LUCHA CHIROPRACTIC QUALITY CENTER

Chiropractic Case History

Name: _____ Sex: _____ SS#: _____

Address _____ City _____ State _____ Zip _____

Phone: _____ Email Address _____

Date of Birth _____ Age _____ Weight _____ lbs. Height ___ ' ___"

Health Insurance Company: _____Plan Name _____

Insurance ID # _____ Group # _____

Heath Insurance Phone # _____ Insured's Name _____

Occupation _____ Marital Status: Single Married Divorced Widow

Emergency Contact Name _____ Phone #: _____

Relationship _____

Reason for seeking chiropractic care: _____

Chief Complaint/Specific Location: _____

When and How did this complaint begin? _____

_____

How do you describe your pain? Dull Achy Sharp Shooting Burning Throbbing Stabbing Sore Spasm

Does pain radiate to any other areas of your body? Y / N If yes, where? _____

Do you have any Tingling/Numbness sensation? Y / N If yes, where? _____

Please, grade intensity of your pain: No pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain ever

How frequent is the pain? _____ How long does it last? _____

Does anything make the complaint feel better? _____

_____

Does anything make the complaint feel worse? _____

_____

Do you have any other complains that you have not mentioned? _____

_____

LUCHA CHIROPRACTIC QUALITY CENTER

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Any other complaints not mentioned? (cont.)

_____

_____

Prior Trauma/Injuries _____

_____

Prior surgeries:

Type of Surgery Date of Surgery

_____ _____

_____ _____

_____ _____

Women only:

Are you pregnant? Y / N If yes, how may months? _____

Congested Breast Y / N

Irregular Cycle Y / N

Menopause Y / N

Lumps in Breast Y / N

_____ _____

Patient / Guardian Signature **Date**

Lucha Chiropractic Quality Center

PERSONAL HEALTH HISTORY

PATIENT NAME: _____

Please check all that apply

GENERAL
[ ] Allergy
[ ] Anemia
[ ] Appendicitis
[ ] Cancer
[ ] Convulsions
[ ] Depression / Nervousness
[ ] Diabetes
[ ] Epilepsy
[ ] Fainting
[ ] Heart disease
[ ] Herpes
[ ] Hepatitis
[ ] HIV/AIDS
[ ] Loss of sleep
[ ] Loss of weight
[ ] Multiple sclerosis
[ ] Neuralgia
[ ] Pacemaker
[ ] Pleurisy
[ ] Stroke
[ ] Tuberculosis
[ ] Tremors
[ ] Ulcers
[ ] Swelling of ankles

EYE, EAR, NOSE & THROAT
[ ] Tonalities
[ ] Deafness
[ ] Earache
[ ] Ear discharge
[ ] Enlarged glands / thyroid
[ ] Eye pain
[ ] Nose bleeds
[ ] Failing vision

SKIN
[ ] Boils
[ ] Bruise easily
[ ] Hives / Rash
[ ] Veracious veins

CARDIOVASCULAR
[ ] Hardening of arteries
[ ] High Blood Pressure
[ ] Low Blood Pressure
[ ] Pain over heart
[ ] Poor blood circulation
[ ] Rapid / Slow heart beat
[ ] Heart Attack

GENITOURINARY
[ ] Bed wetting
[ ] Blood in urine
[ ] Frequent urination
[ ] Lack of bladder control
[ ] Kidney infection
[ ] Prostate problems
[ ] Pus in urine

GASTROINTESTINAL
[ ] Colon trouble
[ ] Constipation / Diarrhea
[ ] Gallbladder trouble
[ ] Vomiting blood
[ ] Liver trouble / disease
[ ] Stomach pain
[ ] Vomiting

RESPIRATORY
[ ] Chest pain
[ ] Asthma / Wheezing
[ ] Difficulty breathing
[ ] Spitting up blood / phlegm

WOMEN ONLY
[] *Congested breasts*
[] *Irregular cycle*
[] *Menopause*
[] *Lumps in breast*

ARE YOU PREGNANT? YES / NO
If so, how many months? _____

[ ] OTHER:_____

_____

_____

I certify the above information is complete and accurate to the best of my knowledge. I agree to notify the doctor immediately whenever I have changes in my health condition.

_____ DOB:_____ Date: _____
Patient / Guardian Signature

Lucha Chiropractic Quality Center

1320 Louisiana Ave. Ste D, St. Cloud, FL 34769
Phone: 407-593-8052 Fax: 407-593-9014

Patient Name:_____ Date of Birth:_____

Social Security Number (at least last 4):_____

Receipt/ Release of Medical Records

I, _____ , hereby request and authorize the following medical documents/ records to be released/disclosed from_____
and records be promptly transferred to the above listed office at Lucha Chiropractic Quality Center.
I understand that I may revoke this release of records at any time by notifying Lucha Chiropractic Quality Center in writing. Further, I agree that a copy of this authorization may be used in place of the original.

__X__ Complete Medical file
__X__ Medical Records
__X__ Daily Notes
__X__ Mental Health Records
__X__ Including HIV/AIDS
__X__ Date of Injury/ Loss _____
__X__ Radiology Reports
____ Radiology Films

This authorization is effective through____/_____/____, one year from date signed, unless revoked or terminated by the patient or patient's personal representative.

Patient Signature:_____ Date:_____

Release of Medical Records

I, _____ , hereby authorize Lucha Chiropractic Quality Center, above listed office to release any and/or all information contained in my medical records file to another physician, my attorney and/or my insurance company on my behalf. I understand that I may revoke this release of records at any time by notifying Lucha Chiropractic Quality Center in writing. Further, I agree that a copy of this authorization may be used in place of the original.

Patient Signature:_____ Date:_____

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

I, _____, have read, understand and received a copy of this office's Notice of Privacy Practices. This notice explains how my medical information will be used and disclosed and how I may obtain access to this information.

Patient Signature:_____ Date:_____

Witness Signature:_____ Date:_____

Lucha Chiropractic Quality Center
1320 Louisiana Ave. Ste D, St. Cloud, FL 34769

Phone: 407-593-8052 Fax: 407-593-9014

Informed Consent

I have been informed it is not uncommon for patients to have some increased discomfort after an adjustment. If that happens, I will apply ice to the area and rest. If I am concerned about this discomfort or develop any new symptoms, I can call the office for attention. If I am out of town or unable to contact the aforementioned number, I can present, myself to the emergency room.
I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various methods of therapy. Listed below are some of the therapies performed in our office.

Chiropractic Adjustments- important to start adjustments to the injured area before scar tissue starts to form so that the issue doesn't become worse.
Manual Therapy- Important to get range of motion in the injured area, relieve pain, reduce swelling, reduce muscle tension, and improve circulation.
Therapeutic Exercise- Important to restore strength and coordination to the muscles and maintain mobility in the joints. These exercises will help to decrease pain, prevent muscle deterioration, promote joint health, increase stability and range of motion.
Heat / Cold Therapy- depending on your injury, you will receive heat therapy and/or cold pack therapy. Heat therapy is used to deeply penetrate and relax your muscles. Along with relieve pain and soreness in joints. Cold therapy is used to decrease and prevent swelling and reduce the pain.
EMS/ TENS Therapy- Used to prevent muscle spasms and muscle atrophy, increasing local blood circulation by stimulating muscle tissue, and strengthen muscle tissue to promote healing.
Mechanical Traction- Spinal traction uses mechanically created forces to stretch and mobilize the spine. Traction may alleviate pain by stretching tight spinal muscles that result from spasm and widen intervertebral foramen to relive nerve root impingement.
Posture Pump- Used to help relieve stiffness and restore cervical posture. Helps restore the natural curvature of the cervical spine to decompress the discs and relieve pain.

I further understand and I am informed that, as in all health and chiropractic medicine there are some slight risks to treatment including, but not limited to, muscle strains and sprains, disc injuries, and stroke. I do not expect the doctor to be able to anticipate and explain all the risks and complications. I wish to rely on the doctor to exercise judgment during the course of procedure which the doctor feels at the time based upon facts then known, is in my best interest.

OUR OFFICE POLICY: We believe that a clear definition of our office polices will allow you, our patient and our office, to concentrate on the big issue- **REGAINING AND MAINTANING YOUR HEALTH.**
If any tests were performed outside of this office (laboratory or diagnostic procedures), I understand the doctor will notify me of the results at my next appointment or when the reports are available.
Staff is not authorized to change or alter your prescribed treatment plan, only the doctor. Our office does appointment reminder calls, texts and/or emails. If you do not wish to receive communication about your appointment in one or more of these manners, please let us know.
Upon final or discharge of care, medical record will only be provided to you the patient, another doctor or attorney with a **signed** medical release form. Medical records will not be released directly to the patient without a written request.

PAYMENT OF BILL: We will require that you honor financial agreements you make with our office. insurance checks sent to your home should be brought or sent to our office within three days, along with the stub or statement to indicate which services were paid.
**Our office will submit your insurance claims for you as a courtesy. However, your insurance is an agreement between you and your company, not between our office and your insurance company.

I have read and understand the above consent, and by signing below, I agree to the above name procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition for which I seek treatment.

_____	_____	____/____/____	_____
Patient Name (please print)	**Patient/ Guardian Signature**	**DOB**	**Date**

_____
Witness **Date**

Dr. Samuel E. Lucha
Lucha Chiropractic Quality Center
1320 Louisiana Ave. Ste D, St. Cloud, FL 34769
Phone: 407-593-8052 Fax: 407-593-9014
Tax ID# 85-1635998

Date: _____
Patient: _____
Employer: _____
Claim or Group #; _____
SS# _____ Claim #: _____

I hereby instruct and direct _____ Insurance Company to pay by check made out and mailed to:

Lucha Chiropractic Quality Center
1320 Louisiana Avenue, Suite D
Saint Cloud, FL 34769

OR

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

1320 Louisiana Avenue, Suite D
Saint Cloud, FL 34769

for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS 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 a current manner, any balance of said professional service charges over and above this insurance payment.

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.

I authorize provider to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Dated at Saint Cloud, Osceola County, this _____ day of _____, 20_____.

Signature of Policyholder _____ Witness _____

Signature of Claimant if other than Policyholder _____