MOVEMENT
CHIROPRACTIC & WELLNESS

HEALTH PROFILE

INFORMATION

Last Name_____ **First Name**_____ **Goes By**_____

Date of Birth____/____/_____ **Gender**: ☐Male ☐Female Status: ☐Single ☐Married ☐Divorced ☐Widowed

Spouse's Name_____ **Children:** ☐No ☐Yes: *Names*_____

Address_____ **City**_____ **State**_____ **Zip**_____

Cell Phone_____ **Work Phone**_____

Email_____ **Best Contact Method:** ☐Cell Phone ☐Email

Occupation_____ **Employer**_____

Emergency Contact Name_____ **Emergency Contact Phone Number**_____

LIFESTYLE

Are you physically active? ☐Not at all ☐Somewhat ☐For the Most Part ☐Yes ☐Very

Physical Activities_____

Quality of sleep: ☐Poor ☐Fair ☐Average ☐Good ☐Excellent

Do you have any emotional or behavioral issues: ☐No ☐Yes: _____

Your opinion on chiropractic care: ☐Skeptical ☐Curious ☐Passionate ☐Indifferent ☐Nervous ☐Excited

SYMPTOMS

CHECK ALL THAT APPLY:

_____Headache	_____Dizziness	_____Depression	_____Fatigue
_____Blurry Vision	_____Buzzing in Ears	_____Diarrhea	_____Neck Pain
_____Head Seems too Heavy	_____Memory Loss	_____Feet Cold	_____Neck Stiff
_____Pins and Needles in Arms	_____Ears Ring	_____Hands Cold	_____Fainting
_____Sleeping Problems	_____Low Back Pain	_____Face Flushed	_____Loss of Balance
_____Pins and Needles in Legs	_____Constipation	_____Tension	_____Nervousness
_____Numbness in Fingers	_____Loss of Smell	_____Fever	_____Irritability
_____Numbness in Toes	_____Loss of Taste	_____Chest Pain	_____Cold Sweats
_____Shortness of Breath	_____Stomach Upset	_____TMJ Pain	
_____Hip Pain Right/Left	_____Midback Pain		_____Wrist Pain Right/Left
_____Leg Pain Right/Left	_____Sciatica Right/Left		_____Elbow Pain Right/Left
_____Knee Pain Right/Left	_____Shoulder Pain Right/Left	Other _____	

PAIN SCALE

On a scale of 1 to 10, 10 being the worst possible pain

1. What is your pain level **right now**? _____
2. What is your **average** level of pain? _____
3. What is your pain level at its **worst**? _____

HEALTH HISTORY

List Current Medications_____

_____

List all Surgical Operations and Dates_____

_____

Have you ever been in an auto accident? ☐No ☐Yes: *Date(s)*_____*Injury?* _____

Have you ever had/have? ☐Stroke ☐Cancer ☐Heart Disease ☐Spinal Surgery ☐Seizures

☐Spinal Bone Fracture ☐Scoliosis ☐Diabetes ☐Bone Fracture ☐Severe Fall ☐Concussion

Have you ever been under regular Chiropractic Care? ☐No ☐Yes

*If yes, where*_____*Date of last adjustment*_____

FAMILY HISTORY (Please Check All that Apply)

Condition	Spouse	Son	Daughter	Mother	Father
Arthritis					
ADHD/ADD					
Bed Wetting					
Cancer					
Carpal Tunnel					
Deceased					
Diabetes					
Digestive Problems					
Fibromyalgia					
High Blood Pressure					
Migraines					
Scoliosis					

RELEASE OF AUTHORIZATION / ASSIGNMENT OF BENEFITS

I authorize and request payment of insurance benefits directly to Marialejandra Julia, D.C. I hereby assign all of my rights under my policy to Marialejandra Julia, D.C., including my right to file suit for benefits. I agree that this authorization will cover all services rendered until I revoke the authorization. I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the patient. It is customary to pay for services when rendered unless other arrangements have been made in advance. I understand that I am financially responsible for charges not covered by insurance.

Signature_____**Date**_____

MOVEMENT CHIROPRACTIC & WELLNESS NOTICE OF PRIVACY PRACTICE AGREEMENT

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your Personal Health Information. In addition, we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as dictated by our office policy, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled 'HIPAA' on tables in the reception. Once you have read this notice, please sign the last page, and return only the signature page to our front desk receptionist. Keep this page for your records.

PERMITTED DISCLOSURES:

1. Treatment purposes- discussion with other health care providers involved in your care
2. Inadvertent disclosures- open treating area mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes- to process a claim or aid in investigation
5. Emergency- in the event of a medical emergency we may notify a family member
6. For Public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement – to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons –discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders -we may call your home and leave messages regarding a missed appointment or apprize you of changes in practice hours or upcoming events.
11. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

YOUR RIGHTS:

1. To receive an accounting of disclosures
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice
3. To request mailings to an address different than residence
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain one copy of your records at no charge, when timely notice is provided (72 hours). X-rays are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call Dr. Marialejandra Julia at (727) 201-2071 if she is unavailable, you may make an appointment with our receptionist to see her within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights 200 Independence Ave. SW Room 509F HHH Building Washington DC 20201

I have received a copy of Chiropractic's Patient Privacy Notice. I understand my rights as well as the practices duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this 'Notice of Privacy Practice" at a time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

Patient Name_____DOB_____

Patient Signature_____Date_____

Witness_____Date_____

JDD,DC 5/2011

INFORMED CONSENT FOR CHIROPRACTIC CARE

CHIROPRACTIC CARE, WHILE OFFERING CONSIDERABLE BENEFITS, MAY ALSO PROVIDE SOME LEVEL OF RISK. IN EXTREMELY RARE CASES, INJURY HAS BEEN ASSOCIATED WITH CHIROPRACTIC CARE. THESE CASES INCLUDE: STRAIN/SPRAIN INJURIES, IRRITATION OF EXISTING DISC CONDITION, AND FRACTURES, ETC. ONE OF THE RAREST COMPLICATIONS ASSOCIATED WITH CHIROPRACTIC WHICH OCCURS AT A RATE BETWEEN ONE INSTANCE PER ONE MILLION TO TWO MILLION CERVICAL SPINE ADJUSTMENTS MAY BE A VERTEBRAL INJURY THAT COULD LEAD TO A STROKE.

PRIOR TO RECEIVING CHIROPRACTIC CARE IN THE OFFICE, A HEALTH HISTORY AND PHYSICAL EXAMINATION WILL BE COMPLETED TO ASSESS YOUR SPECIFIC HEALTH AND SPINAL NEEDS. THESE PROCEDURES WILL ASSIST US IN DETERMINING IF CHIROPRACTIC CARE IS NECESSARY OR IF FURTHER EXAMINATION IS NEEDED. IN ADDITION, THEY WILL HELP US DETERMINE IF THERE IS ANY REASON TO MODIFY YOUR CARE OR PROVIDE YOU WITH A REFERRAL TO ANOTHER HEALTH CARE PROVIDER. ALL RELEVANT FINDINGS WILL BE REPORTED TO ALONG WITH A CARE PLAN PRIOR TO BEGINNING CARE.

I UNDERSTAND THERE ARE RISKS ASSOCIATED WITH CHIROPRACTIC CARE AND GIVE CONSENT TO THE EXAMINATION THE DOCTOR DEEMS NECESSARY AND CHIROPRACTIC CARE, INCLUDING SPINAL ADJUSTMENTS, AS REPORTED FOLLOWING MY ASSESSMENT

Name_____**Signature**_____**Date**_____

Guardian Signature (For Minor)_____**Office Staff Signature**_____

TERMS OF ACCEPTANCE

TO PROMOTE THE MOST EFFECTIVE APPLICATION OF CHIROPRACTIC PROCEDURES AND THE STRONGEST POSSIBLE DOCTOR-PATIENT RELATIONSHIP, WE STATE THE FOLLOWING TO FACILITATE THE GOAL OF OPTIMUM HEALTH THROUGH CHIROPRACTIC.
TO THAT END, WE ASK THAT YOU ACKNOWLEDGE THE FOLLOWING POINTS REGARDING SERVICES WE PROVIDE:

1. CHIROPRACTIC IS A SPECIFIC, SEPARATE, AND DISTINCT PRACTICE AUTHORIZED BY LAW TO ADDRESS SPINAL HEALTH
2. CHIROPRACTIC SEEKS TO RESTORE NORMAL NERVE FUNCTIONING THROUGH THE ADJUSTMENT OF SPINAL SUBLUXATIONS TO MAXIMIZE THE INHERENT HEALING POWER OF THE BODY. SUBLUXATIONS ARE DEVIATIONS FROM NORMAL SPINAL STRUCTURES THAT INTERFERE WITH NORMAL NERVE PROCESSES.
3. THE CHIROPRACTIC ADJUSTMENT PROCESS, AS DEFINED IN THE LAW OF THIS JURISDICTION, INVOLVES THE APPLICATION OF A SPECIFIC DIRECTIONAL THRUST TO A REGION(S) OF THE SPINE WITH THE SPECIFIC INTENT OF REPOSITIONING MISALIGNED SPINAL SEGMENTS. THIS IS A SAFE, EFFECTIVE PROCEDURE APPLIED OVER ONE MILLION TIMES EACH DAY BY DOCTORS OF CHIROPRACTIC IN THE UNITED STATES ALONE
4. CHIROPRACTIC DOES NOT SEEK TO REPLACE OR COMPETE WITH OTHER SPECIFIC HEALTH CARE PROFESSIONALS. THEY RETAIN RESPONSIBILITY FOR CARE AND MANAGEMENT OF MEDICAL CONDITIONS. WE DO NOT OFFER ADVICE REGARDING TREATMENT PRESCRIBED BY OTHERS.
5. YOUR COMPLIANCE WITH THE DOCTOR'S RECOMMENDATIONS IS ESSENTIAL TO ACHIEVING THE MAXIMUM HEALTH BENEFITS
6. WE INVITE YOU TO SPEAK FRANKLY TO THE DOCTOR ON ANY MATTER RELATED TO YOUR CARE AT THIS FACILITY, ITS NATURE, DURATION, OR COST, WHAT WE WORK TO MAINTAIN AS A SUPPORTING, OPEN ENVIRONMENT

BY SIGNING BELOW, I AM STATING THAT I HAVE FULLY READ AND UNDERSTAND THE ABOVE STATEMENTS

Signature_____Date_____

X-RAY AUTHORIZATION

AS YOUR HEALTHCARE PROVIDER, WE ARE LEGALLY RESPONSIBLE FOR YOUR CHIROPRACTIC RECORDS. WE MUST MAINTAIN A RECORD OF YOUR X-RAYS IN OUR FILES

X-RAYS ARE UTILIZED IN THIS OFFICE TO HELP LOCATE AND ANALYZE VERTEBRAL SUBLUXATIONS. HEALTH HISTORY AND EXAMS WILL ALLOW THE DOCTOR TO DETERMINE IF X-RAYS ARE NECESSARY FOR YOUR CASE. THESE X-RAYS ARE NOT USED TO INVESTIGATE FOR MEDICAL PATHOLOGY. THE DOCTOR(S) OF MOVEMENT CHIROPRACTIC & WELLNESS DO NOT DIAGNOSE OR TREAT MEDICAL CONDITIONS. HOWEVER, IF ANY ABNORMALITIES ARE FOUND, WE WILL BRING IT TO YOUR ATTENTION SO THAT YOU CAN SEEK PROPER MEDICAL ADVICE.

AT YOUR REQUEST, WE WILL PROVIDE YOU WITH A COPY OF YOUR X-RAYS

THE FEE FOR COPYING YOUR X-RAYS ON A DISC IS $15.00 WHICH MUST BE PAID IN ADVANCE.

BY SIGNING BELOW, I AM AGREEING TO THE ABOVE TERMS AND CONDITIONS

Signature_____**Date**_____

FEMALE PATIENTS ONLY: TO THE BEST OF MY KNOWLEDGE, I BELIEVE I AM NOT PREGNANT AT THE TIME X-RAYS ARE TAKEN AT MOVEMENT CHIROPRACTIC & WELLNESS

Signature_____**Date**_____