

TAYLOR-MADE HEALTH AND WELLNESS

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

425 Citrus Tower Blvd Suite 103 Clermont, Florida 34711 Office: (352) 989-5555 Fax: (352) 432-2121

PATIENT REGISTRATION

NAME: [REDACTED] D.O.B. [REDACTED] AGE: [REDACTED]
ADDRESS: [REDACTED] CITY: [REDACTED] STATE: [REDACTED] ZIP: [REDACTED]
SEX: [REDACTED] SOCIAL SECURITY#: [REDACTED] EMAIL: [REDACTED]
CELL PHONE: [REDACTED]

***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: [REDACTED]

IF REFERRED, WHO REFERRED YOU TO OUR OFFICE? [REDACTED]

FINANCIAL RESPONSIBILITY

TYPE OF INSURANCE: ☐ HEALTH INSURANCE ☐ CASH PATIENT

INSURANCE COMPANY'S NAME: [REDACTED] MEMBER ID#: [REDACTED]

DED: [REDACTED] MED PAY: [REDACTED] COVERED: [REDACTED] %

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 [REDACTED]

DATE: [REDACTED]

TAYLOR-MADE HEALTH AND WELLNESS

Family Care ♦ Auto Accident Rehabilitation Therapy ♦ Wellness Care

WWW.TAYLOREDWELLNESS.COM

425 Citrus Tower Blvd Suite 103 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 103 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 my 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 103 Clermont, Florida 34711 Office: (352) 989-5555 Fax: (352) 432-2121

1. WHERE IS AREA OF CONCERN: (/10)

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 feel "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: (/10)

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 feel "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: (/10)

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 feel "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 103 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 your 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 103 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 ☐ Palpitations ☐ 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:

Cervical Distraction :(+/-)(L/R/B)

Shoulder Depression :(+/-)(L/R/B)

Max. Cervical Compression :(+/-)(L/R/B)

Valsalva's :(+/-)(L/R/B)

Lumbar:

Kemp's :(+/-)(L/R/B)

Straight Leg Raise :(+/-)(L/R/B)

Braggard's Test :(+/-)(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

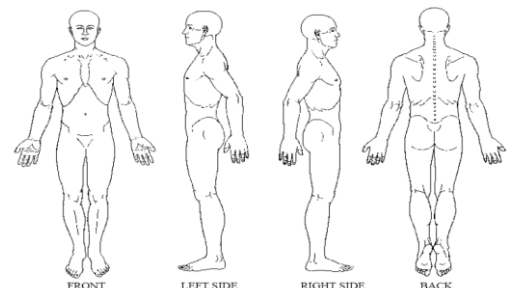
PROGNOSIS ☐ Poor ☐ Fair ☐ Guarded ☐ Good

INITIAL THERAPIES:

☐ E-STIM ☐ TRACTION ☐ ULTRASOUND ☐ COLD/HOT ☐ BIOFREEZE

☐ COLD LASER ☐ STRETCHING ☐ KINETIC ☐ MANUAL

☐ SPINAL DECOMPRESSION ☐ SHOCKWAVE THERAPY



☐ 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 103 Clermont, Florida 34711 Office: (352) 989-5555 Fax: (352) 432-2121

Patient Name:

Date:

DIAGNOSIS PAGE

MVA	HEAD	CERVICAL	THORACIC	LUMBAR
DRIV. V49.88	R51	M54.2 W/ RAD.	M54.6 W/ RAD.	M54.5 W/ RAD.
PASS. V49.59		M54.12	M54.14	M54.16
SHOULDER	ELBOW	HAND	BICEP	FOREARM
LT. M25.512	LT. M25.522	LT. M79.642	LT. M79.602	LT. M79.632
RT. M25.511	RT. M25.521	RT. M79.641	RT. M79.621	RT. M79.631
RIB	HIP	THIGH	KNEE	LEG
R07.82	LT. M25.552 RT. M25.551	LT. M79.652 RT. M79.651	LT. M25.562 RT. M25.561	LT. M79.605 RT. M79.604
ANKLE	FOOT			
LT. M25.572 RT. M25.571	LT. M79.672 RT. M79.671			