



PATIENT INFORMATION

First Name _____ Last Name _____
 Gender: M F Date of Birth ____ / ____ / ____ Age _____ SS# _____ / _____ / _____
 Home Address _____
 City _____ State _____ Zip _____
 Home Phone: _____ Work Phone: _____ Cell Phone: _____
 Employer _____ Occupation _____
 Referred By _____ Email _____

SPOUSE or GUARDIAN

First Name _____ Last Name _____
 Employer _____ Occupation _____
 Work Phone: _____ Cell Phone: _____
 Date of Birth ____ / ____ / ____ Age _____ SS# _____ / _____ / _____

MY PRIVACY - HIPAA

I have received a copy of the **Notice of Privacy Practices**. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: Conduct, plan and direct my treatment and follow-up among the healthcare providers who may be directly and indirectly involved in providing my treatment; Obtain payment from third-party payors; Conduct normal healthcare operations such as quality assessments and accreditation.

Print Name: _____ Sign Name: _____

CONSENT TO TREAT MINOR

I hereby authorize Dr. Pari Limbachia, D.C. and/or Dr. Thuy Nguyen, D.C. and whomever they may designate to administer chiropractic care as deemed necessary to my _____ (indicate relationship of child)

Name of Child: _____

Information concerning sexual activity, alcohol use and/or substance abuse will not be disclosed to you the parent/guardian without consent of your child. Any information concerning suicide ideation or homicide ideation will be disclosed to you immediately. This information is regulated by Florida State Law and HIPAA.

Guardian Name: _____ Guardian Signature: _____

DISCLOSURE OF MEDICAL INFORMATION

Please provide the name, phone number and relationship of the person(s) to whom you want to disclose your personal health information.

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Print Name: _____ Sign Name: _____

Witness: _____ **Sign Name:** _____

Please check all conditions you currently have or have had

General Questions

- Weight loss
- Weight gain
- Change in sleep patterns
- Change in activity capacity

Neurologic and Psychiatric

- Anxiety
- Headaches
- Depression
- Meningitis
- Paralysis
- Seizure
- Stroke
- Tingling
- Tremors
- Memory Loss
- Fainting spells, dizziness
- Head injuries
- Blackouts or near blackouts
- Change in sensation anywhere on your body
- Localized weakness or numbness

Ears, Eyes, Nose & Throat

- Hay fever
- Glaucoma
- Polyps
- Allergy
- Cataracts
- Goiter
- Hoarseness
- Double vision
- Gum problems
- Eye problems
- Ear Infections
- Glasses/contacts
- Hearing Loss
- Ear discharge/pain
- Frequent nosebleeds
- Ringing in your ears
- Sinus infections
- Swollen glands

Cardiovascular

- Angina
- Leg cramps
- Ankle swelling
- Awakening short of breath
- Cardiac catheterization
- Cold hands or feet
- Congenital heart defects
- Dizziness when standing quickly
- Heart attacks
- Heart failure
- High or low blood pressure
- Irregular heart rate
- Purple fingers or lips
- Leg pain that resolves with rest
- Heart palpitations
- Varicose veins

Respiratory

- Pleurisy
- Asthma
- Breathlessness when lying flat
- Prolonged cough
- Coughing up blood
- Emphysema
- Tuberculosis
- Shortness of breath
- Frequent infections (bronchitis)

Skin

- Abscess
- Acne
- Boils
- Hives
- Lumps
- Jaundice
- Psoriasis
- Athlete's foot
- Excessive body odor
- Excessive sweating
- Fungal infections
- Nail problems
- Moles- irregular
- Moles - change/new
- Dandruff
- Oily skin
- Rashes
- Dry skin

Kidneys & Urinary Tract

- Blood in urine
- Brown urine
- Dribbling after urination
- Painful urination
- Excessive thirst
- Involuntary urination/incontinence
- Urinating frequently (day)
- Urinating frequently (night)
- Urine hesitancy
- Weak flow
- Frequent bladder infections
- Kidney disease
- Kidney stone

Endocrine

- Diabetes
- Abnormal body hair
- Changes in skin texture
- Cold intolerance
- Heat intolerance
- History of "borderline" diabetes
- Increased loss of hair
- Rheumatism
- Thyroid disease
- Sickle cell

Male & Female

- Painful sexual intercourse
- Loss of sexual interest
- Unprotected sex
- Groin itching
- Sexually transmitted diseases
- Hernia
- Bloody ejaculation
- Inability to complete intercourse
- Lump on testicle
- Penile discharge
- Sterility
- Sores on penis or warts
- Prostate disease
- Testicular pain
- Testicular swelling

Males Only

Musculoskeletal

- Anemia
- Back pain
- Gout
- Neck pain
- Abnormal Blood Counts
- Blood clots in legs/lungs
- Bone Marrow Biopsy
- Easy Bleeding
- Easy bruising
- Joint swelling
- Morning stiffness
- Muscle aches
- Arthritis
- Bursitis
- Joint aches
- Tendonitis

Gastrointestinal

- Diarrhea
- Reflux
- Ulcers
- Hepatitis
- Abdominal pain
- Anal fissures
- Black tarry stools
- Vomiting blood
- Constipation
- Nausea
- Problems swallowing
- Hiatal Hernia
- Intestinal obstruction
- Liver disease
- Hemorrhoids
- Red blood after bowel movement
- Gallstones
- Vomiting
- Heartburn
- Indigestion

Females Only

- D + C
- Hernia
- Endometriosis
- Abn. bleeding between cycles
- Abnormal pap smear
- Bleeding after intercourse
- Complications with pregnancy
- Heavy bleeding during cycles
- Ovarian cysts
- Pelvic Inflammatory Disease
- Postmenopausal symptoms
- Hot flashes
- Fibroids
- PMS

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize Shant Wellness to provide me with chiropractic care, in accordance with this state's statutes.

Patient or Guardian Signature: _____

Date: _____

Doctors Signature: _____

Date: _____