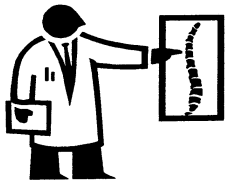
QUICKCHARTS PATIENT CASE HISTORY



Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____-_____-_____ Work Phone: _____-_____-_____

Cell Phone: _____-_____-_____ Email Address: _____

Marital Status: S M W D Referred by: _____

Social Security #: _____-_____-_____ Gender: Male - Female Pregnant? Yes - No

Ever had chiropractic care? No yes When? _____ Why? _____ Where? _____

Race:	Ethnicity:
□ American Indian □Nat. Hawaiian/Pacific Islander □Asian □ Other: _____ □African American □Caucasian □Declined	□Declined □Hispanic or Latino □ Other: _____

List any Allergies:

□Animals □Aspirin □Bees □Chocolate □Dairy □Dust □Eggs □Latex □Molds □Penicillin

□Ragweed/Pollen □Rubber □Seasonal Allergies □Shellfish □Soaps □Wheat □X-Ray Dye

□ Other: _____

List any Surgeries:

□Back □Brain □Elbow □Foot □Hip □Knee □Neck □Neurological □Shoulder □Wrist

□Other: _____

List ALL Past Medical History conditions:

□Ankle Pain □Arm Pain □Arthritis □Asthma □Back Pain □Broken Bones □Cancer □Chest Pain

□Depression □Diabetes □Dizziness □Elbow Pain □Epilepsy □Eye/Vision Problems □Fainting □Fatigue

□Foot Pain □Genetic Spinal Condition □Hand Pain □Headaches □Hearing Problems □Hepatitis

□High Blood Pressure □Hip Pain □HIV □Jaw Pain □Joint Stiffness □Knee Pain □Leg Pain

□Menstrual Problems □Mid-Back Pain □Minor Heart Problem □Multiple Sclerosis □Neck Pain

□Neurological Problems □Pacemaker □Parkinson's □Polio □Prostate Problems □Shoulder Pain

□Significant Weight Change □Spinal Cord Injury □Sprain/Strain □Stroke/Heart Attack

□Other: _____

List Type of Medications you are taking:

□Anxiety □Muscle Relaxors □Pain Killers □Insulin □Birth control □Cardiovascular □Allergy □Seizure

□Other: _____

List your Family History:

□Arthritis □ Asthma □Back Pain □ Cancer □ Depression □Diabetes □ Epilepsy □Genetic Spinal Condition

□High Blood Pressure □Heart Problems □Multiple Sclerosis □Neurological Problems □Parkinson's

□Polio □ Prostate Problems □Stroke/Heart Attack □Other: _____

Have you had any auto or other accidents? □No □Yes - Date of Accident: _____

Describe: _____

Date of last physical examination: _____ Do you smoke? □No □Yes

Do you drink alcohol? □No □Yes - how many per day? _____

Do you drink caffeine? □No □Yes - how many per day? _____

Do you exercise? □No □Yes (what forms and how often): _____

PLEASE MARK YOUR AREAS OF PAIN ON THE DIAGRAM BELOW

Main reason for consulting the office:

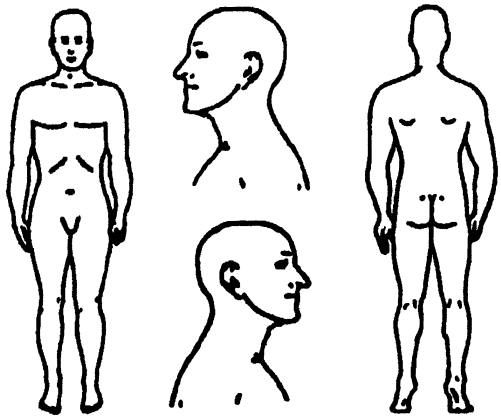
□Become pain free

□Explanation of my condition

□Learn how to care for my condition

□Reduce symptoms

□Resume normal activity level



What is your major complaint? _____Date problem began? _____

How did this problem begin (falling, lifting, etc.)?_____

How is your condition changing? □GETTING BETTER □GETTING WORSE □NOT CHANGING

Have you had this condition in the past? YES - NO

How often do you experience your symptoms?

□Constantly (76-100% of the day) □Frequently (51-75% of the day)

□Occasionally (26-50% of the day) □Intermittently (0-25% of the day)

Describe the nature of your symptoms: □Sharp □Dull □Numb □Burning □Shooting □Tingling □Radiating Pain □Tightness □Stabbing □Throbbing □Other: _____

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

□1□2 □3 □4 □5 □6 □7 □8 □9 □10

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0= no effect and 10= no possible activities) □1 □2 □3 □4 □5 □6 □7 □8 □9 □10

What activities aggravate your condition (working, exercise, etc)?_____

What makes your pain better (ice, heat, massage, etc)? _____

What is your SECOND complaint? _____Date problem began?_____

How did this problem begin (falling, lifting, etc.)?_____

How is your condition changing? □GETTING BETTER □GETTING WORSE □NOT CHANGING

Have you had this condition in the past? YES - NO

How often do you experience your symptoms?

□Constantly (76-100% of the day) □Frequently (51-75% of the day)

□Occasionally (26-50% of the day) □Intermittently (0-25% of the day)

Describe the nature of your symptoms: □Sharp □Dull □Numb □Burning □Shooting □Tingling □Radiating Pain □Tightness □Stabbing □Throbbing □Other: _____

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

□1 □2 □3 □4 □5 □6 □7 □8 □9 □10

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0= no effect and 10= no possible activities) □1 □2 □3 □4 □5 □6 □7 □8 □9 □10

What activities aggravate your condition (working, exercise, etc)?_____

What makes your pain better (ice, heat, massage, etc)? _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I authorize payment from my insurance carrier directly to this office with the understanding that all Monies will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, and fees for professional services rendered me will be immediately due and payable. In the event of default I promise to pay legal interest on the indebtedness together with such collections cost and reasonable attorney fees as may be required to effect collection. I hereby irrevocably assign to Shadowood Chiropractic Center any rights and/or benefits under any insurance policy, indemnity agreement, or any other collateral source defined in Florida statutes for any service and or charges provided by Shadowood Chiropractic Center, Inc.

Print Name _____

Patient (or guardian) Signature_____

Date_____

Our practice is committed to educating our patients about healthcare issues that affect them. As a result, we are providing you with general information about the Privacy Rule, a federal regulation of the Health Insurance Portability and Accountability Act of 1996 (HIPPA) along with a brief overview of our Notice of Privacy. Our practice is complying with HIPPA's regulations.

What is HIPPA and how does the Privacy Rule affect you?
When the Health Insurance Portability and Accountability Act (HIPPA) was passed in August of 1996, this gave the federal government the ability to mandate how healthcare plans, providers, and clearinghouses store and send a patient's personal information as it relates to healthcare. The Privacy Rule was created to protect your rights as a patient of our practice and we are required by law to be compliant with this regulation on April 14, 2003. Under the Privacy Rule you are guaranteed access to your medical records, allowed control over how your protected health information is used and disclosed and allowed to take action if your privacy is compromised by following the practice's policy. Our practice is dedicated to maintaining the privacy of your personal information.

What is the Individually Identifiable Health Information (IIHI)?
Any health information you provide our office, including your mailing address. IIHI is any information that is created and retained by our practice or received by another healthcare provider that relates to treatment, payment, and/or that identifies you as an individual.

What is the Notice of Privacy Practice?
Our practice has an official Notice of Privacy Practice posted in our waiting room informing our patients about their rights surrounding the protection of your IIHI and our obligations concerning the use and disclosure of your IIHI. This notice applies to all records created or retained by our practice. We can update our Notice of Privacy Practices at any time. It will be posted in our waiting room and you can ask for a copy of the current notice at any time.

The following categories describe the different ways in which we may use and disclose your IIHI:

Treatment	Appointment Reminders	Release of Information to Family/Friends
Payment	Treatment Options	Disclosures Required by Law
Health Care Operations	Health-Related Benefits and Services	

The following categories describe unique situations in which we may use or disclose you identifiable health information:

Public Health Risks	Health Oversight Activities	Lawsuits and Similar Proceedings	Law Enforcement
Deceased Patients	Organ and Tissue Donation	Serious Threats to Health or Safety	Research
Military	National Security Inmates	Workers' Compensation	

What are your rights concerning your Individuality Identifiable Health Information (IIHI)?
You have rights regarding the IIHI that we maintain about you. IN our Notice of Privacy you can view the policies and procedures you will need to follow for the areas listed below.

1. Confidential Communications
2. Requesting Restrictions
3. Inspection and Copies
4. Amendment
5. Accounting of Disclosures
6. Right to a Paper Copy of This Notice
7. Right to File a Complaint
8. Right to Provide an Authorization for Other Users and Disclosures

If you have any questions regarding this notice or our health information privacy policies, please contact:

Dr. Allan A. DellaBella, D.C.
Shadowood Chiropractic Center
9799 Glades Road
Boca Raton, FL 33434

I have read the short notice provided by the Shadowood Chiropractic Center, Inc. and have been informed of how to obtain more information regarding our Notice of Policy.

_____ _____

Signature **PRINT NAME OF PATIENT**

SHADOWOOD CHIROPRACTIC CENTER

DR. ALLAN A. DELLABELLA

I, _____ AUTHORIZE

_____

TO RELEASE INFORMATION OF MY RECORDS/X-RAYS,
MEDICAL REPORTS AND BENEFIT INFORMATION TO:

SHADOWOOD CHIROPRACTIC CENTER
9799 GLADES ROAD
BOCA RATON, FLORIDA 33434
561-488-4000
561-488-4116 FAX

_____

PATIENT'S SIGNATURE

SHADOWOOD CHIROPRACTIC CENTER

DR. ALLAN A. DELLABELLA

I_____,give consent to my physician to speak to:

Name_____Ph#_____relationship_____

Name_____Ph#_____relationship_____

Name_____Ph#_____relationship_____

in regarding my medical care.

Signature_____

Date_____

9799 Glades Road • Boca Raton, FL 33434 • Ph: (561) 488-4000 • (561) 488-4116
Web - www.chiroboca.com
Email - chiroboca@aol.com