 0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10 Severe depression/tension
15. Are there emotional problems caused by your pain that interfere with your family, social and or work activities?
No problems 0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10 Severe problems

Patient Signature

Doctor Signature



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Patient Name : _____ Date: _____ File: _____

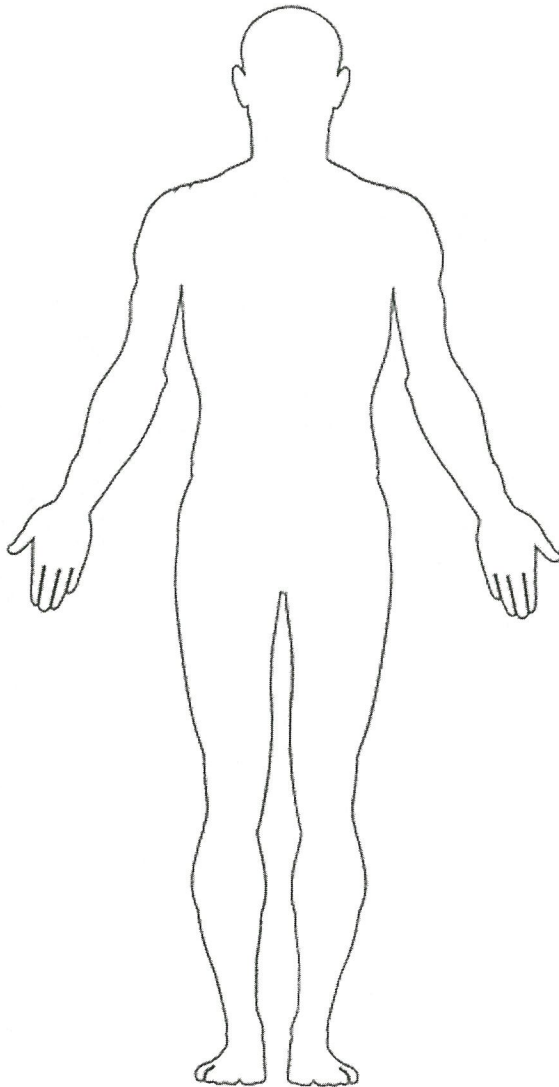
GENERAL SYMPTOMS CHART

Please use the following notations on the figures below to indicate the type and location of your symptoms, as it relates to the purpose of your visit today.

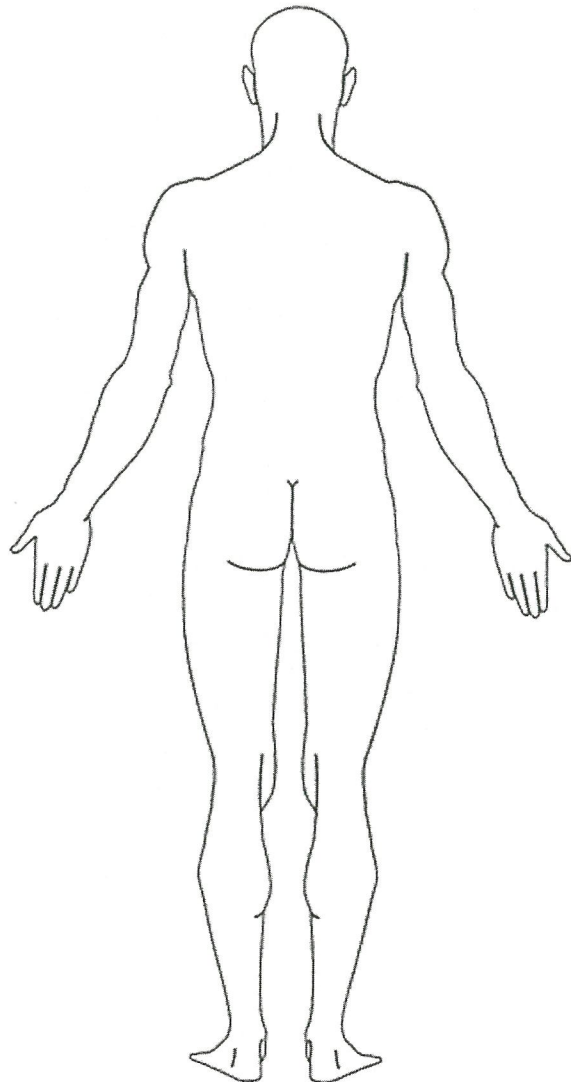
A = ACHE
B = BURNING
P = PINS & NEEDLES

G = STABBING
M = SPASMS
F = STIFFNESS

N = NUMBNESS
T = TINGLING
O = OTHER



FRONT



BACK



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Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name: _____

Last Name: _____

Email address: _____@_____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____

Gender (Circle one): Male / Female

Preferred Language: _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

Smoking Start Date (Optional): _____

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) /
Native Hawaiian or Pacific Islander / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

☐ I choose to decline receipt of my clinical summary after every visit (These summaries are often blank because of the nature and frequency of chiropractic care.)

Patient Signature: _____

Date: _____

For office use only

Height: _____ Weight: _____ Blood Pressure: _____ / _____