JACKSONVILLE HEALTH AND WELLNESS / CASE HISTORY

PATIENT INFORMATION

Name_____ Date _____ Sex M F Age _____ Height_____ Weight_____
Birthdate_____ Social Security # _____
[ ] Married [ ] Widowed [ ] Single [ ] Minor [ ] Separated [ ] Divorced [ ] Partnered for _____ years
Address_____
City_____ State_____ Zip _____
Occupation_____ Patient Employer/School_____

SPOUSE/PARTNER

Name_____ Birthdate_____
Social Security #_____ Employer_____

PHONE NUMBERS/CONTACT INFORMATION

Home Phone (____) _____ Cell Phone (_____) _____
Work Phone (_____) _____
Best time to call and reach you_____ E-Mail address_____
In case of emergency contact:
Name_____Relationship_____ Phone_____

PRIMARY MEDICAL DOCTOR

Doctor Name_____ Practice Name _____
Phone Number_____
Address_____

REFFERAL

How were you referred to our office_____

INSURANCE

Who is responsible for this account and relationship to patient?_____
Primary Insurance Co. _____Policy #_____ Group #_____
Secondary Insurance Co._____ Policy #_____ Group# _____
Subscriber's Name_____ D.O.B._____ Social Security #_____

ACCIDENT INFORMATION

Is condition due to accident? [ ]Yes [ ]No Date of Accident_____ Type of accident [ ] Auto [ ]Work [ ] Home
Attorney Name(if applicable)_____Have you reported your accident and to whom? _____
Location of Accident_____
Insurance Co. _____ Address_____
Phone #_____ Policy #_____ Claim #_____ Adjuster's Name_____

PATIENT CONDITION

Reason for visit _____
Location/Description of Complaint_____
Complaint Began when and how?_____
Please circle quality of complaint/pain: dull ache sharp shooting burning throbbing deep other_____
Does the complaint/pain radiate or travel (shoot) to any areas of your body? Where? _____
Do you have any numbness or tingling in your body? Where? _____
Grade Intensity/Severity (No complaint/pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst possible pain imaginable)
Is the complaint/pain [ ] constant [ ] come and go
How long does it last?_____
Does anything aggravate the complaint? _____
Does anything make the complaint better? _____

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PATIENT CONDITION CONTINUED

What treatment have you already received for your condition?
[ ] None [ ] Surgery [ ] Medications [ ] Physical Therapy [ ] Massage [] Yoga [] Meditation [] Nutrition Counseling
[ ] Chiropractic - When?_____ [ ] Other _____

PAST/ CURRENT MEDICAL HISTORY

******IMPORTANT****YOUR CURRENT OR PAST HEALTH, SURGERIES, & MEDICATION WILL EFFECT THE TYPE OF TREATMENT YOU RECEIVE AT OUR OFFICE**

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Work_____MRI_____

Please list **ALL PAST and CURRENT MEDICAL Problems and Conditions**

Please list **ALL surgeries**

Please list ALL **Medications and/or Vitamins and Herbs AND THE REASON FOR TAKING THEM**

Allergies

FAMILY HISTORY

Family Member_____ Medical Condition_____
Family Member_____ Medical Condition_____

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CURRENT LIFESTYLE

Please describe your current OR past exercise regimen (if applicable) _____

_____

Work Activity: [ ] Sitting [ ] Standing [ ] Light Labor [ ] Heavy Labor [ ] Student
Habits: [ ] Smoking; Packs/Day _____ [ ] Alcohol;Drinks/Week _____ [ ] Coffee; Cups/Day_____
Stress Level: [ ] High [ ] Medium [ ] Low Reason?_____
Dietary Habits: Glasses of Water _____ Daily; Carbonated Beverages _____ Daily; Dairy_____ Daily
Please list typical: Breakfast _____
Lunch _____
Dinner _____
Snacks_____
Sleeping Pattern: [ ] Inability to Fall Asleep [ ] Wake up Often [ ] Other _____

WELLNESS GOALS

Are you interested in achieving (Please check one)?
[] Symptomatic Relief – relief of your signs and symptoms (pain, heartburn, etc.)
[] Symptomatic Relief & Corrective Care – relief of signs and symptoms as well as correcting the cause of the symptom
[] Symptomatic Relief, Corrective Care & Optimal Health – addition of physical, mental, & chemical well being; prevention; & improving quality and quantity of life.

Our treatment protocols incorporate a WHOLE BODY approach to health and wellness as we offer a comprehensive array of services for many health related problems. Therefore, by answering the following questions it will help us to individualize/customize your treatment plan.

Would you like help with:	NO	YES	Additional Health Goals or Comments
Exercise	[]	[]	_____
Nutrition & Eating Better	[]	[]	_____
Stress Reduction	[]	[]	_____
Weight Loss	[]	[]	_____
Decreased Reliance on Medication	[]	[]	_____
Improving Posture	[]	[]	_____
Flexibility	[]	[]	_____
Learning about wellness	[]	[]	_____
Energy Levels	[]	[]	

ACTIVITIES OF DAILY LIVING

Please grade the following activities on how they are impacted by your current health status/condition

	Unable to perform									Able to perform
Personal Care	0	1	2	3	4	5	6	7	8	9	10
Lifting	0	1	2	3	4	5	6	7	8	9	10
Reading & Concentration	0	1	2	3	4	5	6	7	8	9	10
Work	0	1	2	3	4	5	6	7	8	9	10
Driving & Traveling	0	1	2	3	4	5	6	7	8	9	10
Sleeping	0	1	2	3	4	5	6	7	8	9	10
Recreation	0	1	2	3	4	5	6	7	8	9	10
Hand Coordination	0	1	2	3	4	5	6	7	8	9	10
Walking	0	1	2	3	4	5	6	7	8	9	10
Sitting	0	1	2	3	4	5	6	7	8	9	10
Standing	0	1	2	3	4	5	6	7	8	9	10
Social Life	0	1	2	3	4	5	6	7	8	9	10
Household Duties (laundry, etc.)	0	1	2	3	4	5	6	7	8	9	10
Exercising	0	1	2	3	4	5	6	7	8	9	10
Other:	0	1	2	3	4	5	6	7	8	9	10

Patient Signature and Date:_____

JACKSONVILLE HEALTH AND WELLNESS

AUTHORIZATION FOR TREATMENT
THIS CONSTITUTES INFORMED CONSENT FOR MASSAGE, PHYSICAL THERAPY, AND/OR CHIROPRACTIC
I hereby authorize the giving of treatment, performance of diagnostic procedures, examination and the administration of any other judgment by my physician that may be considered necessary or advisable for my diagnosis or treatment while a patient at Jacksonville Health and Wellness Center.
Female patients only **: I am not pregnant**.

PATIENT INITIAL_____

PAYMENT AGREEMENT
I acknowledge that I am financially responsible for non-covered services. I also understand that if I terminate my care and treatment, any fees for professional services rendered me at Jacksonville Health and Wellness Center will be immediately due and payable.

PATIENT INITIAL_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
By my signature on the bottom, I acknowledge that I have received a copy of the Notice of Privacy Practices.

PATIENT INITIAL_____

AUTHORIZATION , ASSIGNMENT AND RELEASE
I hereby assign, direct and authorize my insurance benefits to be paid by check made out and mailed directly to: C/O (in care of) Jacksonville Health and Wellness Center. If my current policy prohibits direct payment to doctor, then I hereby also instruct and direct you to make out the check to me and mail it as follows: C/O (in care of) Jacksonville Health and Wellness Center for professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY**. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment. I understand that there is a possibility that I will receive a payment from my insurance company for services rendered from this facility, thus, those payments will be rendered to said facility otherwise I will be billed. **A PHOTOCOPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.** I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case. Patient/Policy Holder also authorizes the doctor to complain to the insurance commissioner for any reason. I hereby authorize my insurance carrier to release information regarding my insurance coverage

PATIENT INITIAL_____

JACKSONVILLE HEALTH AND WELLNESS

AUTHORIZATION AND ASSIGNMENT MEDICARE BENEFICIARY ONLY

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me, to release to the Social Security Administration, or its intermediaries or carriers any information needed for this or a related Medicare claim. I request payment of authorized Medicare benefits on my behalf for any servicres furnished me to Jacksonville Health and Wellness Center.

PATIENT INITIAL_____

PATIENT RECORD OF DISCLOSURE

I wish to be contacted in the following manner (for emergency, non emergency, disclosure of testing/diagnostic results, scheduling of appointments, etc.) (check all that apply).

- ☐ Home Telephone
- ☐ Work Telephone
- ☐ Written communication

Date_____

_____ _____

Name of Patient (Please Print) Signature of Guardian (If Minor)

Date_____

_____ _____

Signature of Policy Holder Witness

You & Your Massage

Massage can be a very beneficial tool on your way to recovering and feeling better. Massage is an excellent stress buster and can relieve sore muscles. In order to maximize your treatment, listed below are the types of massage that we offer:

Swedish Massage

This form of massage is used to loosen muscles due to stress and overuse. Swedish is wonderful for relaxation and tension release. The pressure used is usually light to moderate.

Deep Tissue Massage

Deep tissue is just as it sounds. This is for someone with knotted muscles that can benefit from a massage that is given with a lot of pressure

Neuromuscular Therapy (NMT)

NMT is designed to zero in on one problem area. It targets a muscle or trigger point that is ultimately causing the pain and discomfort. The pressure is moderate to deep. This is to release the tight and knotted muscle (s).

Pregnancy Massage

Pregnancy Massage is very beneficial for the Mom-to-be. The Mom is positioned comfortably (usually lying on her side) and then given a light/moderate massage on the areas that are causing her discomfort.

Please indicate which massage you are interested in today:

Everyone is different and requires different pressure. Please indicate below the pressure that you would prefer so that we can make your massage the most comfortable for you. With 0 being the least amount of pressure and 10 being the most amount of pressure that you can withstand. Circle one below:

0 1 2 3 4 5 6 7 8 9 10

Thank you so much for entrusting us with your care and please let us know if there is anything we can do to make your Massage experience more pleasurable.

Patient Name:_____

Date:_____ / _____ / _____

JACKSONVILLE HEALTH & WELLNESS CANCELLATION POLICY

9957 Moorings Drive, Suite 403
Jacksonville, Fl 32257

DATE: _____

CANCELLATION POLICY

24-hour notice from time of scheduled appointment is required for:

1. Massage appointments (30 MINUTES OR GREATER) &
2. ALL NUTRITIONAL appointments

… to avoid a **$25.00 charge.**

With my signature below, I have been made aware of the 24-hour cancellation policy.

Printed Name: _____

Signature: _____