TAYLOR-MADE HEALTH AND WELLNESS

Family Care ♦ Auto Accident Rehabilitation Therapy ♦ Wellness Care
WWW.TAYLOREDWELLNESS.COM

425 Citrus Tower Blvd Suite 301 Clermont, Florida 34711 Office: (352) 989-5555 Fax: (352) 432-2121

PATIENT REGISTRATION

NAME: _____ **D.O.B.** _____ **AGE**: _____

ADDRESS: _____ **CITY**: _____ **STATE**: _____ **ZIP**: _____

SEX: _____ **SOCIAL SECURITY#**: _____ **EMAIL**: _____

HOME PHONE: _____ **WORK PHONE**: _____

CELL PHONE: _____

***WE SEND OUT APPT. REMINDER THROUGH EMAIL OR TEXT, WHICH DO YOU PREFER?**

(CHOOSE 2 BEST WAYS) □EMAIL □TEXT □PHONE □NONE.

***HOW DID YOU HEAR ABOUT US?**

□INTERNET □GYM □FRIEND □SIGN □FLYER □NEWSPAPER □OTHER:_____

IF REFERRED, WHO REFERRED YOU TO OUR OFFICE? _____

ATTORNEY (IF ANY): _____ **LOCATION**: _____

FINANCIAL RESPONSIBILITY

WHO IS RESPONSIBLE FOR THE BILL: □ INSURANCE □ MY EMPLOYER □ SPOUSE □ I AM □ OTHER

TYPE OF INSURANCE:□ AUTOMOBILE □ HEALTH □ WORKER COMP. □ CASH

INSURANCE COMPANY'S NAME: _____ **CLAIM#:** _____

MAILING ADDRESS: _____

DED: _____ **MED PAY**: _____ **COVERED**: _____%

ADJUSTER NAME: _____ **PHONE**: _____ **EXT**. _____

WE WILL NEED TO MAKE A COPY OF ID CARD AND INSURANCE CARD

INSURANCE MEDICAL RELEASE/ASSIGNMENT:

I hereby authorize release of Medical Information necessary to process my insurance claim to my insurance company and/or Attorney representing me. I also authorize payment of benefits to provide service. I understand that I am financially responsible for changes not covered by my insurance.

PATIENT SIGNATURE_____ **DATE**: _____

TAYLOR-MADE HEALTH AND WELLNESS

Family Care ♦ Auto Accident Rehabilitation Therapy ♦ Wellness Care
WWW.TAYLOREDWELLNESS.COM

425 Citrus Tower Blvd Suite 301 Clermont, Florida 34711 Office: (352) 989-5555 Fax: (352) 432-2121

PATIENT SIGN-IN REGISTER

PATIENT'S NAME_____ **DATE**_____

TAYLOR-MADE HEALTH AND WELLNESS

Family Care ♦ Auto Accident Rehabilitation Therapy ♦ Wellness Care
WWW.TAYLOREDWELLNESS.COM

425 Citrus Tower Blvd Suite 301 Clermont, Florida 34711 Office: (352) 989-5555 Fax: (352) 432-2121

Consent for Purpose of Treatment, Payment, and Healthcare Operations

I consent to the use or disclosure of my protected health information by **TAYLOR-MADE HEALTH AND WELLNESS P.A.** for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of **TAYLOR-MADE HEALTH AND WELLNESS P.A..** I understand that diagnosis or treatment of me by **TAYLOR-MADE HEALTH AND WELLNESS P.A.** may be conditioned upon my consent as evidence by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. **TAYLOR-MADE HEALTH AND WELLNESS P.A.** is not required to agree to the restrictions that I may request. However, if **TAYLOR-MADE HEALTH AND WELLNESS P.A.** agrees to a restriction that I request, the restriction is binding on **TAYLOR-MADE HEALTH AND WELLNESS P.A.**

I have the right to revoke this consent, in writing, at any time, except to the extent that **TAYLOR-MADE HEALTH AND WELLNESS P.A.** has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review **TAYLOR-MADE HEALTH AND WELLNESS P.A.'S** Notice of Privacy Practices prior to signing this document. **TAYLOR-MADE HEALTH AND WELLNESS P.A.'S** Notice of Privacy Practices has been provided to me. 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 of **TAYLOR-MADE HEALTH AND WELLNESS P.A..** The Notice of Privacy Practices for **TAYLOR-MADE HEALTH AND WELLNESS P.A.** is also provided at the reception desk. This Notice of Privacy Practices also describes my rights and **TAYLOR-MADE HEALTH AND WELLNESS P.A.'S** duties with respect to my protected health information.

TAYLOR-MADE HEALTH AND WELLNESS P.A. 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 me next appointment.

_____
Signature of Patient or Personal Representative

_____
Print Name of Patient or Personal Representative

_____
Date

_____
TAYLOR-MADE HEALTH AND WELLNESS P.A.'s Representative

TAYLOR-MADE HEALTH AND WELLNESS

Family Care ♦ Auto Accident Rehabilitation Therapy ♦ Wellness Care
WWW.TAYLOREDWELLNESS.COM

425 Citrus Tower Blvd Suite 301 Clermont, Florida 34711 Office: (352) 989-5555 Fax: (352) 432-2121

1. WHERE IS AREA OF CONCERN: _____

How often do you experience symptoms:

☐ Constant(100%-75%) ☐Frequent(74%-51%) ☐Occasionally(50%026%) ☐Intermittently(25%-0%)

What does pain feel like?

☐Spasm ☐Numbing ☐Burning ☐Tingling ☐Throbbing ☐Aching ☐Other:_____

What makes pain feel "better?"

☐Nothing ☐Rest ☐Walking ☐Stretching ☐Exercise ☐Other:_____

What makes pain fell "worse?"

☐Bending ☐Twisting, ☐Lifting ☐Sitting ☐Standing ☐Coughing ☐Temp. Changes

Does Pain Radiate (Move) to another part of the body? ☐Yes ☐ No

This pain: ☐is a new pain ☐I've had before, but went away ☐already had but now it is worse

2. WHERE IS AREA OF CONCERN: _____

How often do you experience symptoms:

☐ Constant(100%-75%) ☐Frequent(74%-51%) ☐Occasionally(50%026%) ☐Intermittently(25%-0%)

What does pain feel like?

☐Spasm ☐Numbing ☐Burning ☐Tingling ☐Throbbing ☐Aching ☐Other:_____

What makes pain feel "better?"

☐Nothing ☐Rest ☐Walking ☐Stretching ☐Exercise ☐Other:_____

What makes pain fell "worse?"

☐Bending ☐Twisting, ☐Lifting ☐Sitting ☐Standing ☐Coughing ☐Temp. Changes

Does Pain Radiate (Move) to another part of the body? ☐Yes ☐ No

This pain: ☐is a new pain ☐I've had before, but went away ☐already had but now it is worse

3. WHERE IS AREA OF CONCERN: _____

How often do you experience symptoms:

☐ Constant(100%-75%) ☐Frequent(74%-51%) ☐Occasionally(50%026%) ☐Intermittently(25%-0%)

What does pain feel like?

☐Spasm ☐Numbing ☐Burning ☐Tingling ☐Throbbing ☐Aching ☐Other:_____

What makes pain feel "better?"

☐Nothing ☐Rest ☐Walking ☐Stretching ☐Exercise ☐Other:_____

What makes pain fell "worse?"

☐Bending ☐Twisting, ☐Lifting ☐Sitting ☐Standing ☐Coughing ☐Temp. Changes

Does Pain Radiate (Move) to another part of the body? ☐Yes ☐ No

This pain: ☐is a new pain ☐I've had before, but went away ☐already had but now it is worse

TAYLOR-MADE HEALTH AND WELLNESS

Family Care ♦ Auto Accident Rehabilitation Therapy ♦ Wellness Care
WWW.TAYLOREDWELLNESS.COM

425 Citrus Tower Blvd Suite 301 Clermont, Florida 34711 Office: (352) 989-5555 Fax: (352) 432-2121

When does pain(s) cause you difficulty while doing your normal daily routines?

(check of all that apply)

☐Bathing ☐Dressing ☐Grooming ☐Oral care ☐Toileting ☐Transferring ☐Walking ☐Climbing stairs ☐Eating ☐Shopping ☐Cooking ☐Managing medications ☐Using the phone ☐Housework ☐Doing Laundry ☐Driving managing finances

Past Medical History: (check of all that apply)

☐None ☐Abnormal spine curvature ☐Congenital spine abnormalities ☐Degenerative disc disease ☐Arthritis ☐Spine surgery ☐Diabetes ☐Other ☐Other

Occupational History:

Are you employed? ☐Yes ☐No what is you Occupation? _____

Family History: (check of all that apply)

☐None ☐Abnormal spine curvature ☐Congenital spine abnormalities ☐Degenerative disc disease ☐Arthritis ☐Spine surgery ☐Diabetes ☐Other ☐Other

Past Surgical History: (*Please indicate year)

☐None ☐Brain ☐Back ☐Elbow (L/R) ☐Shoulder (L/R) ☐Wrist (L/R) ☐Hip (L/R) ☐Knee (L/R) ☐Ankle (L/R)

Allergies: (check of all that apply)

☐Penicillin ☐Sulfa ☐Aspirin ☐Latex ☐Amoxicillin ☐Latex ☐Other:_____

Medications: (Please List)

1. _____ 2. _____ 3._____

Social History:

☐Married ☐Single ☐Widowed ☐Divorced

Are you seeing any other doctors treating you for this condition?

☐Yes ☐No

Have you ever received chiropractic care?

☐Yes ☐No

TAYLOR-MADE HEALTH AND WELLNESS

Family Care ♦ Auto Accident Rehabilitation Therapy ♦ Wellness Care
WWW.TAYLOREDWELLNESS.COM

425 Citrus Tower Blvd Suite 301 Clermont, Florida 34711 Office: (352) 989-5555 Fax: (352) 432-2121

Review of systems: (check of all that apply)

☐Unexpected Weight Gain or Loss ☐Fatigue ☐Fever chills ☐Rashes ☐Headaches ☐Head Injury ☐Neck Pains ☐Ringing in Ears ☐Vision Loss/changes ☐Pain ☐Flashing Lights ☐Discharge ☐Bleeding ☐Thrush ☐Lumps ☐Pain ☐Stiffness ☐Coughing up blood ☐Shortness of breath ☐Painful breathing ☐Chest pain or discomfort ☐Tightness ☐Palpations ☐Shortness of breath with activity ☐Sudden awakening from sleep with shortness of breath ☐Swallowing difficulties ☐Change in appetite ☐Constipation ☐Diarrhea ☐Frequency ☐Burning or pain ☐Blood in urine ☐Muscle or joint pain ☐Stiffness ☐Back pain ☐Redness of joints ☐Swelling of joints ☐Dizziness ☐Numbness ☐Tingling ☐Tremor ☐Nervousness ☐Depression memory loss

OFFICE USE:

PAIN:
Occ-C1-C2- C3-C4-C5-C6-C7-T1-T2-T3-T4-T5-T6-T7-T8-T9-T10-T11-T12-L1-L2-L3-L4-L5-Sac.-Pelv.
Extremity: ☐ **Shoulder** L/R/B ☐ **Elbow**: L/R/B ☐ **Wrist**: L/R/B ☐ **Hand**: L/R/B ☐ **Hip**: L/R/B ☐ **Knee**: L/R/B ☐ **Ankle**: L/R/B ☐ **Foot**: L/R/B

SPASM:
Occ-C1-C2- C3-C4-C5-C6-C7-T1-T2-T3-T4-T5-T6-T7-T8-T9-T10-T11-T12-L1-L2-L3-L4-L5-Sac.-Pelv.
Extremity: ☐ **Shoulder** L/R/B ☐ **Elbow**: L/R/B ☐ **Wrist**: L/R/B ☐ **Hand**: L/R/B ☐ **Hip**: L/R/B ☐ **Knee**: L/R/B ☐ **Ankle**: L/R/B ☐ **Foot**: L/R/B

ROM:
Cervical (Inc./ Norm./Dec.) **Thoracic (Inc./ Norm./Dec.)** **Lumbar(Inc./ Norm./Dec.)**

ORTHOPEDIC EXAM:

Cervical:	**Lumbar:**
Cervical Distraction :(+/-)(L/R/B)	**Kemp's :**(+/-)(L/R/B)
Shoulder Depression :(+/-)(L/R/B)	**Straight Leg Raise :**(+/-)(L/R/B)
Max. Cervical Compression :(+/-)(L/R/B)	**Braggard's Test :**(+/-)(L/R/B)
Valsalva's :(+/-)(L/R/B)	**Milgrams :**(+/-)(L/R/B)

Grip Strength: Left(__/200lbs), Right(__/200lbs), N/A

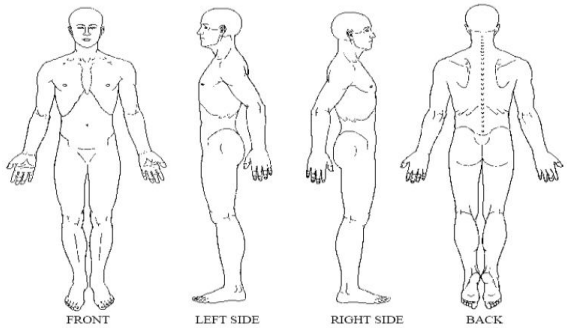
MOTOR
(LEFT) C5__/5 C6__/5 C7__/5 C8__/5 L4__/5 L5__/5 S1__/5 (RIGHT) C5__/5 C6__/5 C7__/5 C8__/5 L4__/5 L5__/5 S1__/5

REFLEX
(Left) C5__/5 C6__/5 C7__/5 L5__/5 S1__/5 (RIGHT) C5__/5 C6__/5 C7__/5 L5__/5 S1__/5

DIAGNOSTIC: ☐ XRAY: 1.____ 2.____ 3.____ ☐MRI: 1.____ 2.____ 3.____

REFERRALS: ☐ ORTHO ☐ NEURO ☐ PAIN MANAGEMENT

PROGNOSIS ☐ Poor ☐ Fair ☐Guarded ☐ Good ☐Excellent



INITIAL THERAPIES:
☐ E-STIM ☐TRACTION ☐UTRASOUND ☐COLD/HOT ☐BIOFREEZ
☐ COLD LASER ☐ STRETCHING ☐KINETIC ☐MANUAL ☐ SPINA

☐RECORDS REQUEST _____ ☐M.D._____

TAYLOR-MADE HEALTH AND WELLNESS

Family Care ♦ Auto Accident Rehabilitation Therapy ♦ Wellness Care
WWW.TAYLOREDWELLNESS.COM

425 Citrus Tower Blvd Suite 301 Clermont, Florida 34711 Office: (352) 989-5555 Fax: (352) 432-2121

Patient Name:_____ Date:_____

- ☐ R51 Headache
- ☐ M53.1 Cervicobrachial syndrome
- ☐ M54.12 Radiculopathy, cervical region
- ☐ M54.16 Radiculopathy, lumbar region
- ☐ S13.4XXA Sprain of ligaments of cervical spine, **initial encounter**
- ☐ S23.3XXA Sprain of ligaments of thoracic spine, **initial encounter**
- ☐ S33.5XXA Sprain of ligaments of lumbar spine, **initial encounter**
- ☐ S16.1XXA Strain of muscle, fascia and tendon at neck level, **initial encounter**
- ☐ S39.012A Strain of muscle, fascia and tendon of low back, **initial encounter**
- ☐ S43.421A Sprain of right rotator cuff capsule**, initial encounter**
- ☐ S46.011A Strain of muscles and tendon of rotator cuff of right shoulder, **initial encounter**
- ☐ S43.422A Sprain of left rotator cuff, **initial encounter**
- ☐ S46.012A Strain of muscles and tendon of rotator cuff of left shoulder, **initial encounter**
- ☐ M99.01 Segmental and somatic dysfunction of cervical region
- ☐ M99.02 Segmental and somatic dysfunction of thoracic region
- ☐ M99.03 Segmental and somatic dysfunction of lumbar region
- ☐ M99.05 Segmental and somatic dysfunction of pelvic region
- ☐ M54.2 Cervicalgia
- ☐ M54.6 Pain in Thoracic spine
- ☐ M54.5 Low back pain
- ☐ M62.830 Muscle spasm