CIOTTI LASER CHIROPRACTIC

Laser focused on your health

Enclosed please find your new patient intake form. We appreciate you taking the time to fill it out in advance.

For non motor vehicle accident patients please only fill out pages 2-8

Thank you for trusting us with you health care.

Dr. John Ciotti DC and Staff

CIOTTI LASER CHIROPRACTIC
Laser focused on your health

Confidential New Patient History

Name_____ Birthday_____ Age_____ Sex M F

Address_____ City_____ Zip_____

Home Phone_____ Work_____ Cell_____

Email _____ Last 4 Security # _____ Marital Status S M D W

Children/Ages _____ ___ Emergency Contact Name and # _____

Ethnicity: American Indian/Alaskan Native Asian African American Native Hawaiian/Islander Caucasian Other

Please describe your complaint(s). Label them individually as a, b, & c as necessary:

_____

_____

_____

How long have you had each of these condition(s)?_____

_____

Have you had these or similar condition(s) in the past? _____

Is your condition(s) getting better, worse or staying the same?_____

What caused you current complaint(s)?_____

What makes it feel better? _____

What makes it feel worse?_____

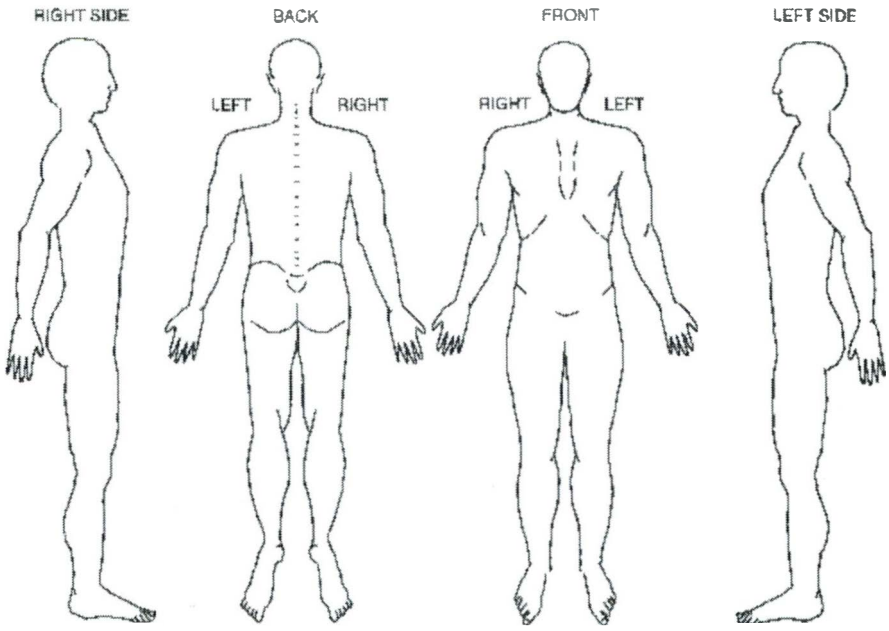
Others who have treated this condition: _____

Family Physician/Last Check-Up :_____

Have you been in a recent auto accident or other personal injury?_____

Mark all areas on your body where you feel the described sensation(s). Use the appropriate symbols listed below. Indicate areas of radiating pain with lines and arrows from the initial site of pain.

Aches: vvvv Burning: xxxx
Numbness/Pins & Needles: oooo
Sharp/Stabbing: ////



On a scale of 1 to 10, with 1 being very little pain and 10 being severe pain, rate your current level(s) of pain (a, b, c):

_____

_____

Patient Initial:_____

Doctor Initial:_____

Hospitalizations within the past year? _____

Medications, dosages, frequency: _____

Known Allergies: _____

Major Illnesses or Surgeries: _____

SOCIAL HISTORY - circle and comment as applicable

Height: _____ Weight: _____ Have you had unexpected weight change? _____

What type of work do you do?: _____

What type of exercise do you perform & how often?: _____

Alcohol Use: Y N Beers/Week_____ Wine/Week_____ Liquor/Week_____ # of years: _____

Smoking: Y N - Current Previous Packs/Day_____ Number of years (current or since quitting): _____

Caffeine (coffee, tea, cola): Cups/Day_____ Number of years: _____

FAMILY HISTORY

Relative	Age if Living	Age at Death	State of Health	Significant Illnesses/Cause of Death
Father				
Mother				
Brother(s)				
Sister(s)				

REVIEW OF SYSTEMS Check only those that apply. Leave blank all that does not apply.

GENERAL	NOW	PAST
Weakness	☐	☐
Fainting	☐	☐
MUSCULOSKELETAL		
Muscle/Joint Pain	☐	☐
Muscle Weakness	☐	☐
Joint Stiffness	☐	☐
NEUROLOGICAL		
Seizures	☐	☐
Vertigo	☐	☐
Dizziness	☐	☐
Numbness/Tingling	☐	☐
GASTROINTESTINAL		
Abdominal Pain	☐	☐
Nausea	☐	☐
Indigestion	☐	☐
GENITOURINARY		
Incontinence	☐	☐
Impotence	☐	☐
Abnormal Menstruation	☐	☐

Date last OBGYN: _____

or last check up: _____

Are you pregnant? Y N Unsure

HEAD	NOW	PAST
Headaches	☐	☐
Concussion	☐	☐
Last Eye Exam: _____		
EARS		
Difficulty Hearing	☐	☐
Ringing	☐	☐
MOUTH		
Loss of Taste	☐	☐
Dental Problems	☐	☐
Last Dental Exam: _____		
NOSE		
Decreased Smell	☐	☐
Pain	☐	☐
LUNGS		
Chronic Cough	☐	☐
Pain	☐	☐
Difficulty Breathing	☐	☐
HEART		
Palpitation/Arrhythmia	☐	☐
Blood Clots	☐	☐
Chest Pain	☐	☐
Pacemaker?	Y	N

PAST MEDICAL HISTORY

-Check current and past issues-

Asthma	☐
Angina	☐
Cancer	☐
Hypertension	☐
Heart Attack	☐
COPD	☐
Stroke	☐
Ulcers	☐
Gallstones	☐
Prostate Problems	☐
Liver Difficulties	☐
Hepatitis	☐
Blood Disorders	☐
Tuberculosis	☐
Polio	☐
Epilepsy	☐
Diagnosed Mental Illness	☐
Migraine Headaches	☐
Sexually Transmitted Dis.	☐
Diabetes	☐

Other: _____

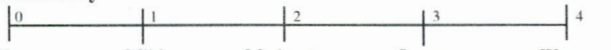
Signature/Guardian: _____ Date: _____ Doctor Initial: _____

Functional Rating Index

For use with **Neck and/or Back Problems** only.

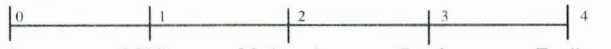
In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities.
For each item below, **please circle the number which most closely describes your condition right now.**

1. Pain Intensity



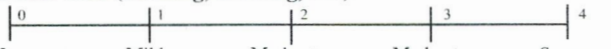
0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping



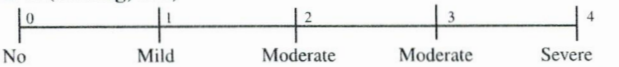
0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)



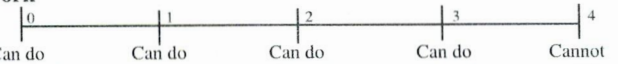
0	1	2	3	4
No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)



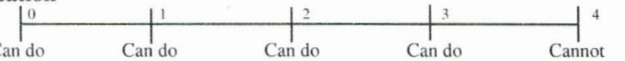
0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work



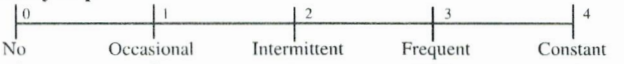
0	1	2	3	4
Can do usual work plus unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation



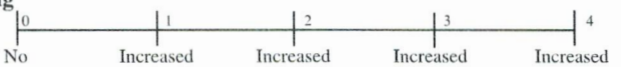
0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. Frequency of pain



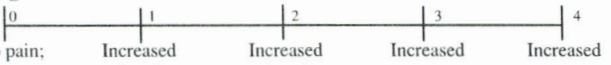
0	1	2	3	4
No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting



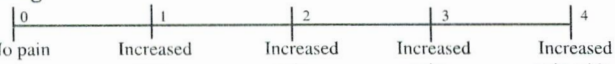
0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking



0	1	2	3	4
No pain; any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

10. Standing



0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

Name _____ **ID#/SS#** _____ **Plan ID** _____ **Total Score** _____

PRINTED

_____

Signature

_____

Date

Informed Consent Form

To determine the cause of a patient's presentation and need for and extent of care, the chiropractic doctor will obtain details about the current complaint[s] as well as one's past health history, subsequently perform a physical examination, and in particular cases acquire diagnostic images (such as x-rays or MRI) or laboratory tests.

Chiropractic doctors employ various manually-applied treatment procedures when caring for patients, the most common being an *adjustment*. A chiropractic adjustment involves the application of a quick, precise and usually painless force directed over a very short distance to a specific body part. Adjustments can be performed by hand, by hand-guided instruments, and with the use of specially designed equipment. In addition to adjustments, chiropractors may use other treatment procedures to care for a patient, such as mobilization procedures, physiotherapy modalities (heat, ice, ultrasound, electrical muscle stimulation), soft-tissue manipulation, nutritional recommendations, and supervised exercise and other rehabilitation measures. Neck and back pain are known to generally improve in time, however, recurrence is common. It is also known that keeping a positive attitude and remaining physically active improves one's chances for recovery.

The beneficial effects associated with chiropractic treatment procedures include decreased pain, improved mobility and function, and reduced muscle spasm. There are some conditions for which chiropractic care is contraindicated; other conditions may not respond to chiropractic treatment or perhaps worsen with chiropractic treatment. In these cases, referral to another healthcare provider may be necessary or suggested by the chiropractor.

The body of evidence suggests that chiropractic care is generally safe; however, as with any form of treatment, some risk may be involved. Listed below are summaries of both common and rare side-effects/complications reported to be associated with chiropractic care:

Common [1,2]

- Reactions most commonly reported are local soreness/discomfort (53%), headaches (12%), tiredness (11%), radiating discomfort (10%), dizziness, the vast majority of which resolve within 48 hours

Rare [3,4]

- Fractures or joint injuries in isolated cases with underlying physical defects, deformities or pathologies
- Burns due to some physiotherapy procedures
- Disc herniation
- Cauda equina Syndrome (1 case per 100 million adjustments)
- Vertebrobasilar artery stroke (1 case per 400,000 to 1 million cervical spine adjustments [manipulations]). A similar level of association to stroke is found for patients under the age of 45 when consulting with a medical doctor; for those older than age 45, the level of association to stroke is higher when seeing a medical doctor than a chiropractic doctor. ***Please indicate to your doctor if you have a headache or neck pain that is the worst you have every felt. These symptoms may indicate a dissection in progress.***

Alternative forms of treatment that a patient may want to consider before undergoing chiropractic care include *prescription and over-the-counter medications, surgical intervention, and non-treatment.* Listed below are summaries of concerns with these alternative procedures:

- Long-term use or overuse of certain medications carry some risk of dependency; with other medications, long-term use or overuse increases the risk of gastrointestinal bleeding
- Surgical risks may include unsuccessful outcome, complications such as infection, pain, reactions to anesthesia, and prolonged recovery[5]
- Potential risks of refusing or neglecting care may result in increased pain, restricted motion, increased inflammation, and worsening of my condition[6]

1. Thiel HW, Bolton JE, Docherty S, Portlock JC. Safety of chiropractic manipulation of the cervical spine: a prospective national survey. *Spine.* Oct 1 2007;32(21):2375-2378; discussion 2379.
2. Rubinstein SM, Leboeuf-Yde C, Knol DL, de Koekkoek TE, Pfeifle CE, van Tulder MW. The benefits outweigh the risks for patients undergoing chiropractic care for neck pain: a prospective, multicenter, cohort study. *J Manipulative Physiol Ther.* Jul-Aug 2007;30(6):408-418.
3. Cassidy JD, Boyle E, Cote P, et al. Risk of vertebrobasilar stroke and chiropractic care: results of a population-based case-control and case-crossover study. *Spine.* Feb 15 2008;33(4 Suppl):S176-183.
4. Boyle E, Cote P, Grier AR, Cassidy JD. Examining vertebrobasilar artery stroke in two Canadian provinces. *Spine.* Feb 15 2008;33(4 Suppl):S170-175.
5. Carragee EJ, Hurwitz EL, Cheng I, et al. Treatment of neck pain: injections and surgical interventions: results of the Bone and Joint Decade 2000-2010 Task Force on Neck Pain and Its Associated Disorders. *Spine.* Feb 15 2008;33(4 Suppl):S153-169.
6. Carroll LJ, Hogg-Johnson S, van der Velde G, et al. Course and prognostic factors for neck pain in the general population: results of the Bone and Joint Decade 2000-2010 Task Force on Neck Pain and Its Associated Disorders. *Spine.* Feb 15 2008;33(4 Suppl):S75-82.

INFORMED CONSENT FORM

Please answer the following questions to help us determine possible risk factors:

Question	Yes	No	Doctor Comments
General			
Have you ever had an adverse (i.e. bad) reaction to or following chiropractic care?	____	____	
Bone Weakness			
Have you been diagnosed with osteoporosis?	____	____	
Do you take corticosteroids (e.g. prednisone)?	____	____	
Have you been diagnosed with a compression Fracture(s) of the spine?	____	____	
Have you been diagnosed with cancer?	____	____	
Do you have any metal implants?	____	____	
Vascular Weakness			
Do you take asprin or other pain medications on a regular basis?	____	____	
If Yes, about how much do you take daily?_____			
Do you take Warfarin (coumadin), heparin, or other similar "blood thinners"?	____	____	
Have you ever been diagnosed with any of the following disorders/diseases?			
	Yes	No	
Rheumatoid Arthritis	____	____	
Reiter's Syndrome, ankylosing spondylitis or Psoriatic arthritis	____	____	
Giant cell arteritis (temporal arteritis)	____	____	
Osteogenesis imperfecta	____	____	
Ligament hypermobility/Marfan's/Ehlers-Danlos	____	____	
Medical cystic necrosis (cystic mucoid degeneration)	____	____	
Bechet's Disease	____	____	
Fibromuscular dysplasia	____	____	
Have you ever become dizzy or lost consciousness when turning your head?	____	____	
Spinal Compromise or Instability			
Have you had spinal surgery?	____	____	
If Yes, when?_____			
Have you been diagnosed with spinal stenosis?	____	____	
Have you been diagnosed with spondyliolithesis?	____	____	
Have you had any of the following issues:			
Sudden weakness in the arms or legs?	____	____	
Numbness in the genital area?	____	____	
Recent inability to urinate or lack of control urinating?	____	____	

I have read the previous information regarding risks of chiropractic care and my doctor has explained my risks (if any) to me and suggested alternatives when those risks exist. I understand the purpose of my care and have been given an explanation of the treatment, the frequency of care, and alternatives to this care. All of my questions have been answered to my satisfaction. I agree to this plan of care understanding any perceived risk(s) and alternatives to this care.

Patient/Parent/Guardian Signature _____ Date _____

Doctor Signature _____ Date _____

NOTICE OF INFORMATION PRACTICES:

Protecting the privacy of your personal health information is important to us. This notice describes how information about you may be used and disclosed and how you can get access to this information. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment, or practice operations will be made only after obtaining your consent. You may request restrictions on disclosures. Disclosures on protected health information are limited to the minimum necessary for the disclosure. This provision does not apply to the transfer of medical records for treatment.

You may inspect and receive copies of your records within 30 days of the request to do so. There may be a reasonable cost-based fee for photocopying, postage, and preparation. You may request changes to your records. Our practice is required to abide by this notice. We have the right to change this notice in the future. Any revisions will be prominently displayed in a clearly visible location in our office. You may file a complaint about privacy violations by contacting our Office Manager.

OFFICE FINANCIAL POLICY:

Our policy is to extend to you the courtesy of allowing you to assign your insurance benefits directly to us. This policy reduces your out-of-pocket expense.

If you DO NOT have insurance: All payments are expected at the time of service or by an authorized payment plan. Your personal balance may not exceed $100 at any time or care may be terminated.

If you DO have insurance: All deductibles and co-payments are expected at the time of service or by an authorized payment plan. Your co-insurance balance may not exceed $100 or care may be terminated. You are considered a cash patient until you bring in your completed insurance forms, and we qualify and accept your insurance coverage. We do not accept assignment for secondary insurance carriers, but will be happy to provide you with a claim form for your secondary carrier. Our fees are considered usual, customary, and reasonable by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees bearing no relationship to the current standard of care in the area.

If your Carrier Has Not paid a claim within 60 days of submission, you agree to take an active part in recovery of your claim. If your insurance carrier has not paid within 90 days of submission, you accept responsibility for payment in full of any outstanding balance.

When your schedule of visits is considered maintenance care, you may not be eligible for insurance assignment. Charges for services rendered will be due and payable as they are rendered. We will continue to provide you with an insurance claim for.

If you discontinue care for any reason other than discharge by the doctor, all balances will become immediately due and payable in full by you, regardless of any claim submitted.

I have read the above information. By signing below, I agree to the above terms.

_____ _____

Print Name Witness

_____ _____

Patient's Signature Date

ACKNOWLEDGMENT OF RECEIPT

OF

NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

_____ _____

Patient Name Date

_____ _____

Parent or Guardian or Legal Representative Date

_____ _____

Patient Signature Date

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.

List below the names and relationship of people to whom you authorize the Practice to release PHI.

_____ _____

_____ _____

_____ _____

_____ _____

ASSIGNMENT OF BENEFITS

I, _____(full legal name), assign all of the rights and benefits of any applicable personal injury protection, medical payments, or other coverage provided by any insurance policy issued pursuant to Florida Statutes *627.730 - *627.7405, to Renew Wellness Center, LLC, for services and supplies provided to me related to personal injuries I suffered in an automobile accident which occurred on, _____.

I agree to pay any co-payment or deductible not covered by the applicable personal injury protection, medical payments, or other insurance coverage.

This assignment includes, but is not limited to:

all rights to collect benefits directly from any insurance carrier obligated to provide benefits for services and supplies I have received.

all rights to take legal or other action against any insurance carrier obligated to provide benefits if for any reason the insurance carrier fails to pay any benefits due; and

all rights to recover attorney fees, legal assistant fees, costs, and any interest on fees and costs, for any legal or other action taken by Renew Wellness Center, LLC, as my assignee.

This is an assignment of rights only, and is not a delegation of any of my duties under the subject insurance policy.

I agree that Renew Wellness Center, LLC, may retain any attorney it chooses to bring legal action against any insurance carrier obligated to provide benefits for services and supplies I have received, and that the attorney chosen may be different than any attorney I may have handling any claim I may have for personal injuries.

I have been given a copy of this assignment to retain for my records; I have read this assignment and I am satisfied that I fully understand the purpose and implications of executing this assignment and do so freely and voluntarily.

_____ _____

Patient Signature Date

The undersigned, as authorized representative of Renew Wellness Center, LLC, accepts the assignment of benefits as set forth above.

_____ _____

Renew Wellness Center, LLC Date

OFFICE OF INSURANCE REGULATION
Bureau of Property & Casualty Forms and Rates

Standard Disclosure and Acknowledgement Form
Personal Injury Protection - Initial Treatment or Service Provided

The undersigned insured person (or guardian of such person) affirms:

1. The services or treatment set forth below were **actually rendered.** This means that those services have **already been provided.**

_____

_____

2. I have the right and the **duty to confirm** that the services have already been provided.

3. I was **not solicited** by any person to seek any services from the medical provider of the services described above.

4. The medical provider has **explained** the services to me for which payment is being claimed.

5. If I notify the insurer in writing of a billing error, I may be entitled to a portion of any reduction in the amounts paid by my motor vehicle insurer. If entitled, my share would be at least 20% of the amount of the reduction, up to $500.

Insured Person (patient receiving treatment or services) or Guardian of Insured Person:

Name *(PRINT or TYPE)*	Signature	Date

The undersigned licensed medical professional or medical director, if applicable, affirms the statement numbered 1 above and also:

A. I have **not solicited** or caused the insured person, who was involved in a motor vehicle accident, to be solicited to make a claim for Personal Injury Protection benefits.

B. The treatment or services rendered were explained to the insured person, or his or her guardian, **sufficiently** for that person to sign this form with informed consent.

C. The accompanying statement or bill is **properly completed** in all material provisions and all relevant information has been provided therein. This means that each request for information has been responded to **truthfully, accurately**, and in a **substantially complete** manner.

D. The coding of procedures on the accompanying statement or bill is proper. This means that **no service has been upcoded, unbundled**, or constitutes an invalid **or not medically necessary diagnostic test** as defined by Section 627.732(14) and (15), Florida Statutes or Section 627.736(5)(b)6, Florida Statutes.

Licensed Medical Professional Rendering Treatment/Services or Medical Director, if applicable *(Signature by his/ her **own hand**)*:

Name *(PRINT or TYPE)*	Signature	Date

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of Claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree per Section 817.234(1)(b), Florida Statutes.

Note: The **original** of this form must be furnished to the insurer pursuant to Section 627.736(4)(b), Florida Statutes and may **not** be electronically furnished. Failure to furnish this form may result in non-payment of the claim.

OIR-B1-1571
Pub. 1/2004

Motor Vehicle Collision/Personal Injury Questionnaire

Please answer all questions completely:

1. Your name and address:

   _____

   _____

   _____

2. Phone #: _____

3. Please describe the collision in your own words:

   _____

   _____

   _____

4. Where did the collision occur? City/Town: _____ State: _____
5. Date of Collision: _____ Time: _____ AM/PM
6. Were you the: (circle one)

   driver passenger pedestrian

7. If passenger were you in the: (circle one)

   front seat right rear seat left rear seat

8. What type of vehicle were you in? _____
9. What type was the other vehicle? _____
10. Did your vehicle strike the other vehicle? _____
11. Was your car struck by the other vehicle?_____
12. What direction was your vehicle going? (circle one) North South East West
13. What direction was the other vehicle going? (circle one) North South East West
14. Was the impact from the: (circle one)

    Front Rear Left Side Right Side

15. What was the approximate speed at the time of impact?
    a. Your vehicle _____mph
    b. Other vehicle _____mph
16. What was the weather at the time of the collision? (circle one) Dry Wet Icy
17. Was your vehicle in: (circle one)

    park neutral in gear moving stopped

18. Were your brakes being applied? Yes/No

19. Was your vehicle shoved: (circle one) forward backward sideways
20. Were you shoved: (circle one) forward whipped backwards
21. Did your seat have a head restraint (headrest)? Yes/No
22. If yes, what was the position: low mid-position high
23. 23.Did your head ride over the headrest? Yes/No
24. Did your hat or glasses end up in the back seat or rear window? Yes/No
25. Did any other part of your body hit the interior of the vehicle? Yes/No
26. If Yes, please specify: (circle all that apply)
    seatbelt restraints steering wheel dashboard
    windshield side door side window other_____
    a. Which part of your body? (circle all that apply)
       chest head chin face R/L knee
       R/L shoulder R/L hand other _____
27. Were you holding on to the steering wheel? Yes/No
28. Did you brace your arms against the dash? Yes/No
29. Did you brace your legs against the floorboard? Yes/No
30. Was your ankle turned? Yes/No
31. Did the vehicle go into a spin or roll as a result of the impact? Yes/No
    If Yes, explain_____
32. How much damage was there to the outside of the vehicle? (circle one)
    none some a lot
33. How much damage was there to the inside of the vehicle? (circle one)
    none some a lot
34. At the point of impact, where did you experience pain? Be specific:
    _____
    _____
35. Immediately after the accident were you: (circle one)
    conscious dazed unconscious
36. If you lost consciousness, how long were you unconscious?_____
37. Were you wearing a seatbelt? Yes/No
38. Did the belt have a shoulder harness? Yes/No
    a. If Yes, did it contribute to the pain you are experiencing? Yes/No
39. At the time of impact were you looking: (circle one)
    Straight ahead left right up down
40. Did the seat break as a result of the impact? Yes/No
41. Were you braced for the impact? Yes/No
42. Were you taken by surprise by the impact? Yes/No
43. Did you go to the hospital? Yes/No If Yes, When?_____

44. If Yes, how did you get there? Ambulance/Other _____
45. If by ambulance did the ambulance attendants place you in a:
    Neck Brace/Back Brace/Other_____
46. Any medication or medical supplies given? _____
47. Did you have x-rays taken at the hospital? Yes/No
48. Did you have MRIs taken at the hospital? Yes/No

If you went to the hospital please provide the following:

Hospital _____

Doctor_____

Diagnosis _____

Treatment Received _____

_____

49. Have you had any similar problems before? Yes/No
    If Yes, explain:_____
50. Are you diabetic? Yes/No
51. Do you have high blood pressure? Yes/No
52. Do you have low blood pressure? Yes/No
53. Do you have arthritis or degenerative joint disease? Yes/No
54. What type of work do you do? _____
55. What are your job requirements?_____
56. Have you lost any days of work from this injury? Yes/No
    If yes, list dates:_____

Patient Signature:_____ Date:_____

Witness: _____ Date:_____