Mid-Florida Medical & Chiropractic Center

100 Park Place Blvd Suite 201 Kissimmee, FL 34741
Phone: 407-847-8900 * Fax: 407-931-3500

PATIENT REGISTRATION FORM

TODAYS DATE: _____/_____/_____

PATIENTS NAME: _____ ☐MR. ☐ MRS. ☐ MISS. ☐ MS.

IS THIS YOUR LEGAL NAME: ☐ YES ☐ NO **IF NOT WHAT IS YOUR LEGAL NAME:** _____

Height_____ **Weight**_____ **Right Handed** ☐ **Left Handed** ☐

MARITAL STATUS: (Please check one) SINGLE ☐ MARRIED ☐ DIVORCED ☐ SEPERATED ☐ WIDOW ☐

DATE OF BIRTH: _____/_____/_____ **AGE:** _____ **SEX:** MALE ☐ FEMALE ☐ SS# _____

STREET ADDRESS: _____ **CITY:** _____ **STATE/ZIP:** _____

CELL PHONE: (_____) _____ **HOME PHONE:** (_____) _____

WORK PHONE: (_____) _____ **E-Mail:** _____

N CASE OF EMERGENCY: NAME OF LOCAL FRIEND OR RELATIVE

NAME: _____ **RELATIONSHIP:** _____ **PHONE #** (_____) _____

Are you: employed ☐ unemployed ☐ retired ☐ disabled ☐ student ☐

(If you are employed please complete the following:)

Where are you employed: _____What type of work do you do?_____

Do you: Work on a computer ☐ Have long sitting periods ☐ Have long standing periods ☐ Do a lot of bending ☐

Social History

1. Do you presently Smoke	Yes ☐	No ☐	If yes :: # Packs/day ____ # Years___
2. Have you ever smoked	Yes ☐	No ☐	If yes :: #Packs/day ____ # Years___
3. Do you drink alcohol	Yes ☐	No ☐	If Yes :: # Drinks _____ per week
4. Have you ever used any addictive substances?	Yes ☐	No ☐	If Yes :: (Substance: _____)
5. **Do you have any children:**	Yes ☐	No ☐	if yes please state # of children _____

FEMALE PATIENTS - PLEASE COMPLETE THE FOLLOWING:

Are you pregnant: Yes ☐ No ☐ (If yes) How Many Months _____ **Are you breast feeding?** Yes ☐ No ☐

When was your last menstrual period? _____ If Not Known please check here ☐

The above information is true to the best of my knowledge. I understand that I am financially responsible for any balance not paid by my insurance company. I authorize Mid-Florida Medical & Chiropractic Center, Inc to release my medical records and appointment information to my insurance company and/or my attorney to help process my case and/or claim. I also authorize the release of my medical records from Mid-Florida Medical & Chiropractic Center to other physicians who treat me for my condition whilst under the care of Mid-Florida Medical & Chiropractic Center.

Patient's Signature: _____ Date: _____/_____/_____

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PERSONAL HEALTH HISTORY

Patient's Name _____ **DOB** _____ **Date** _____

All information will be kept strictly confidential. Your responses will help determine if chiropractic treatment will benefit you. Unless we sincerely feel that your condition will respond satisfactorily, we will not recommend treatment. Please check the degree of all conditions you currently have or have had. To be responsible for your case, we need your complete health history.

Place a check in a box for any symptom you currently have or have had

General
- ☐ Allergy
- ☐ Chills
- ☐ Convulsions
- ☐ Fainting
- ☐ Fatigue
- ☐ Fever
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness, depression
- ☐ Neuralgia
- ☐ Sweats
- ☐ Tremors

Cardiovascular
- ☐ Hardening of arteries
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Pain over heart
- ☐ Poor circulation
- ☐ Rapid heartbeat
- ☐ Slow heartbeat
- ☐ Swelling of ankles

Genitourinary
- ☐ Bed-wetting
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of kidney control
- ☐ Kidney infection
- ☐ Painful urination
- ☐ Prostate trouble
- ☐ Pus in urine

Respiratory
- ☐ Chest pain
- ☐ Chronic cough
- ☐ Difficult breathing
- ☐ Spitting up blood
- ☐ Spitting up phlegm
- ☐ Wheezing

Eye, Ear, Nose and Throat
- ☐ Asthma
- ☐ Colds
- ☐ Crossed eyes
- ☐ Deafness
- ☐ Dental decay
- ☐ Earache
- ☐ Ear discharge
- ☐ Ear noise
- ☐ Enlarged glands
- ☐ Enlarged thyroid
- ☐ Eye pain
- ☐ Failing vision
- ☐ Far sightedness
- ☐ Gum trouble
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Nasal obstruction
- ☐ Near sightedness
- ☐ Nose bleeds
- ☐ Sinus infection
- ☐ Sore throat
- ☐ Tonsillitis

Gastrointestinal
- ☐ Belching or gas
- ☐ Colitis
- ☐ Colon trouble
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficult digestion
- ☐ Bloated abdomen
- ☐ Excessive hunger
- ☐ Gallbladder trouble
- ☐ Hemorrhoids
- ☐ Intestinal worms
- ☐ Jaundice
- ☐ Liver trouble
- ☐ Nausea
- ☐ Pain over stomach
- ☐ Poor appetite
- ☐ Vomiting
- ☐ Vomiting of blood

Skin
- ☐ Boils
- ☐ Bruise easily
- ☐ Dryness
- ☐ Hives or allergy
- ☐ Itching
- ☐ Skin eruptions (rash)
- ☐ Varicose veins

Women only
- ☐ Congested breasts
- ☐ Cramps or backache
- ☐ Excess menstrual flow
- ☐ Hot flashes
- ☐ Irregular cycle
- ☐ Lumps in breast
- ☐ Menopause
- ☐ Painful menstruation
- ☐ Vaginal discharge

Are you pregnant? ☐Yes ☐No

If yes, how many months?____

How many children do you have?___

Check any of the following conditions you currently have or have had:
- ☐ Alcoholism
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Cancer
- ☐ Chicken pox
- ☐ Cholera
- ☐ Cold sores
- ☐ Diabetes
- ☐ Diptheria
- ☐ Eczema
- ☐ Edema
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fever blisters
- ☐ Goiter
- ☐ Gout
- ☐ Heart disease
- ☐ Herpes
- ☐ Influenza
- ☐ Lumbago
- ☐ Malaria
- ☐ Measles
- ☐ Miscarriage
- ☐ Multiple sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pleurisy
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic fever
- ☐ Scarlet fever
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Typhoid fever
- ☐ Ulcers
- ☐ Venereal disease
- ☐ Whooping cough

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Please check all that apply as it relates to your condition -- Do you have/feel any of the following:

Headache ☐	Neck Pain ☐	Neck Stiffness ☐	Fainting ☐
Ringing in ears ☐	Loss of smell ☐	Pain behind eyes ☐	Dizziness ☐
Nausea ☐	Confusion ☐	Fatigue ☐	Tension ☐
Irritability ☐	Mid back pain ☐	Low back pain ☐	Loss of taste ☐
Depression ☐	Anxious ☐	Chest pain ☐	Shortness of breath ☐

Loss of normal vision ☐ Problems winking your eyes ☐ Trouble moving your tongue ☐
Loss of ability to hear ☐ Any Difficulty swallowing ☐ Any hoarseness in your voice ☐
Any sleeping problems ☐ Trouble shrugging your shoulders ☐
OTHER (please describe) _____
Is your pain aggravated in the: **AM** ☐ PM ☐ or AM & PM ☐

Please list any prior Hospitalization/Operations

Date	Reason/Procedure	Hospital

Please list your current Medication(s) (Please include any Vitamins or Herbal Medications)

Name	Dose	Frequency

Medication Allergies

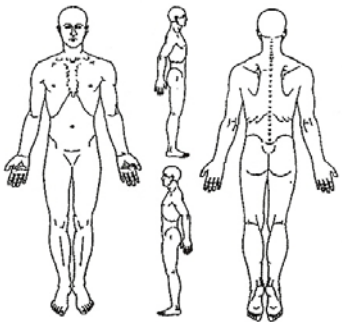
List any Medication Allergies and the type of reaction: If none are known please check here: ☐

_____

PAIN DIAGRAM

On the diagram below, please circle where you are experiencing pain or other symptoms at the present time:
Please indicate the areas circled with one or more of the following:

A = Aches **B** = Burning **N** = Numbness **P** = Pain **PN** = Pins & Needles **S** = Stabbing **O**= Other



I certify that I have read and understand all of the information requested of me concerning my medical history and health problems and that my answers are true and accurate to the best of my knowledge. I further certify that I do have the indicated health problem(s) and that I desire an appropriate medical examination, treatment and/or advice necessary.

Patient's Signature: _____ **Date:** _____

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Medical Release Form

Patient's Name: _____ D.O.B: _____

I request and authorize the following provider(s) and/or physician(s) to release healthcare information and medical records to: **Mid-Florida Medical & Chiropractic Center 100 Park Place Blvd Suite 201 Kissimmee FL 34741** ** **Phone**: 407-847-8900 **Fax**: 407-931-3500

(name of provider/office)_____

Fax #: _____ Notes: _____

(name of provider/office)_____

Fax #: _____ Notes: _____ (name of provider/office)_____

Fax #: _____ Notes: _____ (name of provider/office)_____

Fax #: _____ Notes: _____

This request and authorization applies to:

- ☒ **Full** medical records held by the office **for all dates of service**
- ☐ A specific portion/section of the record as follows: _____
- ☒ MRI/X-Ray Reports
- ☐ Medical Records for the period of _____ through _____
- ☐ Other diagnostic studies: _____

Purpose of the requested disclosure: At the patient's request ☐ Continuing Care ☒

I understand that I have the right to revoke this authorization at any time. my revocation must be in writing in a letter provided to the privacy officer. I am aware that my revocation is not effective to the extent that the person I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization. I understand that I do not have to sign this authorization and that Mid-Florida Medical & Chiropractic Center may not condition treatment on whether I sign this authorization. I further understand that if the person(s) or organization(s) authorized to receive the information is not a health plan or health care provider, the release information may be re-disclosed and would no longer be protected by Federal Privacy Regulations. I agree that a copy of this release of fax of this release shall be as valid as the original release. If I authorize Mid-Florida Medical & Chiropractic Center to fax information, I realize there are inherit risks in faxing protected health information.

Patient's / Guardian's Signature _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES 365 DAYS FROM THE DATE IT IS SIGNED

Federal Law (HIPPA) says that an individual's health information cannot be shared without the individuals consent except in certain situations. This form must be completed and signed by the patient or by the appointed representative for the patient (parent of minor, legal guardian, trustee, power of attorney, personal representative of the state). If you sign this form you are consenting for the medical providers to share the information indicated above.