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: _____

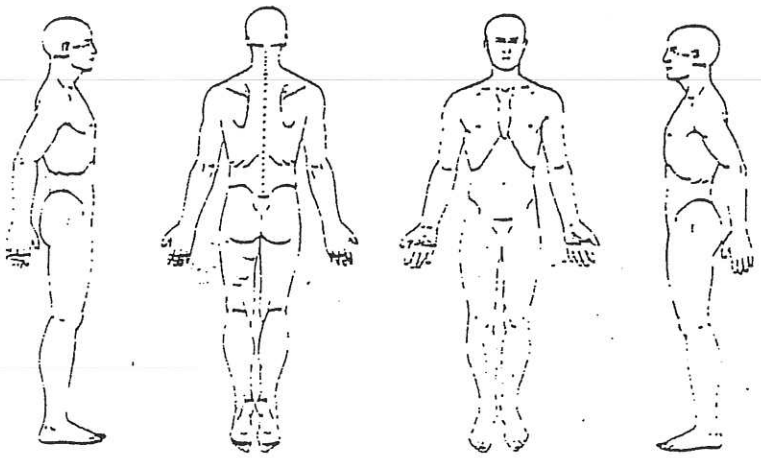
1. When did your symptoms start?: _____

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		Past	Present		Past	Present	
☐	☐	Headaches	☐	☐	High Blood Pressure	☐	☐	Diabetes
☐	☐	Neck Pain	☐	☐	Heart Attack	☐	☐	Excessive Thirst
☐	☐	Upper Back Pain	☐	☐	Chest Pains	☐	☐	Frequent Urination
☐	☐	Mid Back Pain	☐	☐	Stroke	☐	☐	Smoking/Use Tobacco Products
☐	☐	Low Back Pain	☐	☐	Angina	☐	☐	Drug/Alcohol Dependence
☐	☐	Shoulder Pain	☐	☐	Kidney Stones	☐	☐	Allergies
☐	☐	Elbow/Upper Arm Pain	☐	☐	Kidney Disorders	☐	☐	Depression
☐	☐	Wrist Pain	☐	☐	Bladder Infection	☐	☐	Systemic Lupus
☐	☐	Hand Pain	☐	☐	Painful Urination	☐	☐	Epilepsy
☐	☐	Hip/Upper Leg Pain	☐	☐	Loss of Bladder Control	☐	☐	Dermatitis/Eczema/Rash
☐	☐	Knee/Lower Leg Pain	☐	☐	Prostate Problems	☐	☐	HIV/AIDS
☐	☐	Ankle/Foot Pain	☐	☐	Abnormal Weight Loss/Gain			
☐	☐	Jaw Pain	☐	☐	Loss of Appetite			
			☐	☐	Abdominal Pain			
☐	☐	Joint Swelling/Stiffness	☐	☐	Ulcer			
☐	☐	Arthritis	☐	☐	Hepatitis			
☐	☐	Rheumatoid Arthritis	☐	☐	Liver/Gall Bladder Disorder			
☐	☐	General Fatigue	☐	☐	Cancer			
☐	☐	Muscular Incoordination	☐	☐	Tumor			
☐	☐	Visual Disturbances	☐	☐	Asthma			
☐	☐	Dizziness	☐	☐	Chronic Sinusitis			

Females Only

☐	☐	Birth Control Pills
☐	☐	Hormonal Replacement
☐	☐	Pregnancy

Other Health Problems/Issues

☐	☐
☐	☐
☐	☐
☐	☐

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:* _____

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

Authorization for Treatment & Release of Information

I authorize the performance of diagnostic tests, procedures and treatment deemed necessary by personnel involved in my care. I also 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.

Assignment of Benefits & Insurance Benefits

I assign to Essential Mind & Body 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.

I also 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.

Informed Consent for Treatment and Care at Essential Mind & Body

I hereby request and consent to the performance of chiropractic adjustments and other procedures, including various modes of physical therapy, diagnostic xrays, massage therapy, and acupuncture, on me (or on the patient named below for whom I am legally responsible) by Dr. Robert Koch and /or other licensed personnel who now or in the future treat me while employed by, working for or associated with Essential Mind and Body.

In understand I will have the opportunity to discuss with the doctors of Essential Mind & Body, and/or with other office or clinic personnel, the nature and purpose of the procedures and services I will receive in the office.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic, massage therapy, and acupuncture, there are some risks to treatment including, but not limited to, fractures, disk injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure or service which the doctor feels at the time, based upon the facts then known, is in my best interests. I understand that the doctor will not be held responsible for any pre-existing medically diagnosed conditions, or for any medical diagnosis.

I HAVE READ, OR HAVE HAD READ TO ME, the above informed consent statements. I also have had the opportunity to ask questions about its content and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment at Essential Mind & Body.

Your Financial Responsibility

Payment is due when services are rendered unless prior arrangements (including insurance participation) have been made. I understand that a $30 returned check fee will be charged should payments be made via check. I understand that I will be responsible for any appropriate collection or attorney's fees which may accrue if it is necessary to engage collection services to pursue payment of any outstanding balance.

Signature of Patient or Legal Guardian:_____ Date ____/____/____

Relationship to Patient: _____

415 East Michigan St., Orlando, FL 32806 • (407) 423-1616 • fax (407) 423-1889 • Essentialmb.com

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