Chiropractic Life Center of Boca Raton
Andre Voskressensky DC & Janet Goldsein DC
9070 Kimberly Blvd. #58, Boca Raton, FL 33434

CONFIDENTIAL PATIENT HEALTH HISTORY

Please PRINT clearly.

Today's Date: _____

PATIENT INFORMATION

Name: (Last, First, MI) _____ **Preferred Name**: _____

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

Home Phone: _____ **Mobile**: _____ **Work**: _____

Email: _____ **Gender**: M / F **Marital Status**: Married / Single / Other

Date of Birth: _____ **Occupation**: _____ **Employer**: _____

Spouse/Significant Other: _____ **Children and Ages**: _____

Are you: Military Veteran / Active Duty Service Member / Reservist / National Guard / ROTC

Referred by *(name)*: _____

☐ **Family** ☐ **Friend** ☐ **Co-Worker** ☐ **Doctor** ☐ **Other**: _____

-CMS requires providers to report both race and ethnicity-

Ethnicity: Not Hispanic or Latino / Hispanic or Latino / Other / Decline to Answer **Preferred Language**: _____

Race: Asian / Black or African American / American Indian or Alaskan Native / White (Caucasian) / Hawaiian or Pacific Islander / Other / Decline

Smoking Status: Every Day / Some Days / Former / Never

EMERGENCY CONTACT INFORMATION

Full Name: _____ **Preferred Contact Number**: _____

Relationship: Child / Parent / Spouse / Other: _____

Primary Care Physician: _____ **Doctor's Phone**: _____

FINANCIAL INFORMATION -- *Please allow us to photocopy your insurance card.*

Self Pay (Cash) **Insurance** **Personal Injury/Auto** **Other (please explain)** _____

PRIMARY INSURANCE: _____ **SECONDARY INSURANCE**: _____

Policy Holder: _____ **Policy Holder**: _____

Relation to Insured: Self / Spouse / Parent / Child / Other **Relation to Insured**: Self / Spouse / Parent / Child / Other

Patient Name: _____

CURRENT CONDITION INFORMATION *PLEASE ANSWER ALL QUESTIONS*

Major Complaint: _____

When Did It Start (date):_____ **What Event Caused It:**_____

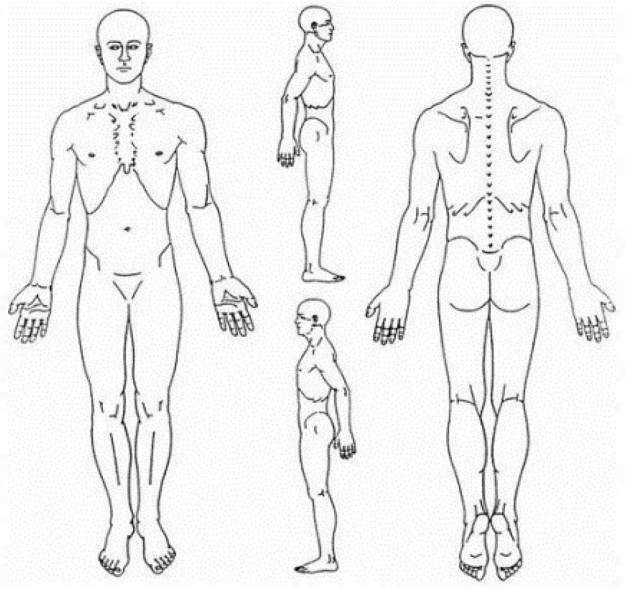
Intensity: None (0) Mild (1-2) Mild-Moderate (2-4) Moderate (4-6) Moderate-Severe (6-8) Severe (8-10)

Is The Complaint: Constant / Off and On

Is The Complaint: Sharp / Stabbing / Burning / Achy / Dull / Stiff & Sore / Pins and Needles Other:_____

Does It Radiate/Shoot To Any Areas Of Your Body? No / Yes **If YES, where:**_____

DRAW AREAS OF COMPLAINTS:



What Makes It Better? Ice / Heat / Rest / Movement / Stretching / OTC Meds / RX Meds / Chiropractic

What Makes It Worse? Sit / Stand / Walk / Lying / Sleep / Movement

Who Else Have You Seen For This? No One / DC / MD / PT / Massage / ER / Other:_____

- Where: _____

Diagnostic Tests: None / X-rays / MRI / CT / Other:_____ **When and Where:**_____

Any Other Complaints:_____

Patient Name: _____

Does anyone in your IMMEDIATE family have a history of (circle condition): ☐ **NONE**

Heart Disease If yes, who _____ **Stroke** If yes, who _____

Cancer If yes, who _____ Type_____ **Other Relevant Family History**:_____

PAST HEALTH HISTORY: (List even if it was 20 years ago…)

Injuries, Traumas or Hospitalizations: ☐ **NONE** _____

Surgeries – Date, Type and Reason: ☐ **NONE** _____

Current Medications: ***Did you bring a list? Can we make a copy?*** ☐ **NONE** _____

Allergies to Medications: *(List and reactions)* ☐ **NONE**

_____

Vitamins & Supplements: *(List all and frequency)* ☐ **NONE**

_____

Are you ***CURRENTLY*** experiencing any of these symptoms? (Check all that apply)

General:
- ❑ Recent Intentional Weight Change
- ❑ Fever
- ❑ Fatigue
- ❑ *None in this Category*

Musculoskeletal:
- ❑ Low Back Pain
- ❑ Mid Back Pain
- ❑ Neck Pain
- ❑ Arm Problems
- ❑ Leg Problems
- ❑ Broken Bones
- ❑ Muscle Spasms/Cramps
- ❑ *None in this Category*

Neurological:
- ❑ Numbness or Tingling Sensations
- ❑ Loss of Feeling
- ❑ Dizziness or Light Headed
- ❑ Frequent or Recurrent Headaches
- ❑ Convulsions or Seizures
- ❑ Have you ever had a head injury?
- ❑ Had an auto accident? Year:_____
- ❑ *None in this Category*

Gastrointestinal:
- ❑ Loss of Appetite
- ❑ Blood in Stool
- ❑ Change in Bowel Movements
- ❑ Nausea or Vomiting
- ❑ Abdominal Pain
- ❑ Constipation
- ❑ *None in this Category*

Cardiovascular & Heart:
- ❑ Chest Pains
- ❑ Rapid or Heartbeat Changes
- ❑ Blood Pressure Problems
- ❑ Swelling of Hands, Ankles, or Feet
- ❑ Heart Problems
- ❑ *None in this Category*

Respiratory:
- ❑ Difficulty Breathing
- ❑ Persistent Cough
- ❑ Coughing Blood
- ❑ Asthma or Wheezing
- ❑ Tobacco Use
- ❑ *None in this Category*

Eyes and Vision:
- ❑ Wear Contacts/Glasses
- ❑ Blurred or Double Vision
- ❑ Eye Disease or Injury
- ❑ *None in this Category*

Ears, Nose and Throat:
- ❑ Swollen Glands in Neck
- ❑ Ringing in the Ears
- ❑ Ear-Ache/Ringing/Drainage
- ❑ Sinus/Allergy Problems
- ❑ *None in this Category*

Mind/Stress:
- ❑ Nervousness
- ❑ Depression
- ❑ Sleep Problems
- ❑ Memory Loss or Confusion
- ❑ *None in this Category*

Endocrine, Hematologic, and Lymphatic:
- ❑ Thyroid Problems
- ❑ Diabetes
- ❑ Cold Extremities
- ❑ Heat or Cold Intolerance
- ❑ Immune System Disorder
- ❑ *None in this Category*

Skin and Breasts:
- ❑ Rash or Itching
- ❑ Non-healing Sores
- ❑ Breast Pain
- ❑ Breast Lump
- ❑ Breast Discharge
- ❑ *None in this Category*

Genitourinary:
- ❑ Kidney Stones
- ❑ Burning/Painful Urination
- ❑ Change in Force/Strain w/Urination
- ❑ Frequent Urination
- ❑ Urinary Leakage or Bed Wetting
- ❑ Blood in Urine
- ❑ *None in this Category*

Women Only:

Are you pregnant?
- ❑ Yes-Due Date: _____
- ❑ No-Last Menstrual Period: _____
- ❑ Painful or Irregular Periods
- ❑ Urine Leakage with Coughing or Sneezing
- ❑ Urine Leakage with Laughing or Lifting
- ❑ *None in this Category*

Pregnancies with Outcome & Date

_____

_____

Other Conditions not listed:_____

Is there anything else you would like the doctor to know? _____

I have read the above information and certify it to be true and correct to the best of my knowledge and hereby authorize this office to provide me with chiropractic care, diagnostic testing, and/or therapeutic services, in accordance with this state's statutes. I choose to decline receipt of my clinical summary after every visit. (These summaries are often blank as a result of the nature and frequency of chiropractic care.)

Patient or Guardian Signature _____ Date_____

Doctor Signature _____ Date _____

CHIROPRACTIC LIFE CENTER OF BOCA RATON

Practice Member Information (Must be Completed Before Services Can Be Rendered)

NAME: _____
FIRST MIDDLE LAST

PHONE: Home_____ Cell_____ Work_____

SOCIAL SECURITY NUMBER: _____ MARITIAL STATUS: _____

DATE OF BIRTH: _____

CONTACT IN CASE OF EMERGENCY: _____ Phone #: _____

NAME OF PRIMARY INSURANCE CARRIER: _____

Name of Insured_____ Insured Date of Birth _____

Insured Social Security Number _____

NAME OF SECONDARY INSURANCE CARRIER: _____

Name of Insured_____ Insured Date of Birth _____

Insured Social Security Number: _____

Insurance Policies and Fee Schedule

- **Consultation**- includes practice member history. This service is generally included with the assessment fee, unless there are extenuating circumstances i.e. injuries which require greater time have additional fees.
- **Assessment (new or established practice member)-** may include one or more of the following: range of motion and/or static palpation, temperature gradient study, surface EMG and posture check $125-$235.
- **Chiropractic Adjustment-** The actual movement of the vertebra done by hand or instrument. Often a sound will be heard, but if there is no sound result, it does not mean that the adjustment has not taken place: $65-$85.
- **X-rays-** Specific x-ray views taken of your spine to determine a misalignment/subluxation of your vertebrae. These can also be used to indicate progress after a period of care. $125 to $180 per area.
- **Time of service payment:** Consult and exam $100; Chiropractic Adjustment $55-70; X-rays $100 per area.

Release of Authorization/Assignment of Benefits

I authorize and request payment of insurance benefits directly to Andre Voskressensky, DC / Janet Goldstein, DC. I agree that this authorization will cover all services rendered until I revoke the authorization. I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the patient. It is customary to pay for services when rendered unless other arrangements have been made in advance. I understand that I am financially responsible for charges not covered by this assignment.

Signed_____ **Date**_____

CHIROPRACTIC LIFE CENTER OF BOCA RATON

INFORMED CONSENT FOR CHIROPRACTIC CARE

CHIROPRACTIC CARE, LIKE ALL FORMS OF HEALTH CARE WHILE OFFERING CONSIDERABLE BENEFITS MAY ALSO PROVIDE SOME LEVEL OF RISK. THIS LEVEL OF RISK IS MOST OFTEN VERY MINIMAL, YET IN RARE CASES, INJURY HAS BEEN ASSOCIATED WITH CHIROPRACTIC CARE. THE TYPES OF COMPLICATIONS THAT HAVE BEEN REPORTED SECONDARY TO CHIROPRACTIC CARE INCLUDE: SPRAIN/STRAIN INJURIES, IRRITATION OF A DISC CONDITION, AND RARELY, FRACTURES. ONE OF THE RAREST COMPLICATIONS ASSOCIATED WITH CHIROPRACTIC CARE OCCURRING AT A RATE BETWEEN ONE INSTANCE PER ONE MILLION TO ONE PER TWO MILLION CERVICAL SPINE (NECK) ADJUSTMENTS MAY BE A VERTEBRAL INJURY THAT COULD LEAD TO A STROKE.

PRIOR TO RECEIVING CHIROPRACTIC CARE IN THIS CHIROPRACTIC OFFICE, A HEALTH HISTORY AND PHYSICAL EXAMINATION WILL BE COMPLETED. THESE PROCEDURES ARE PERFORMED TO ASSESS YOUR SPECIFIC CONDITIONS, YOUR OVERALL HEALTH AND IN PARTICULAR YOUR SPINAL HEALTH. THESE PROCEDURES WILL ASSIST US IN DETERMINING IF CHIROPRACTIC CARE IS NEEDED, OR IS ANY FURTHER EXAMINATIONS OR STUDIES ARE NEEDED. IN ADDITION, THEY WILL HELP US DETERMINE IS THERE IS ANY REASON TO MODIFY YOUR CARE OR PROVIDE YOU WITH A REFERRAL TO ANOTHER HEALTH CARE PROVIDER. ALL RELEVANT FINDINGS WILL BE REPORTED TO YOU ALONG WITH A CARE PLAN PRIOR TO BEGINNING CARE.

I UNDERSTAND AND ACCEPT THAT THERE ARE RISKS ASSOCIATED WITH CHIROPRACTIC CARE AND GIVE CONSENT TO THE EXAMINATION THAT THE DOCTOR DEEMS NECESSARY AND THE CHIROPRACTIC CARE, INCLUDING SPINAL ADJUSTMENTS, AS REPORTED FOLLOWING MY ASSESSMENT.

_____

PRINT PATIENT'S NAME HERE

_____ _____

PATIENT'S SIGNATURE **DATE**

IF THIS HEALTH PROFILE IS FOR A MINOR/CHILD, PLEASE FILL OUT AND SIGN BELOW

WRITTEN CONSENT FOR A CHILD

NAME OF PATIENT WHO IS A MINOR/CHILD _____

I AUTHORIZE DR. ANDRE VOSKRESSENSKY/DR. JANET GOLDSTEIN AND ANY AND ALL CHIROPRACTIC LIFE CENTER OF BOCA RATON STAFF TO PERFORM DIAGNOSTIC PROCEDURES, RADIOGRAPHIC EVALUATIONS, RENDER CHIROPRACTIC CARE AND PERFORM CHIROPRACTIC ADJUSTMENTS TO MY MINOR/CHILD.

AS OF THIS DATE, I HAVE THE LEGAL RIGHT TO SELECT AND AUTHORIZE HEALTH CARE SERVICES FOR MY MINOR/CHILD. OF MY AUTHORITY TO SELECT AND AUTHORIZE CARE IS REVOKED OR ALTERED, I WILL IMMEDIATELY NOTIFY CHIROPRACTIC LIFE CENTER OF BOCA RATON.

_____ _____

DATE GUARDIAN SIGNATURE **AND** RELATIONSHIP TO MINOR /CHILD

_____ _____

WITNESS SIGNATURE (OFFICE STAFF) **DATE**

CHIROPRACTIC LIFE CENTER OF BOCA RATON

Terms of Acceptance

In order to provide for the most effective healing environment, most effective application of chiropractic procedures, and the strongest possible doctor-patient relationship, it is our wish to provide each patient with a set of parameters and declarations that will facilitate the goal of optimum health through chiropractic.

To that end, we ask that you acknowledge the following point regarding chiropractic care and the services that are offered through this clinic:

A. Chiropractic is a very specific science, authorized by law to address spinal health concerns and needs. Chiropractic is a separate and distinct science, art and practice. It is not the practice of medicine.
B. Chiropractic seeks to maximize the inherent healing power of the human body by restoring normal nerve functions through the adjustment of spine and/or extremity joint motion dysfunction(s). Spine and joint structural dysfunction is deviation from normal joint function that interferes with normal nerve processes.
C. The chiropractic adjustment process, as defined in the law of this jurisdiction, involves the application of a specific directional thrust to a region or regions of the spine or extremities with the specific intent of restoring motion and alignment. This is a safe, effective procedure applied over one million times each day doctors of chiropractic in the United States alone.
D. A thorough chiropractic examination and evaluation is part of the standard chiropractic procedure. The goal of this process is to identify any spinal health problems and chiropractic needs. If during this process, any condition or question outside the scope of chiropractic is identified, you will receive a prompt referral to an appropriate provider or specialist, according to the initial indications of the need.
E. Chiropractic does not seek to replace or compete with your medical, dental or other type(s) of health professionals. They retain responsibility for care and management of medical conditions. We do not offer advice regarding treatment prescribed by others.
F. Your compliance with care plans, home and self-care, etc., is essential to maximum healing and optimal health though chiropractic
G. We invite you to speak frankly to the doctor on any matter related to your care at this facility, its nature, duration, or cost, in what we work to maintain as a supporting, open environment.

By my signature below, I have read and fully understand the above statements.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my satisfaction. I therefore accept chiropractic care on this basis.

_____ _____

(Signature) **(Date)**

Notice of Privacy Practices Acknowledgement

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physician's certifications.

I acknowledge that I have received a copy of the NOTICE OF PRIVACY PRATICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used to disclosed to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

_____ _____

(Signature) **(Date)**

Consents

Consent to Bill/Collect Insurance: I consent, if I am using a third party for payment of my services (health insurance, auto accident insurance, worker's compensation insurance, Parent/Guardian, etc.), to allow Chiropractic Life Center of Boca Raton (Dr. Andre Voskressensky and/or Dr. Janet Goldstein) to submit all necessary information needed to receive payment for the services I received to these third parties. I further consent to accept assignment of payments from my insurance company to be paid directly to the office or doctor.

_____ _____ Patient/Guardian (circle)
Name Patient/Guardian Signature Date

Consent to Examination and Treatment: I give the doctors and staff of Chiropractic Life Center of Boca Raton permission to perform all examinations, x-rays, and treatment deemed necessary by the doctor. I understand that some of these procedures may be performed by either the staff or the doctor.

_____ _____ Patient/Guardian (circle)
Name Patient/Guardian Signature Date

Consent to Retrieve Medical Records: I give the doctors and staff of Chiropractic Life Center of Boca Raton permission to obtain any and all medical records from other providers, offices or hospitals which may assist with my care.

_____ _____ Patient/Guardian (circle)
Name Patient/Guardian Signature Date

HIPPA: A copy of the full Health Information Privacy Policy for our office can be requested at the front desk. In brief, it states that we will not give any information about you except as consented above. The only people we give information to are your parents/guardians if you are a minor or whomever is responsible for your bill (i.e. insurance company, third party, or attorney if you have one).

_____ _____ Patient/Guardian (circle)
Name Patient/Guardian Signature Date

Clinical Summary Report (CCR): I understand that a clinical summary report is created after each visit for the purpose of EHR and is available for my review. At this time, I am asking Chiropractic Life Center of Boca Raton to save these electronically for me and not print them out after each visit. I understand that, upon request, these reports are available to be printed or emailed to me for review.

_____ _____ Patient/Guardian (circle)
Name Patient/Guardian Signature Date

Pregnancy Waiver (Women Only): By my signature below, I am stating that to the best of my knowledge, I am not pregnant nor is pregnancy suspected at this time.

_____ _____ Patient/Guardian (circle)
Name Patient/Guardian Signature Date