Tampa Spine & Wellness

Patient's Name: _____ Date:_____

What is the reason for your visit today?		
SSN:		
Height:	Weight:	Age:
Left Handed	Right Handed:	DOB:
Does any position relieve your pain? (explain)		
What makes your condition worse?		
Is it ☐ Better ☐ Worse in the ☐ Morning ☐ Evening?		

1. Have you ever had an adverse (i.e. bad) reaction to or following chiropractic care? (if applicable)	Yes	No	
2. Have you been diagnosed with compression fracture(s) of the spine?	Yes	No	
3. Are you experiencing or have you ever experienced a change in bowel (i.e. loss of control)?	Yes	No	
4. Have you ever been diagnosed with cancer?	Yes	No	
5. Do you have any metal implants?	Yes	No	
6. Do you take warfarin (coumadin, heparin, or other similar "blood thinners"?	Yes	No	
7. Have you ever had a stroke or TIA (transient ischemic attack)?	Yes	No	
8. If you have a complaint of neck pain or headache, does this pain seem unlike anything you have experienced before?	Yes	No	
9. Have you recently had any unusual bleeding or discharge?	Yes	No	
10. Are you experiencing or have you ever experienced problems with recurring headaches?	Yes	No	
11. Are you experiencing or have you ever experienced a thickening/lump(s) in the breast or elsewhere?	Yes	No	
12. Are you experiencing or have you ever experienced a sore that does not heal?	Yes	No	
13. Are you experiencing or have you ever experienced difficulty speaking or swallowing?	Yes	No	
14. Does your pain wake you up at night?	Yes	No	
15. Are you experiencing or have you ever experienced a nagging cough or hoarseness?	Yes	No	

_____
Dr's Initials:

Tampa Spine & Wellness

Patient's Name: _____ Date:_____

16. Are you or have you ever experienced double vision, blurred vision or other visual disturbances?	Yes	No	
17. Are you experiencing or have you ever experienced dizziness?	Yes	No	
18. Are you experiencing or have you ever experienced nausea or vomiting?	Yes	No	
19. Are you experiencing or have you ever experienced numbness and/or tingling	Yes	No	
20. Are you experiencing or have you ever experienced any nervous system diseases and/or mental health problems?	Yes	No	
21. Are you experiencing or have you ever experienced any gland and/or hormone problems?	Yes	No	
22. Are you experiencing or have you ever experienced any allergy or immunity problems?	Yes	No	
23. Are you experiencing or have you ever experienced any muscle, tendon, or ligament problems?	Yes	No	
24. Are you experiencing or have you ever experienced any bone or joint disease (osteoporosis, arthritis)?	Yes	No	
25. Have you ever loss consciousness?	Yes	No	
26. Are you experiencing or have you ever experienced difficulty walking?	Yes	No	
27. Are you experiencing or have you ever experienced urinary (including kidney or bladder) problems? (I.e., inability to urinate or lack of control when urinating)?	Yes	No	
Male			
28. Are you experiencing or have you ever experienced genital problems (erectile dysfunction or impotence, prostate problems, testicular pain or lumps, breast lumps)?	Yes	No	
Female			
29. When was your last menstrual cycle?	Date:		
30. Are you experiencing or have you ever experienced menstrual problems?	Yes	No	
31. Have you ever taken birth control pills?	Yes	No	
32. Is there any chance that you are currently pregnant?	Yes	No	

_____ _____

Patient Signature: Dr's Initials:

Tampa Spine & Wellness

Past Medical History

Patient Name:_____ Date: _____

Do you have or have you been treated for any of the following: Circle Yes or No

Asthma	Y/N	Heart Disease	Y/N	High Blood Pressure	Y/N
Fibromyalgia	Y/N	Stroke	Y/N	Osteoporosis	Y/N
Liver Disease	Y/N	Depression	Y/N	Immunodeficiency	Y/N
Diabetes	Y/N	Seizures	Y/N	Bleeding Disorder	Y/N
Cancer (type)_____			Y/N	Hepatitis (type)_____	Y/N
HIV/AIDS (precautionary measures)			Y/N	Contagious Skin Disorder	Y/N

Please list any health problems not listed above:_____

Hospitalization (include this accident)/Operations/Previous Auto Accidents

Date Incident Reason/Procedure Hospital

_____
_____
_____

Current Medication (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 check here ____)

_____

Family History, please check all that apply to your family members (M=Mother, F=Father)

Allergies	___M ___F N/A ___	High Blood Pressure	___M ___F N/A ___
Osteoporosis	___M ___F N/A ___	Kidney Disease	___M ___F N/A ___
Seizures	___M ___F N/A ___	Stroke	___M ___F N/A ___
Cancer	___M ___F N/A ___	Depression	___M ___F N/A ___
Diabetes	___M ___F N/A ___	Heart Disease	___M ___F N/A ___
Other	___M ___F N/A ___		

Social History

1. Do you presently smoke Yes ___ No ___ #packs/day ___ #yrs ___
2. Have you ever smoked? Yes ___ No ___ #packs/day ___ #yrs ___
3. Do you drink alcohol? Yes ___ No ___ #drinks/day ___
4. Have you ever used any addictive substances? Yes ___ (substance _____) No ___

Review of systems Please circle Yes or No. If Yes, please explain

1. Ear - ringing/dizziness/drainage/hearing loss Y/N Explain _____
2. Mouth/throat - pain or difficulty swallowing/hoarseness/lumps in neck Y/N Explain _____
3. Cardiopulmonary - check pain/palpitations/short of breath/heart murmur/cough Y/N Explain _____
4. Genitourinary - burning or frequency of urination Y/N Explain _____
5. Gastrointestinal - heartburn/vomiting/diarrhea/abdominal pain Y/N Explain _____
6. Psychological - depression Y/N Explain _____
7. Sleep pattern - snoring/daytime sleepiness Y/N Explain _____
8. Endocrine - heat intolerance/cold intolerance/excessive thirst Y/N Explain _____
9. Eyes - recent changes in vision/impaired vision/double vision Y/N Explain _____
10. Neurologic - weakness/numbness Y/N Explain _____
11. Musculoskeletal - TMJ disorder/arthritis Y/N Explain _____
12. General - nausea/fever/fatigue/weight gain Y/N Explain _____
13. Skin cancer Y/N Explain _____
14. Hematologic/Lymphatic - swollen lymph nodes Y/N Explain _____
15. Immunologic - Hepatitis/frequent infections/immune disorders Y/N Explain _____
16. Constitution - Sudden weight loss or gain? Y/N Explain _____
17. Are you pregnant? Yes ___ No ___ Y/N Explain _____
18. Are you breast feeding? Yes ___ No ___ Y/N Explain _____

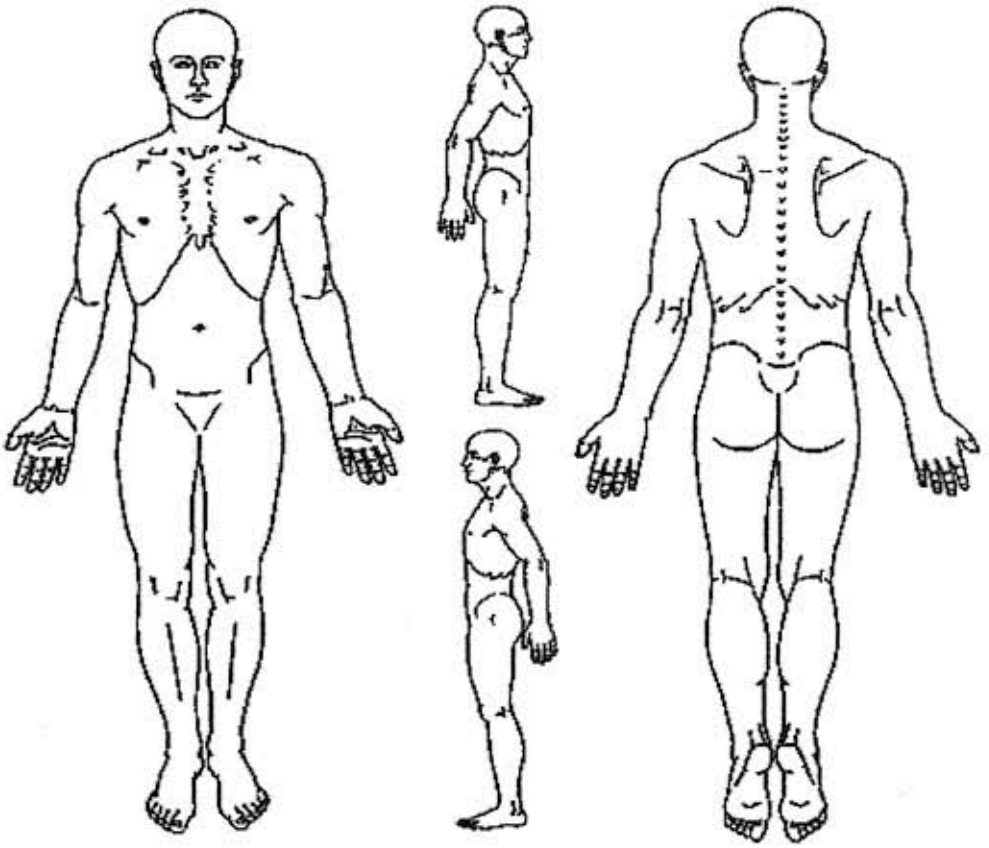
_____ _____
Patient Signature Dr's Initials

Tampa Spine & Wellness

Pain Diagram

NAME _____ DATE _____

On the diagram below, please indicate where you are experiencing pain or other symptoms, right now.



A = ACHE
B = BURNING
N = NUMBNESS
P = PINS & NEEDLES
S = STABBING
O = OTHER

I certified 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.

Date_____ Print Name_____

Patient Signature_____

I have personally reviewed the history and review of systems:

Date_____ Doctor's Signature:_____

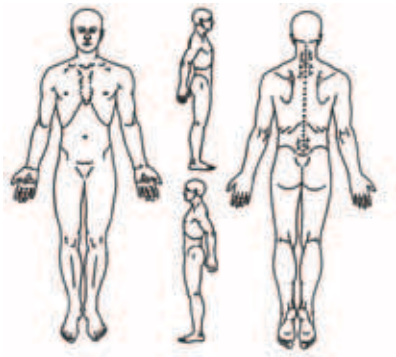
Dr. Seth M. Lott, DC

Tampa Spine & Wellness

Patient's Name: _____ Date:_____

Please rate your level of pain on a scale between 1 - 10 (1=low 10=high)

Neck Pain	0 1 2 3 4 5 6 7 8 9 10	Neck Stiff	0 1 2 3 4 5 6 7 8 9 10	Headache	0 1 2 3 4 5 6 7 8 9 10
Middle Back Pain	0 1 2 3 4 5 6 7 8 9 10	Middle Back Stiff	0 1 2 3 4 5 6 7 8 9 10	Wrist	0 1 2 3 4 5 6 7 8 9 10
Low Back Pain	0 1 2 3 4 5 6 7 8 9 10	Low Back Stiff	0 1 2 3 4 5 6 7 8 9 10	Elbow	0 1 2 3 4 5 6 7 8 9 10
L-Shoulder Pain	0 1 2 3 4 5 6 7 8 9 10	R Shoulder Pain	0 1 2 3 4 5 6 7 8 9 10		
L-Leg/Hip Pain	0 1 2 3 4 5 6 7 8 9 10	R Leg/Hip Pain	0 1 2 3 4 5 6 7 8 9 10		
L-Knee/Ankle	0 1 2 3 4 5 6 7 8 9 10	R Knee/Ankle	0 1 2 3 4 5 6 7 8 9 10		



TREATMENT

___ Exam
___ Re-Exam
___ Final Exam
___ Acupuncture
___ Spinal Adjustment
___ Manual Low Force
___ Manual Traction
___ Kinesio Tape

___ Hot/Cold Therapy C T L S
___ Vibratory Therapy C T L S
___ E Stim C T L S
___ Trigger Point Tx C T L S
___ Myofascial Release C T L S
___ Cervical Traction C T L S

Doctors Notes: _____

_____

_____

_____

_____

FINDINGS

Cervical (Tenderness / Spasm) Thoracic (Tenderness / Spasm) Lumbar (Tenderness / Spasm) Sacro-illiac (Tenderness/Spasm)

L R Shoulder L R Knee Other: _____

Goals: Pain Relief ↑ ROM ↑ Strength ↓ Edema Other: _____

ASSESSMENT

Diagnosis: ___ Unchanged ___ Improvement C T L S ___ Aggravation C T L S

Progress: ___ As expected ___ Slower then expected ___ Complicated by _____

Prognosis: ___ Excellent - continued improvement expected, permanent residuals not expected.

___ Good - continued improvement anticipated permanent residuals possible.

___ Favorable - continued improvement possible, permanent residuals probable.

___ Poor - continued improvement doubtful, permanent residuals expected.

PLAN

___ Continue with treatment as outlined. Treatment is medically necessary.

___ Acute phase: Stabilized condition, control inflammation, reduce spasm and pain. (tx-daily for 2-4 days

___ Sub-acute phase: Support soft tissue repair, mobilize spinal joints to improve ROM. (tx-3X/wk for 3-6 wks)

___ Rehabilitation phase: Continued passive care with addition of active care to increase ROM, endurance, & strength for return to normal daily activities, (tx-1-2 wk for 6-8 weeks until MMI)

___ Exacerbation: Aggravation of condition, stabilize condition to prior status. ___ Pt not @ MMI ___ Pt @ MMI

I attest that the above information is accurate to the best of my knowledge and that the above services were rendered on my behalf.

_____ _____

Dr Seth M. Lott, D.C. Patient Signature

Tampa Spine & Wellness
205 W. Martin Luther King Blvd
Suite 102
Tampa, Florida 33603
O: (813) 331-5753 F: (813) 330-3022

Informed Consent To Chiropractic Adjustments And Care

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical/massage therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working, or associated with, or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic.

I have had the opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personal the nature and purpose of chiropractic adjustments and other procedures. I understand that the results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to fractures, disc 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 judgement during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interest.

I have read, or have had read to me the above consent. I have also had an opportunity to ask questions about this consent, 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(s) and for any future condition(s) for which I seek treatment.

_____
Print Patient's Name

_____
Signature of Patient

_____
Date

_____
Print Name of Patient

_____
Print Name of Patient's Representative

_____
Signature of Patient's Representative

As: _____
Relationship or Authority of Patient's Representative

_____
Date

A copy of this form is as valid as the original

To be completed by doctor or staff

Print name(s) of doctor(s) treating this patient:

_____
Witness to Patient's Signature

_____
Translated by:

Informed Consent for Acupuncture Treatment and Care

I hereby request and consent to the performance of acupuncture treatments and other Oriental Medicine procedures, including various modes of physiotherapy on me (or on the patient named below, for whom I am legally responsible) by the below named licensed physician certified in acupuncture for now or in the future treat me while employed by, working or associated with or servicing as a back-up for the treating acupuncturist named below, including those working at this office/clinic or any other office or clinic.

I understand the methods of treatment may include but are not limited to, acupuncture, acupressure, moxibustion, cupping, electrical stimulation, Chinese or Western herbs and nutritional counseling.

I have had the opportunity to discuss with the physician named below and/or other office or clinic personnel the nature and purpose of acupuncture treatments and other procedures.

Acupuncture had the effect to normalized physiological functions, to modify the perception of pain, and to treat certain diseases or dysfunctions of the body. I have been informed that acupuncture is a safe method of treatment, but occasionally there may be some bruising or tingling near the needling sites that last a few days. There have been very rare instances of fainting, infections and scarring. There have been extremely rare instances of spontaneous miscarriage and pneumothorax. There may be some bruising after cupping.

I do not expect the physician to be able to anticipate and explain all risks and complications, and I wish to rely on the physician to exercise judgment during the course of the procedure which the physician feels at the time, based upon the facts then known, is in my best interest.

I understand the clinical and administrative staff may review my medical records and la reports, but all my records will be kept confidential and will not be released without my written consent.

I have read, or have had read to me, the above consent. I have also 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 conditions and any future condition(s) for which I seek treatment.

To be completed by patient:

_____
Print patient's name

_____
Patient Signature

To be completed by the patient's representative, if necessary, e.g. if the patient is a minor or is physically or legally incapacitated:

_____
Print patient's name

_____
Print name of patient's representative

_____
Signature of patient's representative

_____
Relationship of representative to patient

Dr. Seth M. Lott, DC,
certified in acupuncture
Tampa Spine & Wellness
813-331-5753

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice takes effect on **March 24, 2014** and remains in effect until we replace it.

1. OUR PLEDGE REGARDING MEDICAL INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. OUR LEGAL DUTY

Law Requires Us to:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, private practices, and your rights regarding your medical information.
3. Follow the terms of the notice that is now in effect.

We have the Right to:

1. Change our privacy practices and the terms of the notice at anytime, provide that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including previously created or received before the changes.

Notice of Change to Privacy Practices:

1. Before we make an appointment change in our policy practices, we will change this notice and make the new notice available upon request.

3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes different ways that we use and disclose medical information. Not every use or disclose will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

FOR TREATMENT: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

FOR PAYMENT: We may use and disclose your medical information for payment purposes.

FOR HEALTH CARE OPERATIONS: We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

NOTICE OF PRIVACY PRACTICES

Additional Uses And Disclosures: In addition to using and disclosing your medical information for treatment, payment, and health care operations, we may use and disclose medical information for the following purposes.

Facility Directory: Unless you notify us that you object, the following information about you will be placed in our facilities directories: your name; your location in our facility; your condition described in general terms; your religious affiliation, if any. We may disclose this information to members of the clergy or, except for your religious affiliation, to others who contact us and ask for information about you by name.

Notification: Medical information to notify or help notify: a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition, or death. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of an emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray or medical information for you.

Disaster Relief: Medical information with a public or private organization or person who can legally assist in disaster relief efforts.

Fundraising: We may provide medical information to one of our affiliated fundraising foundations purposes. We will limit our use and sharing to information that describes you in general, not personal, terms and the dates of your health care. In any fundraising materials, we will provide you a description of how you may choose not to receive future fundraising communications.

Research in Limited Circumstances: Medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.

Funeral Director, Coroner, Medical Examiner: To help them carry out their duties, we may share the medical information of a person who has died with a coroner, medical examiner, funeral director, or an organ procurement organization.

Specialized Government Functions: Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

Court Orders and Judicial and Administrative Proceedings: We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

Public Health Activities: As required by law, we may disclose your medical information to the public health or legal authorities charged with preventing or controlling disease, injury, or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs, or replacements, to track products, or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

Tampa Spine & Wellness
205 W. Martin Luther King Blvd
Suite 102
Tampa, Florida 33603
813-331-5753

PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name: _____

Date of Birth: _____/_____/_____

Signature: _____ Date: _____

Tampa Spine & Wellness
205 W. Martin Luther King Blvd
Suite 102
Tampa, Florida 33603
813-331-5753

24 hour Cancellation Policy

Thank you for providing this personal information. It will enable us to more completely understand your individual pattern and come up with the most accurate diagnosis for your condition. Everything you disclose will be held in the utmost confidentiality, and will not be shared in any circumstances without the patient's expressed, written consent.

We find that communicating our office policies will assist us in providing you with optimal service. Should you need to reschedule an appointment, a **24 hour notice is required**. If you fail to notify us 24 hours in advance, you will be charged a $35.00 dollar fee for your missed appointment. A missed appointment is a loss for everyone. For a Monday cancellation, please call on Saturday.

_____
Patient's Signature

_____
Parent's Signature if patient is a minor

_____
Date

Tampa Spine & Wellness
205 W. Martin Luther King Blvd
Suite 102
Tampa, Florida 33603
813-331-5753

Confidentiality Agreement

To Our Valued Patients:

We at Tampa Spine and Wellness have always made your privacy one of our top priorities. We would like to inform you of the measures our office has taken to insure your rights of patient privacy. (In accordance with HIPPA)

We communicate with our patients through mail, e-mail, and by phone. Below is a list of ways in which our office corresponds with you. Please indicate any items that you do NOT wish to receive.

Mailer in Office -

1) ____ Birthday greeting
2) ____ Health care maintenance reminders
3) ____ Holiday cards
4) ____ Thank you cards for your referrals
5) ____ Health Newsletter

I prefer all mailed correspondence to sent to my - Home ____ Office ____ (please check one)

Address: _____ email: _____

City: _____ State: _____ Zip: _____

Phone Calls - Home: _____ Mobile: _____

6) ____ Health care maintenance reminders
7) ____ Appointment reminders
8) ____ Missed appointment rescheduling

In the event that we are unable to speak with you directly, please indicate the ways in which it is acceptable for our office to leave a courtesy message for you.

____ On your home answering machine or with family
____ Office voice mail or with receptionist
____ Okay to leave detailed message with information
____ Please leave message with a call back number only

We will do our best to always honor your requests when communicating with you.

Yours In Health,
Tampa Spine & Wellness

_____ _____

Patient Signature *Date*