

INITIAL PATIENT QUESTIONNAIRE

NAME: _____ DOB: ____ / ____ / ____ AGE: ____ SSN: ____ / ____ / ____ SEX: M / F

Home Address: _____
Street City State Zip

Phone: (H) _____ (Cell) _____ Email: _____

Marital Status: _____ Occupation: _____ Employer: _____

Emergency Contact & Relation: _____ Phone: _____

PATIENT INFORMED CONSENT

State law requires offices to obtain your informed consent prior to examination and treatment. The purpose of this form is to inform you. What your being asked to sign is simply a confirmation that you have been informed of the following.

EXAMINATIONS

X-RAYS: This office uses highly sensitive x-ray film, intensifying screens and filters that provide high quality x-rays with the lowest possible x-ray exposure. The only risk with taking x-rays deals with pregnancy. If there is any possibility that you are pregnant, inform us prior to any x-ray procedure. If there is no possibility of this condition, the risks are so rare we have no available statistics to qualify their probability.

TREATMENT

Chiropractic adjustment/manipulation: The doctor will use his hands or a mechanical device upon your body in such a way as to move your joints in various directions. This procedure may cause an audible "pop" or "click" to be heard coming from your joints, this is not a cause for alarm. There are some material risks involved in doing these procedures they are as follows:

Pain: Chiropractic treatments may result in a temporary increase in soreness in the area receiving treatment.

Rib Fractures: Fractures caused by chiropractic treatments are rare. They occur most frequently in patients with osteoporosis or weakened bones. Evidence of osteoporosis can be noted on your x-rays, and if detected, the most appropriate and gentle treatments are used, minimizing the possibility of fractures to the ribs.

Disc Injury: Chiropractic treatment is appropriate for the treatment of many kinds of back problems, including some disc problems.* Occasionally, chiropractic may aggravate or cause a problem if the disc is in a severely weakened state. However, this occurs so rarely that statistics to quantify the probability are unavailable, but estimates place risk of serious injury at about 1 serious complication per 100 million low back manipulations.**

Stroke: The overall incidence of stroke in the general population is about 2 per 1000 people.*** Although chiropractic adjustment/manipulation has been implicated as a possible cause of stroke, this possibility is extremely rare. The best available data suggests that stroke secondary to chiropractic adjustment/manipulation may occur in 1 per 100,000 patients **** - a rate well below the overall average risk in the general population. In comparison, the overall average risk of death from taking non-steroidal anti-inflammatory drugs (aspirin, Ibuprofen, Naproxen sodium, etc.) is 4 per 100,000 patients.***** The risk of serious complication or death from spine surgeries of the neck is 11.25 per 1000 patients.***** As you can see, the risk of stroke from chiropractic treatments is much lower than other common medical treatments. Even though the risk is small, we have implemented procedures and test that will likely reduce the potential for stroke even more.

Chiropractic is a system of health care delivery. As with any health delivery system we cannot promise a cure for any symptom, disease, or condition as a result of treatment in this office. We will always give you our best care, and if your results are not acceptable, we will refer you to another health care provider who we feel will assist your situation.

If you have any questions on the above information, please ask the doctor. When you have a clear understanding, please sign and date below.

I HAVE READ OR HAVE HAD READ TO ME THIS CONSENT FORM AND I HAVE BEEN INFORMED OF THE MOST LIKELY COMPLICATIONS, OF THE POSSIBLE UNDESIRE RESULTS OF CHIROPRACTIC EXAMINATION AND TREATMENT IN THIS OFFICE AND UNDERSTAND THEM. I HEREBY AUTHORIZE AND DIRECT DR. COBB AND HIS ASSOCIATES OR ASSISTANTS TO PROVIDE SUCH ADDITIONAL SERVICES AS THEY MAY DEEM REASONABLE AND NECESSARY.

Patient's Signature _____ Date _____

Patient's Printed Name _____ Date _____

Parent's/Guardian's Signature _____ Date _____
If patient is less than 18 years of age.

Parent's/Guardian's Printed Name _____ Date _____

References

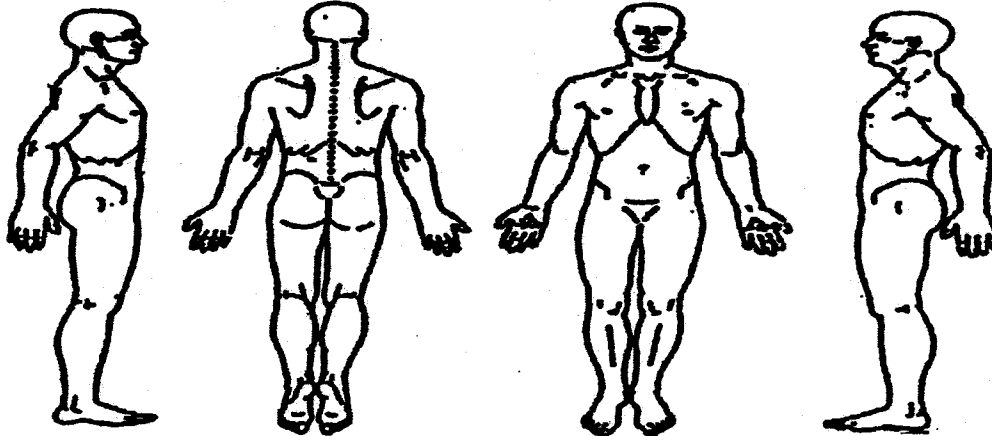
- * Troyanovich SJ, Harrison DE. Low Back pain and the lumbar intervertebral disc: Clinical considerations for the doctor of chiropractic.
- ** Shekelle PG. Spine update: Spinal Manipulation, Spine 1994; 19; 858-86
- *** Clayman CB. The American Medical Association Home Encyclopedia. New York: Random House: 947-948
- **** Dabbs V, Laurenti WJ. Risk Assessment of Cervical Manipulation vs. NSAIDS for the treatment of neck pain. J Manipulative Physiol Ther 1995; 18:530-536.
- ***** Harwiz EL, Aker PD, Adams AH, Meeker WC, Shekelle PG. Manipulation and mobilization of the cervical Spine: A systematic review of the literature, Spine 1996; 21: 1746-1760.

PATIENT INTAKE FORM

Patient Name: _____ Date: _____

1. Is today's problem caused by: Auto Accident Workman's Compensation

2. Indicate on the drawings below where you have pain/symptoms



3. How often do you experience your symptoms?

- Constantly (76-100% of the time) Occasionally (26-50% of the time)
 Frequently (51-75% of the time) Intermittently (1-25% of the time)

4. How would you describe the type of pain?

- Sharp Numb
 Dull Tingly
 Diffuse Sharp with motion
 Achy Shooting with motion
 Burning Stabbing with motion
 Shooting Electric like with motion
 Stiff Other: _____

5. How are your symptoms changing with time?

- Getting Worse Staying the Same Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (Please circle)

7. How much has the problem interfered with your work?

- Not at all A little bit Moderately Quite a bit Extremely

8. How much has the problem interfered with your social activities?

- Not at all A little bit Moderately Quite a bit Extremely

9. Who else have you seen for your problem?

- Chiropractor Neurologist Primary Care Physician
 ER physician Orthopedist Other: _____
 Massage Therapist Physical Therapist No one

10. How long have you had this problem? _____

11. How do you think your problem began?

12. Do you consider this problem to be severe?

- Yes Yes, at times No

13. What aggravates your problem?

14. What concerns you the most about your problem; what does it prevent you from doing?

15. What is your: Height _____ Weight _____ Date of Birth _____
Occupation _____

16. How would you rate your overall Health?

Excellent Very Good Good Fair Poor

17. What type of exercise do you do?

Strenuous Moderate Light None

18. Indicate if you have any immediate family members with any of the following:

Rheumatoid Arthritis Diabetes Lupus
 Heart Problems Cancer ALS

19. 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
<input type="checkbox"/>	<input type="checkbox"/> Headaches	<input type="checkbox"/>	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/> Diabetes
<input type="checkbox"/>	<input type="checkbox"/> Neck Pain	<input type="checkbox"/>	<input type="checkbox"/> Heart Attack	<input type="checkbox"/>	<input type="checkbox"/> Excessive Thirst
<input type="checkbox"/>	<input type="checkbox"/> Upper Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Chest Pains	<input type="checkbox"/>	<input type="checkbox"/> Frequent Urination
<input type="checkbox"/>	<input type="checkbox"/> Mid Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Stroke	<input type="checkbox"/>	<input type="checkbox"/> Smoking/Tobacco Use
<input type="checkbox"/>	<input type="checkbox"/> Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Angina	<input type="checkbox"/>	<input type="checkbox"/> Drug/Alcohol Dependence
<input type="checkbox"/>	<input type="checkbox"/> Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/> Allergies
<input type="checkbox"/>	<input type="checkbox"/> Elbow/Upper Arm Pain	<input type="checkbox"/>	<input type="checkbox"/> Kidney Disorders	<input type="checkbox"/>	<input type="checkbox"/> Depression
<input type="checkbox"/>	<input type="checkbox"/> Wrist Pain	<input type="checkbox"/>	<input type="checkbox"/> Bladder Infection	<input type="checkbox"/>	<input type="checkbox"/> Systemic Lupus
<input type="checkbox"/>	<input type="checkbox"/> Hand Pain	<input type="checkbox"/>	<input type="checkbox"/> Painful Urination	<input type="checkbox"/>	<input type="checkbox"/> Epilepsy
<input type="checkbox"/>	<input type="checkbox"/> Hip Pain	<input type="checkbox"/>	<input type="checkbox"/> Loss of Bladder Control	<input type="checkbox"/>	<input type="checkbox"/> Dermatitis/Eczema/Rash
<input type="checkbox"/>	<input type="checkbox"/> Upper Leg Pain	<input type="checkbox"/>	<input type="checkbox"/> Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/>	<input type="checkbox"/> Knee Pain	<input type="checkbox"/>	<input type="checkbox"/> Abnormal Weight Gain/Loss		
<input type="checkbox"/>	<input type="checkbox"/> Ankle/Foot Pain	<input type="checkbox"/>	<input type="checkbox"/> Loss of Appetite		For Females Only
<input type="checkbox"/>	<input type="checkbox"/> Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/> Birth Control Pills
<input type="checkbox"/>	<input type="checkbox"/> Joint Pain/Stiffness	<input type="checkbox"/>	<input type="checkbox"/> Ulcer	<input type="checkbox"/>	<input type="checkbox"/> Hormonal Replacement
<input type="checkbox"/>	<input type="checkbox"/> Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Hepatitis	<input type="checkbox"/>	<input type="checkbox"/> Pregnancy
<input type="checkbox"/>	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Liver/Gall Bladder Disorder		
<input type="checkbox"/>	<input type="checkbox"/> Cancer	<input type="checkbox"/>	<input type="checkbox"/> General Fatigue		
<input type="checkbox"/>	<input type="checkbox"/> Tumor	<input type="checkbox"/>	<input type="checkbox"/> Muscular Incoordination		
<input type="checkbox"/>	<input type="checkbox"/> Asthma	<input type="checkbox"/>	<input type="checkbox"/> Visual Disturbances		
<input type="checkbox"/>	<input type="checkbox"/> Chronic Sinusitis	<input type="checkbox"/>	<input type="checkbox"/> Dizziness		
<input type="checkbox"/>	<input type="checkbox"/> Other: _____				

20. List all prescription medications you are currently taking:

21. List all of the over-the-counter medications you are currently taking:

22. List all surgical procedures you have had:

23. What activities do you do at work?

<input type="checkbox"/> Sit:	<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half the day	<input type="checkbox"/> A little of the day
<input type="checkbox"/> Stand:	<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half the day	<input type="checkbox"/> A little of the day
<input type="checkbox"/> Computer work:	<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half the day	<input type="checkbox"/> A little of the day
<input type="checkbox"/> On the phone:	<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half of the day	<input type="checkbox"/> A little of the day

24. What activities do you do outside of work?

25. Have you ever been hospitalized? No Yes
if yes, why _____

26. Have you had significant past trauma? No Yes

27. Anything else pertinent to your visit today? _____

Patient Signature _____ Date: _____

Cobb Rehab and Wellness

4209 E. Busch Blvd.
Tampa, FL 33617
(813) 914-8500

**ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES**

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

Patient Name (please print)

Date

Parent, Guardian or Patient's legal representative

Signature

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.



DR. GREGORY COBB

4209 E. BUSCH BLVD. TAMPA, FL 33617
phone: (813) 914-8500 fax: (813) 914-8511
cobbrehabwellness.com

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____ to
release healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

This request and authorization applies to:

Healthcare information relating to the following treatment, condition, or dates: _____

All healthcare information

Other: _____

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.

**ASSIGNMENT OF BENEFITS,
LIENS AND DIRECT PAYMENT AUTHORIZATION**

MEDICAL PROVIDER: **Cobb Rehab and Wellness** (formerly Bode Spinal Center)
4209 E. Busch Blvd.
Tampa, FL 33617
(813) 914-8500

INSURANCE COMPANY: _____

For and in consideration of the above-mentioned provider agreeing to pursue my insurance provider for payment of benefits due me and not requiring prepayment for services. I hereby irrevocably assign to the aforementioned medical provider (the "Provider") any Personal Injury Protection benefits I may have in accordance with Florida Statute 621.736(3). This includes any benefits from my insurance company or any other entity that may be responsible for expenses incurred, and I authorize the 'Provider' to prosecute said action and collect legal expenses as they see fit. THIS DOCUMENT CONSTITUTES AN ASSIGNMENT OF BENEFITS. I hereby further give a lien to the 'Provider' against any and all insurance benefits named herein, and any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of the injuries or illness for which I have been treated by the 'Provider'. This is to act as an irrevocable assignment of my rights and benefits to the extent of the services provided. I agree to cooperate with the 'Provider' and any attorney that the 'Provider' chooses, and to do all things reasonable to effect payment of the bills by the insurance company to the 'Provider' including, but not limited to, disclosing patient's medical condition and treatment. This assignment concerns only the bills for the 'Provider' and those costs (including, but not limited to attorney's fees, court costs and interest) necessary in procuring payment from the above-named insurance company, etc. This assignment is not intended to assign any other causes of action that any belong to the undersigned patient. I agree to pay any applicable deductible or co-payment not covered by the PIP insurance coverage. I understand that this is a benefit and convenience to me in that the provider will pursue collection against the insurance company on my behalf I hereby instruct and direct my insurance company to pay my benefits by check made payable to and mailed to the 'Provider' at the address listed above, if my current policy prohibits direct payment to doctors, then I hereby instruct and direct my insurance company to make the check payable to me and mail it to the 'Provider' at the address listed above, if this 'Provider' is providing medical care related to an auto accident, 'Provider is charging a reasonable fee for necessary care related to the accident and these bills should be paid to the full extent of the benefits available under my policy of insurance. If any portion of any charge for these services is either reduced or denied in whole or in part, both the provider and the insured request that my insurance company place funds equal to the amount of the reduced or denied charges into escrow. My insurance company is to hold the escrowed funds for 'Provider', until such time as all escrowed funds are paid to 'Provider', or 'Provider' instructs my insurance company that 'Provider' is no longer making any claim to the escrowed funds. Furthermore, I hereby give the 'Provider' limited power of attorney to endorse/sign my name on any and all checks for payment to the 'Provider'. This agreement is intended to serve as an assignment of the patient's rights and benefits under his/her aforementioned insurance policy in favor of the 'Provider'. If any language within this agreement has the effect of invalidating this assignment, that language shall be deemed void and the assignment shall remain in full force and effect. A photocopy of this assignment shall be considered as effective and valid as the original.

Expire Date _____

Patient Signature

Date

Witness Signature

Date

COBB REHAB & WELLNESS

4209 E Busch Blvd
Tampa, FL 33617
(813) 914-8500

HOW DID YOU HEAR ABOUT OUR CLINIC:

PPO-HMO Provider book: _____

Sign / Location: _____

Friend / Relative / Co-worker: _____

Yellow Pages: _____

Attorney: _____

Another Doctor / Clinic: _____

**THANK YOU FOR CHOOSING *COBB REHAB & WELLNESS* FOR YOUR
HEALTH CARE NEEDS.**