



Kevin Fogarty, D.C., F.I.C.A. (Hon)

Megan Traficante, D.C.

Please fill in below:

Name: _____ Date: _____

Address: _____ Apt: _____ City, State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Gender: M ___ F ___ Date of Birth: _____ Height: _____ Weight: _____

Marital Status: _____ SS#: _____ Email: _____

Chief Complaint: _____

Mechanism of Injury: _____

How long have you had this problem? _____

Are you under the care of any other physician? Yes _____ No _____

If yes, please list the doctors you are seeing and the conditions you are being treated for:

Please list any medication you are presently taking and the reason for taking it:

Please list any previous surgeries: _____

Please list any accidents, auto accidents, or broken bones in the past: _____

Please list previous imaging: _____

Have you been to a chiropractor before? Yes _____ No _____ Date of last visit: _____

How long were you under care? _____ Condition treated for: _____

Name of chiropractor: _____

Your occupation: _____

Duties you are required to perform regularly at work or home: _____

Do you smoke cigarettes? Yes _____ No _____ # of packs per day: _____

Do you drink coffee? Yes _____ No _____ # of cups per day: _____

Do you consume alcohol? Yes _____ No _____ Approximately how much daily? _____

Do you exercise regularly? Yes _____ No _____ What type and how much? _____

Family Health History

Please describe the health of your:

Father: _____ Mother: _____

Spouse: _____ Children, give ages: _____

FEMALES: Is there a possibility of you being pregnant? _____

Have you EVER had any of the following? Please check:

- | | | | | |
|---------------------------------------|--|---|---|--|
| <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> T.B. | <input type="checkbox"/> Gout | <input type="checkbox"/> Thyroid Trouble | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Epilepsy/Seizures |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Cancer | <input type="checkbox"/> Tonsillitis | <input type="checkbox"/> Liver Trouble |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Gall Bladder Trouble | <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Slipped Disc | <input type="checkbox"/> Asthma | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Bowel Trouble | <input type="checkbox"/> Menstrual Problems | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Kidney Trouble |

Other: _____

Systems Review

Are you PRESENTLY suffering from any of the following? Please check:

- | | | | | |
|--|---|---|---|--|
| <u>Eyes</u> | <u>Cardiovascular</u> | <u>Musculoskeletal</u> | <u>Cognitive</u> | <u>Skin</u> |
| <input type="checkbox"/> change in vision | <input type="checkbox"/> heart palpitations | <input type="checkbox"/> back pains | <input type="checkbox"/> poor appetite | <input type="checkbox"/> dry skin |
| <input type="checkbox"/> eye pain | <input type="checkbox"/> chest pains | <input type="checkbox"/> hip pains | <input type="checkbox"/> poor memory | <input type="checkbox"/> skin discoloration |
| <input type="checkbox"/> watery eyes | <u>Abdominal</u> | <input type="checkbox"/> leg pains | <input type="checkbox"/> insomnia | <input type="checkbox"/> itching |
| <u>Ears</u> | <input type="checkbox"/> indigestion | <input type="checkbox"/> neck pains | <input type="checkbox"/> inner tension | <input type="checkbox"/> burning |
| <input type="checkbox"/> ear discharge | <input type="checkbox"/> heart burn | <input type="checkbox"/> shoulder/arm pains | <input type="checkbox"/> nervousness | <input type="checkbox"/> skin eruptions/rash |
| <input type="checkbox"/> impaired hearing | <input type="checkbox"/> belching | <input type="checkbox"/> other muscle pains | <input type="checkbox"/> personality changes | <input type="checkbox"/> excessive sweating |
| <input type="checkbox"/> ear aches | <input type="checkbox"/> vomiting | <input type="checkbox"/> numbness | <u>Pulmonary</u> | <input type="checkbox"/> bruising |
| <input type="checkbox"/> ringing in ears | <input type="checkbox"/> rectal bleeding | <input type="checkbox"/> tingling | <input type="checkbox"/> cough | <u>Other</u> (please list) |
| <u>Nose</u> | <input type="checkbox"/> irritable bowel | <input type="checkbox"/> joint pains | <input type="checkbox"/> shortness of breath | _____ |
| <input type="checkbox"/> sinus pains | <input type="checkbox"/> gas | <input type="checkbox"/> swelling of ankles | <input type="checkbox"/> dizziness | _____ |
| <input type="checkbox"/> nose bleeds | <input type="checkbox"/> constipation | <input type="checkbox"/> swelling of joints | <input type="checkbox"/> fainting | _____ |
| <u>Throat</u> | <input type="checkbox"/> diarrhea | <u>Neurological</u> | <u>Urinary</u> | _____ |
| <input type="checkbox"/> blisters in mouth | <input type="checkbox"/> abdominal pains | <input type="checkbox"/> headaches | <input type="checkbox"/> blood in urine | _____ |
| <input type="checkbox"/> problems swallowing | <input type="checkbox"/> nausea | <input type="checkbox"/> balance issues | <input type="checkbox"/> frequency of urination | _____ |
| <input type="checkbox"/> throat lumps | <input type="checkbox"/> change in weight | <input type="checkbox"/> fatigue | <input type="checkbox"/> pain on voiding | _____ |
| <input type="checkbox"/> sore throat | <input type="checkbox"/> swelling | <input type="checkbox"/> weakness | <input type="checkbox"/> cloudy urine | _____ |

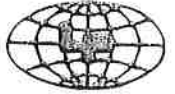
Insurance Information

Type of insurance: Regular Medical _____ Medicare _____ Medicaid _____ Auto _____ Workers Comp _____
 Name of Insured: _____ SS# _____
 Insured's Date of Birth: _____ Name of Employer: _____
 Insurance Company: _____ Phone #: _____
 Insurance Company Address: _____
 Policy # _____ Group # _____ Claim # _____

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

Patient Name: _____ Date: _____

Signature: _____ Relation to patient: _____



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Doctor Patient Relationship

Privacy:

The *Standards for Privacy of Individually Identifiable Health Information* ("Privacy Rule") establishes, for the first time, a set of national standards for the protection of certain health information. The U.S. Department of Health and Human Services issued the Privacy Rule to implement the requirement of the *Health Insurance Portability and Accountability Act* of 1996 ("HIPAA"). A major goal of the Privacy Rule is to assure that individuals' health information is properly protected while allowing the flow of health information needed to provide and promote high quality health care and to protect the public's health and well being.

You can be assured that our clinic takes your privacy seriously and is in compliance with all HIPPA guidelines. Your health information will not be disclosed without your permission or will your name, address or telephone number be disclosed to any third party. Our privacy policy is posted in the reception area and is available at the front desk upon your request.

Questions

Just as in a good marriage, proper communication is an absolute necessity. We want to help you attain your goal of health. If at any time your response is not satisfactory, we will gladly assist you in choosing a referral doctor for another opinion. Your health is our number one priority.

Acknowledgement:

I have read or have had read to me the above consent. I have had the opportunity to ask questions, about its context and by signing below I agree to the above named procedures. I intend this consent to cover the course of treatment for my present condition and for any future condition(s) for which I seek treatment.

I have read and understand the foregoing.

Date _____ Patient Name: _____

Signature: _____

Name of Guardian/Parental and Relationship to Patient: _____

Guardian/ Parental Signature: _____

Date _____ Witness: _____

Fogarty Chiropractic Life Clinic

839 Barton Blvd.
Rockledge, FL 32955-3127
Phone (321) 636-5200

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

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 / Other / 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 as a result of the nature and frequency of chiropractic care.)

Patient Signature: _____ Date: _____

For office use only

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



Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date: _____

Parent or Guardian: _____ Signature: _____ Date: _____

Witness Name: _____ Signature: _____ Date: _____

Fogarty

Chiropractic Life Clinic



LASTING PURPOSE

Kevin Fogarty, D.C., F.I.C.A. (Hon)

FINANCIAL RESPONSIBILITY

Lifetime Assignment and Instruction for Direct Payment to Doctor Private and Group Accident and Health Insurance Authorization to Release/Request Records

Patient name: _____ SSN: _____ Date of Birth: _____

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

**FOGARTY CHIROPRACTIC LIFE CLINIC
839 BARTON BLVD.
ROCKLEDGE, FL 32955**

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 service rendered. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY TO FOGARTY CHIROPRACTIC LIFE CLINIC FOR PAYMENT OF PROFESSIONAL SERVICES RENDERED.** 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. I assign to said clinic all rights patient has under any contract of insurance for collection of same.

This also certifies that the above named individual agrees to pay in full for all professional services rendered at the time they are performed, unless other arrangements are made in advance of the set appointment. The below named guarantor understands a \$25.00 returned check fee will be charged along with any appropriate collection or attorney's fee which may accrue upon collection of any outstanding balance.

Initials

RECORDS REQUEST

This is to certify that the above named patient authorizes full request of any records pertinent to the health care of same individual from but not inclusive of any insurance carrier, adjustor, attorney, hospital or other health care provider.

This also authorizes Fogarty Chiropractic Life Clinic to release records, upon receipt of the above named patient's signature, or on an emergency basis, to but not inclusive of, any insurance carrier, attorney, health care provider, hospital or immediate family member.

Initials

A photocopy of this assignment shall be considered as effective and valid as the original. This document is considered a living document and does not expire.

Privacy: The *Standards for Privacy of Individually Identifiable Health Information* ("Privacy Rule") establishes, for the first time, a set of national standards for the protection of certain health information. The U.S. Department of Health and Human Services issued the Privacy Rule to implement the requirement of the *Health Insurance Portability and Accountability Act* of 1996 ("HIPAA") A major goal of the Privacy Rule is to assure that individuals' health information is properly protected while allowing the flow of health information needed to provide and promote high quality health care and to protect the public's health and well being.

You can be assured that our clinic takes your privacy seriously and is in compliance with all HIPPA guidelines. Your health information will not be disclosed without your permission or will your name, address or telephone number be disclosed to any third party.

I have read and understand the foregoing. I have also received a copy of the HIPPA privacy statement and Fogarty Chiropractic Life Clinic's Fee Sheet.

Date _____

Patient/Policyholder _____

Date _____

Witness _____