Gildea Chiropractic
Martin S Gildea DC DACBN CFMP
400 S Indiana Ave Suite A
Englewood, Florida 34223

OFFICE USE ONLY
_____
_____
_____

Date: _____

Full Legal Name: _____ **Date of Birth:** _____

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

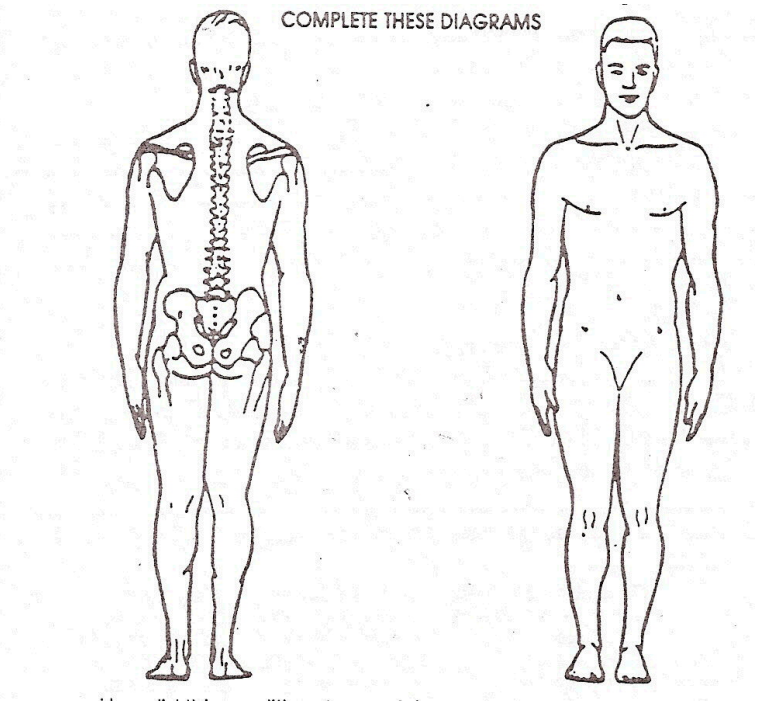
Phone Number: _____ **Email:** _____

Please circle one of the following: Married Single Widowed Divorced Separated

Name of Spouse: _____ **Patient's Employer/Occupation**_____

Referred to Our Office By: _____ **How Payment will be made: Self-Pay**_____ **Insurance**_____

If you are in pain, please mark the exact location of your pain on the diagram below. Also describe the type and frequency of your pain, as well as any activity which brings on or aggravates the pain. For example, dull, sharp, constant, off & on, when standing, sitting, etc.



MAJOR COMPLAINT

(Please describe only your major problem)

_____
_____
_____
_____
_____

How did this condition develop? (What caused it?)

_____

When were you first aware of this problem?

_____

Have received any treatment for this condition? If yes, when, where and what were the results?

_____
_____

ANY ACCIDENTS, FALLS, ETC THAT MIGHT HAVE CAUSED YOUR PROBLEM? _____

ADJUSTING PREFERENCES

THIS SECTION IS FOR PEOPLE WHO HAVE BEEN TREATED BY A CHIROPRACTOR IN THE PAST. IF YOU HAVE NEVER BEEN ADJUSTED, THE DOCTOR WILL DISCUSS WITH YOU YOUR OPTIONS AND CONCERNS DURING YOUR INTAKE.

Hands on physical adjusting: Y or N All OR Neck Y or N Mid Back Y or N Low Back Y or N OR

Non-Invasive treatment, No "popping" (mechanical – clicker) Y or N

Height_____**Weight**_____ **Are you Pregnant?** _____

Have you consulted other Chiropractors in the past? _____ **How long ago?** _____

Have you ever been diagnosed with cancer? _____ **When?** _____ **What Type?** _____

What is your surgical history? _____

Drugs you now take: _____

Fees are payable at the time treatments are received unless other arrangements are made in advance.

_____ **XXX-XX-**_____

Patient Signature **Social Security Number** **Date**

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Patient Name: _____ Date:_____

PLEASE CHECK ALL THAT APPLY TO YOU:

Digestive Track
___nausea & vomiting
___diarrhea
___constipation
___bloated feeling
___stomach pains or cramps
___heart burn
___blood and/or mucous in stools

Ears
___itchy ears
___earaches/infections
___drainage from ear
___ringing in ear
___hearing loss
___reddening of ears

Emotions
___mood swings
___anxiety/fear/nervousness
___anger/irritability/aggressiveness
___argumentative
___frustrated/cries easily
___depression

Eyes
___watery or itchy eyes
___red/swollen/itchy eyelids
___bags or dark circles under eyes
___blurred or tunnel vision

Head
___headaches
___faintness
___dizziness
___insomnia/sleep disorder
___facial flushing

Heart
___irregular/skipped heartbeat
___rapid/pounding heartbeat
___chest pain
___rhythm issues

Joints & Muscles
___pains/aches in joints
___arthritis/osteoarthritis
___stiffness/limited movement
___pain/aches in muscles
___feeling weak/tired
___swollen/tender joints
___growing pains in legs
___psoriatic/gouty arthritis
___rheumatoid arthritis
___foot/ankle pain
___carpal tunnel

Lungs
___chest congestion
___bronchitis
___shortness of breath
___difficulty breathing
___persistent cough
___wheezing

Mind
___poor memory
___difficulty completing projects
___difficulty with mathematics
___underachiever
___poor/short attention span
___confusion
___easily distracted
___difficulty making decisions
___mild learning disabilities

Mouth & Throat Thrush
___chronic coughing
___gagging/clearing throat often
___sore throat/hoarse voice/voice loss
___swollen/discolored tongue/lips
___canker sores
___itching on roof of mouth

Nose
___stuffy nose
___chronically red/inflamed nose
___sinus problems
___hay fever
___sneezing attacks
___excessive mucous formation

Skin
___acne
___itching
___hives/rash/dry skin
___hair loss
___flushing/hot flashes
___rosacea

Weight
___binge eating/drinking
___craving certain foods

___excessive weight
___compulsive eating
___water retention

General
___frequent illness
___frequent/urgent urination
___genital itching/discharge
___anal itching

Genitourinary
___kidney problems
___urinary tract
___bladder
___yeast infections

Other Conditions
___Autism
___A.D.H.D.
___A.D.D.
___psoriasis
___eczema
___auto immune disorder
___chronic fatigue
___multiple chemical sensitivities
___asthma
___congestive heart failure
___severe diabetic
___severe depression
___obsessive compulsive disorder

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By my signature below, I hereby acknowledge receipt of services and give my consent for treatment. I further authorize the above-named Doctor or Clinic to furnish information concerning my present illness or injury and DIRECT the insurer to pay without equivocation directly to the above-named Doctor or Clinic any and all benefits due as a result of treatment provided as indicated. I am aware that I am personally responsible for charges and/or balances not covered by my insurance carrier. I hereby state and agree that a photocopy of this document will be deemed as valid and binding on all parties involved as the original copy.

ATTENTION MEDICARE PATIENTS:
In accordance with the Medicare Act, Section 1842(1), this letter is to advise you that Medicare will only pay for services that it determines to be reasonable and necessary under Section 1862(1) of the Medicare Act. By my signature I acknowledge notification by my physician that he/she believes that in my case Medicare is likely to deny payment for the services identified for the reasons stated. If Medicare denies payment, I agree to be personally and fully responsible for payment.

_____ _____
Patient Signature Date

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CANCELLATION POLICY

When you **NO SHOW or MISS** your appointment, **THREE** people lose:

1. **You**, the patient, because you don't receive the care you need.

2. The **PERSON** who had to wait for another day or time, because **YOU** had an appointment for care and discarded it.
3. **Gildea Chiropractic** as a new business is trying to grow, care for people who need it, and keep prices reasonable, and an empty time slot does none of that.

Due to excessive **NO SHOWS** and **MISSED** appointments, a new cancellation policy is in effect. Kindly give 12 hours' notice or a fee of $25 will be applied to your account and due upon your next visit. Life happens, things come up, certain exceptions apply. **Thank you** to those who keep track of their schedules.

With my signature I have read this notice and acknowledge the cancellation policy.

Patient Signature_____ Date_____

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Informed Consent for Chiropractic Treatment

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or traction/decompression may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Rare complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves, or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke has been estimated at one in one million to one in twenty million, and can further be reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

Other treatment options which could be considered may include the following:

- *Over the counter analgesics.* The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- *Medical Care,* typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in significant number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

Unusual risks: I have had risks as listed above applicable to my case explained to me.

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment.

_____
Printed Name, Signature and Date

WITNESS:

_____
Printed Name, Signature and Date