ESSENTIAL MIND & BODY **Dr. Robert Koch, D.C.**

Patient

Name: (first)________________ (middle) ____________ (last)______________ Date: ____/____/____

Date of Birth ____/____/_____ Age:_____ Gender: ☐ Male ☐ Female Soc Sec #____-___-_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other:_____________________

Address_________________________________ City_________________ State______ Zip __________

Home phone (____)____-______ Cell phone (____)____-_____ Work phone (____)____-______

Email address: ___________________ *(note: Your email may be used to remind you of future appointments, occasional office announcements or promotions. It will NOT be shared with any 3rd parties)*

Employer: ____ Occupation: ______________________

Spouse/Partner/Family

Name:_________________________ Cell phone (____)____-_____ Work phone (____)____-______

Employer:__________________________________ Occupation:______________________________

Children's names & ages:____

Emergency Contact

Name: __________________________ Phone#(____)____-_____ Relationship to patient___________

Whom may we thank for referring you to our office? ____

Personal Health Insurance

Insurance company name:_______________________________________ Phone# (____)____-______

Address_________________________________ City_________________ State______ Zip __________

Insurance ID#/Policy#___________________________ Group #_________________

Insured name: _____________________Date of Birth ___/___/____ Relationship to patient__________

Auto Insurance/Workers Compensation (if injury related to auto acc or work incident)

Insurance company name:_______________________________________ Phone# (____)____-______

Address_________________________________ City_________________ State______ Zip __________

Insured name: _____________________Date of Birth ___/___/____ Relationship to patient__________

Date of Injury ___/___/____ Claim #____________________________ Policy #__________________

Claim adjustor name:______________________________ Phone # (____)____-______ Ext _________

If auto accident injury: ☐ Patient was driver in the car ☐ Patient was passenger in the car

Attorney (if applicable)

Firm & Attorney Name:____ Phone# (____)____-______

Address_________________________________ City_________________ State______ Zip __________

Contact name at Attorney office__________________________________ Phone# (____)____-______

Patient Health Questionnaire

Patient Name: ______________________________ Date: ______________

1. When did your symptoms start?: ______________________________

Describe your symptoms and how they began: ______________________________

____

2. How often do you experience your symptoms? Indicate where you have pain or other symptoms:

1. Constantly (76%-100% of the day)
2. Frequently (51%-75% of the day)
3. Occasionally (26%-50% of the day)
4. Intermittently (0%-25% of the day)

3. What describes the nature of your symptoms?

1. Sharp
2. Dull ache
3. Numb
4. Shooting
5. Burning
6. Tingling

4. How are your symptoms changing?

1. Getting better
2. Not changing
3. Getting Worse

5. How bad are your symptoms at their:

	None										Unbearable
a. worst:	0	1	2	3	4	5	6	7	8	9	10
b. best:	0	1	2	3	4	5	6	7	8	9	10

6. How do your symptoms affect your ability to perform daily activities?

0	1	2	3	4	5	6	7	8	9	10
No Complaints		Mild, forgotten with activity		Moderate, interferes with activity		Limiting, prevents full activity		Intense, preoccupied with seeking relief		Severe, no activity possible

7. What activities make your symptoms worse? ______________________________

8. What activities make your symptoms better? ______________________________

9. Who have you seen for your symptoms?

1. No one
2. Other Chiropractor
3. Medical Doctor
4. Physical Therapist
5. Other

a. When and what treatment? ______________________________

b. What tests have you had for your symptoms and when were they perfomed?

1. X-rays date: ____________
2. MRI date: ____________
3. CT Scan date: ____________
4. Other date: ____________

10. Have you had similar symptoms in the past? 1. Yes 2. No

a. If you have received similar treatment in the past for the same or similar symptoms, who did you see?

1. This office
2. Other Chiropractor
3. Medical Doctor
4. Physical Therapist
5. Other

11. What is your occupation?

1. Professional/Executive
2. White Collar/Secretarial
3. Tradesperson
4. Laborer
5. Homemaker
6. FT Student
7. Retired
8. Other

a. If you are retired, a homemaker, or a student, what is your current work status?

1. Full-time
2. Part-time
3. Self-employed
4. Unemployed
5. Off work
6. Other

12. What do you hope to get from your visit/treatment? (select all that apply):

1. Reduce symptoms
2. Resume/increase activity
3. Explanation of condition/treatment
4. Learn how to take care of this on my own
5. How to prevent this from occurring again
6. ______________________________

Patient Signature: ______________________________ *Date:* ______________

Patient Health Questionnaire - page 2

Patient Name: ______________________ Date: ____________

What type of regular exercise do you perform? 1. None 2. Light 3. Moderate 4. Strenuous

What is your height and weight? **Height:** ______ Feet ______ Inches **Weight:** ________ lbs.

For each of the conditions listed below, place a check in the Past column if you have had the condition in the past. If you presently have a condition listed below, place a check in the Present column.

Past	Present	Condition
☐	☐	Headaches
☐	☐	Neck Pain
☐	☐	Upper Back Pain
☐	☐	Mid Back Pain
☐	☐	Low Back Pain
☐	☐	Shoulder Pain
☐	☐	Elbow/Upper Arm Pain
☐	☐	Wrist Pain
☐	☐	Hand Pain
☐	☐	Hip/Upper Leg Pain
☐	☐	Knee/Lower Leg Pain
☐	☐	Ankle/Foot Pain
☐	☐	Jaw Pain
☐	☐	Joint Swelling/Stiffness
☐	☐	Arthritis
☐	☐	Rheumatoid Arthritis
☐	☐	General Fatigue
☐	☐	Muscular Incoordination
☐	☐	Visual Disturbances
☐	☐	Dizziness

Past	Present	Condition
☐	☐	High Blood Pressure
☐	☐	Heart Attack
☐	☐	Chest Pains
☐	☐	Stroke
☐	☐	Angina
☐	☐	Kidney Stones
☐	☐	Kidney Disorders
☐	☐	Bladder Infection
☐	☐	Painful Urination
☐	☐	Loss of Bladder Control
☐	☐	Prostate Problems
☐	☐	Abnormal Weight Loss/Gain
☐	☐	Loss of Appetite
☐	☐	Abdominal Pain
☐	☐	Ulcer
☐	☐	Hepatitis
☐	☐	Liver/Gall Bladder Disorder
☐	☐	Cancer
☐	☐	Tumor
☐	☐	Asthma
☐	☐	Chronic Sinusitis

Past	Present	Condition
☐	☐	Diabetes
☐	☐	Excessive Thirst
☐	☐	Frequent Urination
☐	☐	Smoking/Use Tobacco Products
☐	☐	Drug/Alcohol Dependence
☐	☐	Allergies
☐	☐	Depression
☐	☐	Systemic Lupus
☐	☐	Epilepsy
☐	☐	Dermatitis/Eczema/Rash
☐	☐	HIV/AIDS

Females Only

Past	Present	Condition
☐	☐	Birth Control Pills
☐	☐	Hormonal Replacement
☐	☐	Pregnancy

Other Health Problems/Issues

Past	Present	Condition
☐	☐	
☐	☐	
☐	☐	
☐	☐	

Indicate if an immediate family member has had any of the following:

☐ Rheumatoid Arthritis ☐ Heart Problems ☐ Diabetes ☐ Cancer ☐ Lupus ☐ ____________

List all prescription and over-the-counter medications, and nutritional/herbal supplements you are taking:

____

____

List all the surgical procedures you have had and the times you have been hospitalized:

____

____

Patient Signature: ______________________ *Date:* ____________

Doctor's Additional Comments

____

____

____

Doctor's Signature: ______________________ *Date:* ____________

Phone: (407) 423-1616
Fax: (407) 423-1889

ESSENTIAL MIND & BODY

Robert Koch, D.C.
415 E. Michigan St.
Orlando, FL 32806

Date:____________________

Accident History

Name:____
Address:____
City:_________________________ State:______________ Zip:_________________
Phone:________________________________

Check One: ☐ Personal Injury (Auto Accident/Slip & Fall)
☐ Worker's Compensation
☐ Other:____

Date of Accident:______________________

History:

1. Were you a (Check one): ☐ Driver ☐ Passenger ☐ Other:__________
2. Location of accident: (Street):____
3. Was your vehicle (Check one): ☐ Traveling along ☐ Stopped ☐ Accelerating
4. Were you (Check one): ☐ Stopped at red light/stop sign and rear-ended
   ☐ Hit head on
   ☐ Car ran a stop sign
   ☐ Car ran a red light
   ☐ Side swiped
   ☐ Lost control of car
   ☐ Other:______________________________________
   ____
5. Please describe the accident:____
____
____
____
6. What type of vehicle were you in?_______________________________________
7. What other type of vehicle involved in accident?___________________________
8. Were you wearing your seat belt? ☐ Yes ☐ No
9. Did airbags go off? ☐ Yes ☐ No
10. Did you strike any objects inside the car: ☐ Yes ☐ No
    If yes (Check one): ☐ Steering column ☐ Rearview mirror ☐ Dash Board
    ☐ Windshield ☐ Headrest ☐ Cannot remember details ☐ Other:________
____

11. What portion of your body did you strike: ☐ head ☐ chest ☐ face ☐ arms ☐ other: ______________________________

12. Were you rendered unconscious, cut, or bleeding? ☐ Yes ☐ No

13. Did you feel any immediate pain? ☐ Yes ☐ No

If yes, please explain:

	Right Side	Left Side
Headache:	☐	☐
Neck pain:	☐	☐
Mid back pain:	☐	☐
Low back pain:	☐	☐
Extremity:	☐	☐

Other: ______________________________

14. When did your symptoms start: ☐ Immediately ☐ Later that day ☐ The next day ☐ Other: ______________________________

15. After the accident, did you: (Check one) ☐ Go Home ☐ Go about your business ☐ Go to the hospital

If you did not go to the hospital, please go to question 17

16. If taken to hospital, how? (Check one) ☐ By ambulance ☐ Driven by friend or relative ☐ Drove yourself ☐ Went home and drove/was take to the hospital later that day

Were you seen in the emergency room? ☐ Yes ☐ No
Were you admitted to the hospital? ☐ Yes ☐ No
If admitted, how long did you stay? ______________________________
Name of hospital and admitting physician: ______________________________
In the emergency room or hospital, what was done:

☐ Examination ☐ Stitches
☐ X-rays ☐ Physical Therapy
☐ Cervical Collar ☐ Complete Bedrest
☐ Prescription ☐ Other: ______________________________

After your release, what did you do? (Check one) ☐ Returned home to bed ☐ Returned to work ☐ Other: ______________________________

17. When did you first consult a physician? ☐ Same day ☐ Following day ☐ Within a few days ☐ Other: ______________________________

18. Who did you consult? Dr.: ______________________________
(Check one) ☐ Family Physician ☐ Chiropractor ☐ Orthopedic ☐ Osteopath ☐ Neurologist ☐ Other: ______________________________

19. What did the doctor do? (Check one)

☐ Examination ☐ Stitches
☐ X-rays ☐ Physical Therapy
☐ Cervical Collar ☐ Complete Bedrest
☐ Prescription ☐ Other: ______________________________

20. How long were you under the care of a physician? ______________________
Are you still under his care?: ☐ Yes ☐ No

21. Did the doctor refer you or have you been to any other physicians?
☐ Yes ☐ No If yes, please explain to whom and where: ______________
____

Past History

22. Have you ever been in any previous accident of any kind? ☐ Yes ☐ No
If yes, please explain: ____
____

23. Have you ever been treated for neck or back problems by any other physicians prior to this accident? ☐ Yes ☐ No If yes, please explain: ______
____

24. Have you ever had same or similar symptoms? ☐ Yes ☐ No

25. Are your symptoms solely a result of the accident? ☐ Yes ☐ No

26. Do you have any significant major medical history? _______________
____

27. Have you ever had any fractures? _____________________________

Present Complaints:

28. What are your present complaints? ____________________________
____

29. Have you lost any time from work since the accident? ☐ Yes ☐ No
Still off work? ____
Date returned to work: _______________________________________

30. Do you have an attorney representing you? ☐ Yes ☐ No
If yes: Name: ______________________________
Address: ____________________________
City: ____________ State: _____ Zip: _______
Phone Number: ________________________

31. Name of your auto insurance company: ___________
Address: _________________________________
City/State/Zip: ____________________________

Name of insured: ___________________________
Claim Number: ______________________________
Name of Claim's Adjuster: ____________________

Thank you for completing these forms.

ESSENTIAL MIND & BODY
Robert Koch, D.C.
415 East Michigan Street
Orlando, FL 32806
(407) 423-1616
Fax (407) 423-1889

Patient: ____

ASSIGNMENT OF BENEFITS

I hereby authorize payment to be made directly to ESSENTIAL MIND & BODY all benefits which may be due and payable under insurance coverage for the above named patient. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments. I further acknowledge that this assignment of benefits does not in any way relieve me of liability and that I will remain financially responsible to ESSENTIAL MIND & BODY.

Furthermore, I hereby IRREVOCABLY ASSIGN to ESSENTIAL MIND & BODY the rights and benefits under any policy of insurance, indemnity agreement, or any other collateral source as defined in Florida Statutes for any service and/or charges provided by ESSENTIAL MIND & BODY.

AUTHORIZATION TO RECEIVE MEDICAL RECORD INFORMATION

ESSENTIAL MIND & BODY is hereby authorized to request the release of any medical records, laboratory test results, and radiographic & diagnostic imaging results, pertinent to the health care of the above named patient from, but not inclusive of, any insurance carrier, adjustor, attorney, or other health care provider.

AUTHORIZATION TO RELEASE MEDICAL RECORD INFORMATION

ESSENTIAL MIND & BODY is also authorized to release any medical records pertinent to the health care of the above named patient to, but not inclusive of, any insurance carrier, adjustor, attorney, health care provider, or immediate family member, upon receipt of the signature of the above named patient or the signature of the patient's legal guardian. This authorization is given with full knowledge that such disclosure may contain information of a confidential nature and may result in a denial of insurance coverage (in the event that claims are submitted to an insurance company on your behalf) for services rendered by said ESSENTIAL MIND & BODY.

______________________________________ ____________________
Signature of patient or parent/legal guardian Date

______________________________________ ____________________
Signature of staff member Date

Dear Patient or Legal Representative: Please initial each section

Authorization to Release Information

_____ I authorize this health care facility to release all information related to the care I receive to my insurance company, third party payor, or their designee, as may be necessary for the payment of my bill for services rendered, for determining benefits, and for utilization and quality review purposes.

Consent for Treatment

_____ I authorize the performance of diagnostic tests, procedures and treatment deemed necessary by personnel involved in my care. My name and other personal information is kept confidential.

Assignment of Benefits

_____ I assign to Action Chiropractic Clinic all benefits payable to me for my care. I understand that this health care facility will be paid directly by the insurance company or other payor. This assignment will remain in effect until revoked to me in writing. A photocopy of this assignment is considered as valid as the original.

Insurance Benefits

_____ I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged to me are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for services rendered to me will be immediately due and payable.

Guarantee of Payment

_____I guarantee payment of all charges incurred for treatment in accordance with the rates and terms of this health care facility.

Information About Possible Risks of Treatment

Doctors of Chiropractic, Medical Doctors and Physical Therapists using manual therapy treatments for patients with headache and cervical spine (neck) complaints, are required to explain that there have been rare cases of injury to a vertebral artery as a result of treatment. Such an injury has been known to cause a stroke, sometimes with serious neurological damage. The chances of this happening are estimated to be 1 per 10 million treatments.

Appropriate tests will be performed to help identify if you may be susceptible to this type of injury and you will be notified if that is the case. If you have any questions about this, please do not hesitate to speak with your Doctor of Chiropractic.

As with any health procedures, complications may arise during treatment. These complications include soreness, muscle or ligament strain, dislocations, fractures, disk injuries, or physical therapy burns. These are extremely rare occurrences.

Signature of Patient or Responsible Party: ______________________________ Date ____/____/____

Relationship to Patient: ____

Consent for Purposes of Treatment, Payment & Healthcare Operations and Acknowledgement of Receipt of Privacy Practices

I consent to the use or disclosure of my protected health information by Essential Mind & Body for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct the health care operations of Essential Mind & Body. I understand that diagnosis or treatment of me by the doctors and associates of Essential Mind & Body may be conditioned upon my consent as evidenced by my signature on this document.

I understand that I have the right to request a restriction as to how my protected health information (PHI) is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Essential Mind & Body is not required to agree to the restrictions that I may request. Unless Essential Mind & Body is notified otherwise, I consent to being contacted by Essential Mind & Body by telephone, mail, or other electronic means including but not limited to email and text messages in order to confirm or reschedule appointments, advise me of changes in office hours, provide newsletters, or invite me to any special events.

I have the right to revoke this consent, in writing, at any time, except to the extent the Essential Mind & Body had taken action in reliance on this consent.

Protected Health Information (PHI)-
My "protected health information" (PHI) means health information, including my demographic information, collected from me and created or received by my physician, another health car provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

Essential Mind & Body may disclose your PHI to a family member or a close friend if those persons accompany you while you are receiving health care services: or if we determine that it is in your best interest so we can provide you with the best health care possible. Essential Mind & Body may also disclose your PHI to a family member or someone else who helps pay for your health care treatment.

Notice of Privacy Practices
The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of healthcare operations of Essential Mind & Body. The Notice of Privacy Practices also describes my rights and Essential Mind & Body's duties with respect to my protected health information. The Notice of Privacy Practices is provided at 415 East Michigan Street, Orlando, FL 32806.

I acknowledge that I am able to review a complete copy of Essential Mind & Body's Notice of Privacy Practices upon my request. I understand that this form will be placed in my patient file and maintained for six years.

______________________________	______________________________
Name of Patient	Date
______________________________	______________________________
Signature of Patient or Legal Representative	Description of Legal Representative's Authority