2117 49 ST N
St Petersburg FL 33710
Phone (315) 406-2471
Email: DrMaltese@spineandsport.clinic
WWW.SpineandSport.Clinic

PRIMAL PERFORMANCE
SPINE & SPORT

Dr. Joseph M. Maltese
Chiropractic Physician

File #_____

Consent for Purposes of Treatment, Payment, and Healthcare Operations

I acknowledge that the Chiropractic Office of Primal Performance's "Notice of Privacy Practices" is available to me upon request.

I understand I have a right to review the Chiropractic Office of Primal Performance's "Notice of Privacy Practices" prior to signing this document. The "Notice of Privacy Practices" describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of health care operations, and describes my rights and the duties of the Chiropractic Offices of Primal Performance Spine & Sport, with respect to my protected health information. This policy is also provided on request at the main administration desk of the practice.

The Chiropractic Office of Primal Performance reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____
Signature of Patient or Personal Representative Date

Name of Patient

Description of Personal Representative's Authority

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Dr. Joseph M. Maltese
Chiropractic Physician

File # _____

Informed Consent

Informed Consent To Chiropractic Examination, Diagnostic Procedures, Chiropractic Adjustments and Care

I hereby request and consent to the performance of: physical examinations and evaluations required to be performed to diagnose my condition(s), of chiropractic adjustments and other chiropractic procedures, including various modes of physical medicine, any associated nutrition supplements, home healthcare products, on me (or on the patient named below for whom I am legally responsible) by or under the supervision of the doctor of chiropractic named below and/or other licensed doctors of chiropractic: who now or in the future treat me while employed by **Primal Performance Spine & Sport**, working, or associated with, or serving as back-up for the doctor of chiropractic named below, including those working at any of the listed **Primal Performance Spine & Sport**.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel, the nature and purpose chiropractic adjustments and other procedures as well as home healthcare products and nutrition supplementation, I understand that 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, fracture, disc injuries, strokes, dislocations, sprains, swelling and abruising. 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, what is in my best interests.

I have read, or had read to me, the above consent. I have also had an 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 condition(s) and for any future condition(s) for which I seek treatment at **Primal Performance Spine & Sport**.

Intial Treatment Schedule: _____

ROF Doctor Signature _____

<u>To be completed by patient</u>:

_____
Print Patient's Name

_____
Signature of Patient

_____
Date Signed

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

_____
Print Patient's Name

_____
Print Name of Patient's Representative

_____
Signature of Patient' Representative
As: _____
Relationship of Authority of Patient's Representative

Confidential Patient Health Patient _____ File # _____ Date _____

□ Dr. □ Mr. □ Ms □ Mrs First: _____ Mid Initial: _____ Last _____

Birth Date: ___/___/_____ Age: _____ Sex: Male / Female SSN: _____

Email Address: _____

Address: _____ Apt # _____

City: _____ State: _____ Zip: _____ County: _____

Home Phone: ( ) _____ Work Phone: ( ) _____ ext _____

Cell Phone: ( ) _____ Fax # ( ) _____

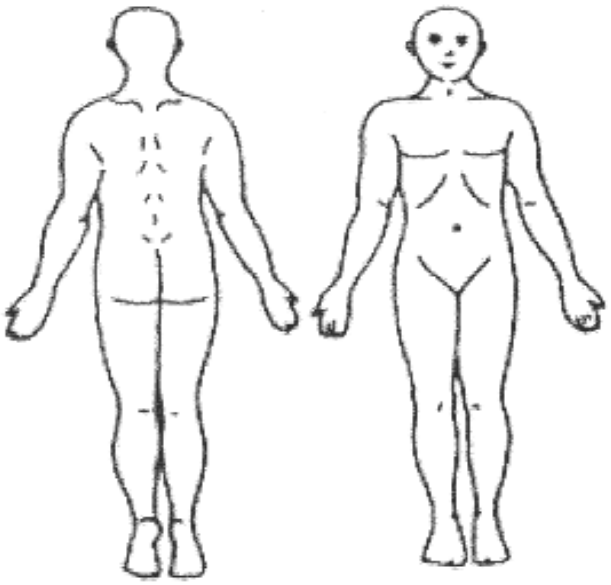
□ Single □ Married □ Widowed □ Divorced □ Separated Spouse's Name: _____

Children (Names & Ages) _____

Emergency Contact Name: _____ Phone: ( ) _____

CURRENT HEALTH CONDITION

PLEASE LABEL THE DIAGRAM, AREA OF SYMPTOM:
Mark on figure below area of pain/numbness/burning.
Use Letters BELOW to indicate **TYPE & LOCATION**
A=Ache B=Burning N=Numbness P=Pins&Needles S=Stabbing



Unwanted Condition/Pain (Why are you here today?):
_____

I currently have: □ PAIN □ STIFFNESS □ NUMBNESS □ WEAKNESS

Condition/Pain STARTED on what date? _____
Has it ever occurred before? Yes / No When? _____
Is this condition: □ Auto Related □ Job Related □ Home Injury
□ Slip or Fall □ Lifting □ Slept Wrong □ Unknown Cause □ Other

EXPLAIN in your own words how the injury/pain/condition happened:
_____
_____
_____

If caused by an Accident: Date _____ Time: _____

List **any other** Condition/Pain related or unrelated to the one listed above that you are experiencing: _____
_____

Please rate your overall pain/unwanted condition/discomfort/stiffness on a scale of 0 to 10:
0 (none) 1 2 3 4 5 6 7 8 9 10 (I should be in the ER right now)

PRIOR TESTS	Date	File #					Location/Facility
□ X-RAY		□ Head	□ Neck	□ Mid back	□ Low Back	□ Other	
□ MRI		□ Head	□ Neck	□ Mid back	□ Low Back	□ Other	
□ CT SCAN		□ Head	□ Neck	□ Mid back	□ Low Back	□ Other	
□ NCV							
□ EMG							
□ OTHER							

MEDICATIONS: Are you taking now or have you been taking. . .

Any Over The Counter meds? □ No □ Yes _____

Have you taken any of the following? □ Acetaminophen □ Tylenol □ Percocet □ Vicodin □ Lortab □ Excedrin _____

Any Blood Thinners? □ No □ Yes _____

Any prescription muscle relaxers? □ No □ Yes _____

Any other prescription meds? □ No □ Yes _____

EMPLOYMENT:

Occupation/Job Title: _____

Description of Work: _____

Work Activity Postures: □ Bending □ Climbing □ Kneeling □ Pulling □ Pushing
□ Reaching □ Sitting □ Standing □ Twisting □ Walking

PAST CONDITIONS:

□ Arthritis	□ Depression	□ Hepatitis	□ Seizures
□ Asthma	□ Diabetes (insulin dependent)	□ HIV	□ Shingles
□ Bedwetting	□ Diabetes (non-insulin dependent)	□ High Blood Pressure	□ Spina bifida
□ Cancer	□ Ear infections	□ Multiple Sclerosis	□ Vertigo
□ Chicken pox	□ Fibromyalgia	□ Parkinson's	□ Other _____
□ Crohn's/colitis	□ Headaches	□ Pneumonia	□ Problems with Bruising
□ CVA (stroke)	□ Heart Disease	□ Scoliosis	□ Blood Clot Disorders

SURGERIES:

□ Appendectomy	□ Cosmetic	□ Laminectomy Level? _____	□ Spinal fusion Level? _____
□ C-section	□ Gall bladder		
□ Cardiac Cath	□ Hernia repair	□ Pacemaker insertion	□ Other _____
□ Carpal tunnel (Left / Right)	□ Hip replacement (Left / Right)	□ Rotator cuff repair	_____
□ Coronary artery bypass	□ Knee repair (Left / Right)	(Left / Right)	_____

SOCIAL HISTORY:

Do you consume alcohol? □ Yes □ No If yes, how much/often? _____

Do you smoke? □ Yes □ No If yes, how much/often? _____

Is there any daily or recreational activity that you have had to stop or limit due to your pain/discomfort? □ Yes □ No

If yes, please list: _____