DATE:_____ MARITAL STATUS: S M W SEP D
Male:_____Female:_____

PATIENT NAME:_____ Social Security #_____

STREET ADDRESS:_____

CITY:_____STATE:_____ZIP_____

HOME PHONE #:_____ CELL PHONE#:_____

DATE OF BIRTH: _____ EMAIL ADDRES_____

REFERRED BY: _____ CHIEF COMPLAINT: _____

SPOUSE NAME:_____

SPOUSE EMPLOYER:_____SPOUSE CELL#:_____

If patient is a minor, under 18 years of age:

PARENT/GUARDIAN NAME:_____

EMERGENCY CONTACT (Other than spouse)
NAME:_____PHONE:_____ RELATION TO PATIENT:_____

PRIMARY CARE PHYSICAN/REFERRING DOCTOR:_____

PATIENT EMPLOYER INFORMATION:

EMPLOYER NAME_____TEL:_____

EMPLOYER ADDRESS:_____CITY/STATE_____

PATIENT OCCUPATION:_____

Current Activity Level

□ Fully active; normal
□ Have difficulty with strenuous activity; can do light activities (housework, office work)
□ Unable to work; can care for self; out of bed or chair more than 50%
□ Can only do limited self care; stay in bed or chair more than 50% of waking hours
□ Cannot do self care; confined to bed or chair

Please rate your fatigue/energy level: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
(0 = not tired, full of energy) (10 = total exhaustion)

How many hours do you sleep at night?_____ Do you nap during the day? q Yes q No

Is your appetite _____ good _____ fair _____ poor

Current weight: _____ Weight 6 months ago: _____ Normal weight: _____

1. If you currently have pain, where is it?
2. If you currently have pain, please rate your pain: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

(0 = no pain)` (10 = worst possible pain)

3. What are you currently doing to relieve your pain?

Past Medical History

Please review the following list. If you have any of these conditions check □ Yes or No and the approximate year of diagnosis. If you have other conditions not listed, please write them down in the space provided.

Condition / disease	Yes	No	Year	Condition / disease	Yes	No	Year
Alcoholism / Cirrhosis				Gallbladder disease / stones			
Anemia				Glaucoma			
Arthritis				Crohn's disease / colitis			
Asthma / Emphysema				Heart disease			
Bleeding/Blood Disorders/Clots				Hepatitis / Jaundice / Liver			
Cancer (past)				Heart attack (MI)			
Lymphoma				Tuberculosis			
Cataracts				Ulcers / stomach pain			
Diabetes (high blood sugar)				Other: Significant illness for			
HIV positive / AIDS				which you have			
Lung disease				taken medicine			
Prostate disease				and/or seen a			
Seizures / epilepsy				physician.			
Stroke(s)							
Thyroid disease							

(Please list all hospitalizations, and surgeries with the approximate date)

Hospitalizations and/or surgeries	Date	Hospitalizations and/or surgeries	Date
1.		4.	
2.		5.	
3.		6.	

Allergies (List all medication / health products with which you have had a bad reaction and what type of reaction occurred). _____

_____

Medications (List all medication names including non-prescription medications, vitamins, herbs, or supplements.) Please include the dosage, and how many you take daily (example: Lasix 20 mg 1 tablet daily)

1.	5.
2.	6.
3.	7.
4.	8.

Social History

1. Marital status (circle one) Married/ Single/ Separated/ Divorced/ Widowed
2. Do you live alone? (circle one)Yes No
3. What is your occupation?_____ Are you retired? (circle one) Yes No
4. Do you use tobacco products? (circle one) Yes No How many years?_____
5. Have you stopped? (circle one) Yes No When?_____
6. What did/do you use? (circle one) Cigarettes (# of packs / day) _____ Cigars Pipe Chewing tobacco
7. Do you use drugs or alcohol? (circle one) Yes No
8. If you drink alcohol products, what do you drink and how many per day? _____
9. If you use recreational (street) drugs, what do you use and how often? _____

10. Have you ever been exposed to radiation or asbestos? (circle one) Yes No

11. Have you ever received treatment for emotional or mental problems? (circle one) Yes No What type of treatment did you receive?_____

Family History

Do you have anyone in your immediate family who has been diagnosed with Heart disease, Diabetes, Arthritis, Kidney disease, Blood disorder, Blood clots, etc.? Yes No Please list below the family member affected and what their condition was? _____

_____

Review of Systems

Review the following and Check √ C for current problem or P for past problem in space provided. Leave the spaces blank if you have never had any of the following.

Problem	C	P	Problem	C	P
Pain - Where?_____			Muscle pain or weakness		
Fatigue / weakness			Numbness or tingling		
Fevers / chills / night sweats			Difficulty walking		
Lump(s) or swelling			Decreased appetite		
Rashes / Moles			Abdominal pain / Swelling		
Bruising easily			Black or bloody stools		
Bleeding or Blood clotting			Bloating		
Sleeping disturbance / insomnia / too much sleep			Bladder pain or pain with urination		
Weight loss or gain (how much?) _____			Diarrhea		
Changes in Breast / Breast Lumps			Constipation		
Headaches			Increased gas		
Vision changes			Nausea and/or vomiting		
Seizures / epilepsy			Bleeding with urination		
Memory loss			Needing to urinate frequently		
Dental problems / Hoarseness			Lump(s) in testicles		
Mouth sores			Loss of sexual potency		
Sinus trouble			Hot flashes		
Chest pain / Pressure			Vaginal discharge/Odor/Bleeding		
Ankle swelling			Pain with intercourse		
Rapid heartbeat			Feel Depressed		
Cough			Loss of interest in usual activities		
Cough up blood			Recent infections or allergies		
Difficulty swallowing			Other:		
Difficulty breathing					

INSURANCE AND BILLING INFORMATION:

1) PRIMARY Insurance Company:_____

Policy#: _____ Group#_____ Insured:_____

2) SECONDARY Insurance Company: _____

Policy#: _____ Group #: _____ Insured: _____

WORKER COMPENSATION CLAIMS

Is your visit here today due to an injury at work?_____ If so please provide the following:
Place of Employment/Injury:_____
When Injury occurred?_____
Workers Comp Carrier responsible for bills today:_____
Attorney Name and Number:_____

AUTOMOBILE ACCIDENT CLAIMS

Is your visit due to an Automobile accident?_____ If so Please provide the following:
Date of Accident:_____Place of Accident(city/state):_____
Automobile Insurance:_____
Name Insurance Adjuster :_____
Case number_____
Attorney Name and number_____
Attorney Case number_____

LETTER OF PROTECTION MUST BE RECEIVED BY ATTORNEYS IN ORDER TO HAVE UNINTERRUPTED TREATMENT AT OUR FACILITY******

ASSIGNMENT OF INSURANCE BENEFITS/FINANCIAL AGREEMENT AND UNDERSTANDING

I hereby certify that I am receiving or are about to receive health care services at : RIVERBRIDGE CHIROPRACTIC CENTER, MICHAEL CORRY, D.C.,'s office. I understand and agree that services rendered to me are charged directly to me and that I am personally responsible for payment. I further agree to pay for services rendered on a current basis. I also acknowledge and agree that should these charges become past due or delinquent, that I will be responsible for and pay all costs of collection including but not limited to court costs, reasonable attorneys fees, interest and collection agency fees.

This authorization or photocopy hereof, will authorize the release of full and complete medical records when necessary to authorize physicians, hospitals, medical attendants, attorneys and/or insurance companies.

I hereby authorize direct payment of surgical/medical benefits to Dr. Corry for services rendered by him in person or under his supervision.

I certify that the information given by me in applying for payments is correct. I request that payment of authorized benefits be made on my behalf.

Patient Name_____
(Please Print)
If minor, Parent/Guardian Name:_____
(Please Print)

Patient Signature:_____Date:_____

Riverbridge Spine & Therapy Center
SUMMARY OF PRIVACY PRACTICES
(A Copy of the complete " Notice of Privacy Practices" is available upon request)

Revised Effective Date: 01/02/2020

In the course of providing healthcare services to you, we may use and disclose your protected health information to carry out treatment, to pursue **payment,** for **health care operations at our facilities** and for other purposes that **are permitted or required by law**. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Some of the ways that we may use your information could include the following:

Appointment Reminders
To Discuss Treatment Alternatives
As Required by Law
Fundraising Activities
Health-Related Benefits and Services
Individuals Involved in a Patient's Care or Payment for a Patient's Care
Research
Hospital Directory
To Avert a Serious Threat to Health or Safety

In the following special situations we may also be required to use or disclose your health information:

Organ and Tissue Donation
Military and Veterans
Health Oversight Activities
Law Enforcement
National Security and Intelligence Activities
Workers' Compensation
Public Health Risks
Lawsuits and Disputes
Coroners, Medical Examiners and Funeral Directors
Inmates

Other uses and disclosures of medical information not covered by our Notice of Privacy Practices or the laws that apply to us will be made only with a patient's written permission.

Patient Rights

Patients have the following rights regarding medical information maintained by River Bridge Spine & Therapy Center

Right to Request Restrictions on who has access to information
Right to Receive Confidential Communication
Right to Inspect and Copy
Right to Amend
Right to an Accounting of Disclosures
Right to a Paper Copy of River Bridge Spine & Therapy Center's Notice of Privacy Practices
Right to File a Complaint

Patients will not be penalized for filing a complaint. River Bridge Spine & Therapy Center. is committed to protecting an individual's rights under the Health Insurance Portability and Accountability Act ("HIPAA") and at no point will require an individual to waive their right to file a complaint as a condition of the provision of treatment.

Important Contact Information

River Bridge Spine & Therapy Center
Michael Corry, D.C.
6858 Forest Hill Blvd
West Palm Beach, FL 33413
http://www.hhs.gov/ocr/

US Dept of Health and Human Services (HHS)
Office for Civil Rights (OCR)
Voice phone 404-562-7886
Fax 404-562-7881

By signing this form, I acknowledge that I have been made aware of River Bridge Spine & Therapy Center Notice of Privacy Practices and was offered a copy. I understand I am not required to sign this authorization.

_____ _____
Signature Date

_____
Witness

RIVERBRIDGE SPINE & THERAPY CENTER

MICHAEL E.CORRY, D.C.

6858 Forest Hill Blvd., West Palm Beach, FL 33413

Phone: (561)968-0922 Fax: (561)968-4863

riverbridgechiro@live.com

Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may effect the restoration and preservation of health. Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

I understand that, as with any health procedure, there are certain conditions that may arise during a chiropractic adjustment. Those complications include but are not limited to: fractures, dislocations, muscle strain, costovertebral strains and separations. Some types of manipulations of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications. This is a very rare occurrence (a one in three million chance).

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

_____	_____	_____
Print Name	Signature	Date

Pregnancy Release:

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: _____

_____	_____
Signature	Date

Patient Name _____ Date ____/____/____

How long have you had your symptoms? _____days _____ weeks _____ months _____years
On the diagram below, please indicate where, and what type of symptoms that you are experiencing, right now. Write the appropriate abbreviations (see the key below) over the area of the body where those symptoms are occurring.

A = ACHE

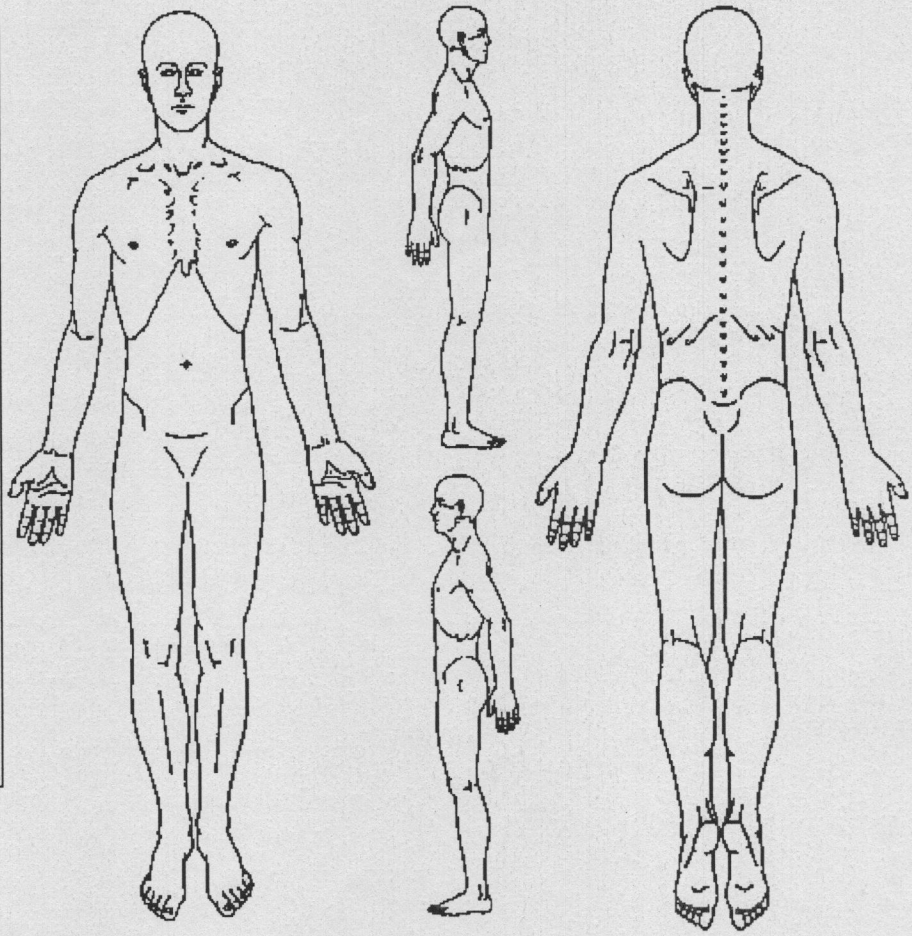
B = BURNING

N = NUMBNESS

P = PINS & NEEDLES

S = STABBING

O = OTHER _____



Instructions: Please fill in the bubble that corresponds to the pain level that you are experiencing.
Note: If you have more than one complaint, please indicate your pain levels for each complaint. Please indicate your pain level for
[1] your pain at its worst, [2] your pain right now and [3] your average pain level.

[1] My pain when it is at its worst is:
No Pain ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ **Worst Possible**

[2] My pain right now is:

No Pain ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ **Worst Possible**

[3] My average pain level is:

No Pain ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ **Worst Possible**

Patient Signature _____ Date _____

If patient a minor, Parent/Guardian Signature _____

RIVERBRIDGE SPINE & THERAPY CENTER
MICHAEL E.CORRY, D.C.
6858 Forest Hill Blvd., West Palm Beach, FL 33413
Phone: (561)968-0922 Fax: (561)968-4863
riverbridgechiro@live.com

NOTICE TO PATIENTS

SERVICES NOT COVERED BY MEDICARE PART B OR OTHER INSURANCE CARRIERS ARE THE RESPONSIBILITY OF THE PATIENT.

NON-COVERED SERVICES INCLUDE INTERFERENTIAL THERAPY, ULTRASOUND, LASER/LIGHT THERAPY, MANAUL/TRIGGER POINT THERAPY, MASSAGE, SPINAL DECOMPRESSION AND ACUPUNCTURE.

PAYMENT FOR NON-COVERED SERVICES IS THE PATIENT'S RESPONSIBILITY, AND DUE AT THE TIME SAID SERVICES ARE RENDERED. THIS MEANS, YOU MUST PAY FOR THE THERAPIES.

CURRENTLY, A FEE OF $20 PER THERAPY, $45 FOR SPINAL DECOMPRESSION, $60-120 FOR MASSAGES AND $80 FOR ACUPUNCTURE IS CHARGED BY THIS OFFICE. (PLEASE NOTE THESE PRICES ARE ONLY FOR SERVICES RENDERED IN CONJUNCTION WITH YOUR SPINAL MANIPULATION).

Please Note: We request 24 hour notice to cancel appointments to avoid our $25 cancellation fee.

_____
PATIENT'S NAME (PLEASE PRINT)

_____ _____
PATIENT'S SIGNATURE TODAY'S DATE