

THE CHIROPRACTIC & ACUPUNCTURE CENTER OF SARASOTA

NEW PATIENT PROFILE

Date: _____ Name: _____

Date of Birth: _____ Age: _____ Soc.Sec. No. ____/____/____ Marital Status _____

Spouse's Name: _____ No. of Children: _____

Address: _____ City: _____ State: ____ Zip: _____

Phone: Home: (____)____-____ Cell: (____)____-____ Work: (____)____-____

Emergency Contact: _____ Phone: _____ Relationship: _____

* E-MAIL: _____@_____

* Your email will NOT be shared with any 3rd parties, and is used for occasional office announcements and promotions.

Employer: _____ Occupation: _____

Address: _____ City: _____ State: ____ Zip: _____

Nature of Injury: Auto ____ Work ____ Other ____ Please describe below: _____

Date of injury _____ Date symptoms appeared _____

Have you ever had same condition? Yes ____ No ____ If yes, when? _____

List of physicians also seen for this injury/condition? _____

Have you ever been under chiropractic care: Yes ____ No ____ If yes, please describe _____

Method of Payment: Cash/Check: _____ Health Insurance: _____

Workers Comp: _____ Auto Accident: _____

Medicare: _____ Medicaid: _____ Other: _____

Name of party responsible for payment _____ Phone: _____

Insurance Company: _____ Subscriber: _____ D.O.B. _____

Insurance I.D/Policy #: _____ Grp: _____

Please Present Copy of Insurance Card

Name of the insured: _____

I understand and agree that health/accident insurance policies are an arrangement between and insurance carrier and myself. I understand and agree that all services rendered to me and charge are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees fro professional services rendered to me will be immediately due and payable.

Patient's Signature: _____ Date _____

Spouse's or Guardian's Signature: _____ Date _____

4010 Sawyer Road • SARASOTA, FL 34233
941-924-9892 (phone) • 941-924-7283 (fax)

Medical History

Have you been treated for any conditions in the last year? No Yes

If yes, please describe

Date of last physical exam Is there a chance that you are pregnant? No Yes

Have you had X-rays taken? No Yes If Yes, where?

What medications are you taking and for what conditions (Please list dosage and amounts, etc.)

What vitamins, minerals, or herbs do you currently take? (Please list for what conditions, dosage, and frequency).

Have you ever:	No	Yes	Briefly Explain
Broken bones?	<input type="radio"/>	<input type="radio"/>	<input type="text"/>
Been hospitalized?	<input type="radio"/>	<input type="radio"/>	<input type="text"/>
Been in an auto accident?	<input type="radio"/>	<input type="radio"/>	<input type="text"/>
Had Sprains/Strains?	<input type="radio"/>	<input type="radio"/>	<input type="text"/>
Been struck unconscious?	<input type="radio"/>	<input type="radio"/>	<input type="text"/>
Had surgery?	<input type="radio"/>	<input type="radio"/>	<input type="text"/>

Family History

Family Members - Present and past health conditions (Example: heart disease, cancer, diabetes, arthritis, etc.)

Do you experience pain every day?	<input type="radio"/> No	<input type="radio"/> Yes
Do your symptoms interfere with daily life?	<input type="radio"/> No	<input type="radio"/> Yes
Does pain wake you up at night?	<input type="radio"/> No	<input type="radio"/> Yes
Are your symptoms worse during certain times of the day?	<input type="radio"/> No	<input type="radio"/> Yes
Do changes in weather affect your symptoms?	<input type="radio"/> No	<input type="radio"/> Yes
Do you wear orthotics?	<input type="radio"/> No	<input type="radio"/> Yes
Do you take vitamin supplements?	<input type="radio"/> No	<input type="radio"/> Yes
What activities aggravate your symptoms?	<input type="radio"/> No	<input type="radio"/> Yes

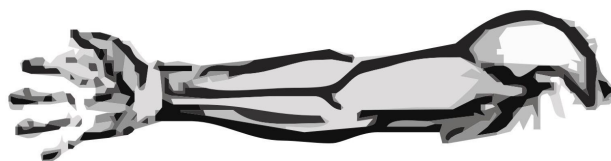
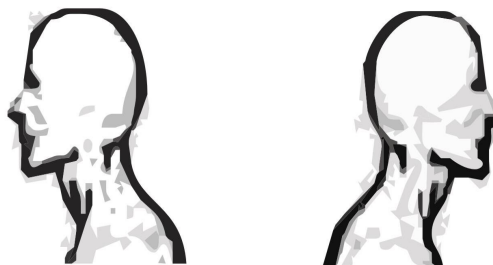
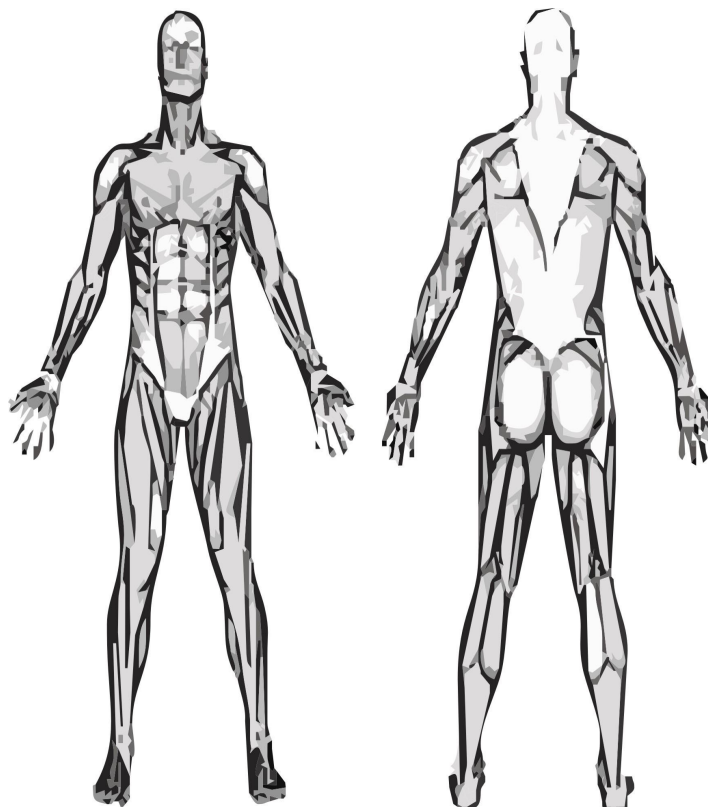
Habits	None	Light	Moderate	Heavy
Alcohol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Coffee	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Tobacco	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Drugs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Exercise	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Appetite	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Soft Drinks	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Water	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Salty Foods	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sugary Foods	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Artificial Sweeteners	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Have you ever suffered from:

- Alcoholism
- Allergies
- Anemia
- Arteriosclerosis
- Arthritis
- Asthma
- Back Pain
- Breast Lump
- Bronchitis
- Bruise Easily
- Cancer
- Chest Pain/Conditions
- Cold Extremities
- Constipation
- Cramps
- Depression
- Diabetes
- Digestion Problems
- Dizziness
- Ears Ring
- Excessive Menstruation
- Eye Pain or Difficulties
- Fatigue
- Frequent Urination
- Headache
- Hemorrhoids
- High Blood Pressure
- Hot Flashes
- Irregular Heart Beat
- Irregular Cycle
- Kidney Infection
- Kidney Stones
- Loss of memory
- Loss of balance
- Loss of smell
- Loss of taste
- Lumps In Breast
- Neck Pain or Stiffness
- Nervousness
- Nosebleeds
- Pacemaker
- Polio
- Poor Posture
- Prostate Trouble
- Sciatica
- Shortness of breath
- Sinus Infection
- Sleep problems or Insomnia
- Spinal Curvatures
- Stroke
- Swelling of ankles
- Swollen Joints
- Thyroid Condition
- Tuberculosis
- Ulcers
- Varicose Veins
- Venereal Disease
- Other:

Please use the following letters to indicate TYPE and LOCATION of the symptoms you currently are experiencing.

- A**=Ache **O**=Other
- B**=Burning **P**=Pins & Needles
- N**=Numbness **S**=Stabbing





Abraham Kozma, D.C., P.A.

AUTHORIZATION FOR TREATMENT AND CONSENT FOR CARE

I hereby voluntarily consent to chiropractic care and/or diagnostic treatment by The Chiropractic & Acupuncture Center of Sarasota, its physicians and employees as explained to me by the attending physician and whomever he/she may designate as their assistant. I am aware that the practice of chiropractic, acupuncture and/or medicine is not an exact science and that any procedure has an inherent risk. I acknowledge that no guarantees can be made to me as a result of any treatment or examination in this office.

I understand and agree that I am personally responsible for payment of all services rendered. Health and accident policies are an arrangement between an insurance carrier and myself, however, The Chiropractic and Acupuncture Center of Sarasota may accept certain insurance assignments of benefits. The acceptance of insurance assignment is individually determined and prior authorization is required. I understand that upon termination of care, any outstanding charges for professional services rendered will be immediately due and payable. Fees incurred for any account turned over to a third party for the purpose of collections on your account is the patient's financial responsibility.

Patient Signature: _____ Date: _____

Relationship, if Guardian: _____

ALL FEMALE PATIENTS PLEASE COMPLETE THIS SECTION

In order to protect you, the patient, we need to be assured that if the Doctor orders x-rays, there is no possibility of you being pregnant.

I hereby release The Chiropractic & Acupuncture Center of Sarasota and the staff from any responsibility for injury or complications to my fetus or myself should I be pregnant on this date.

_____ There is a possibility of my being pregnant.

_____ There is NO possibility of my being pregnant.

Signature of Patient _____ Date: _____

Relationship, if guardian: _____

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PATIENT CONSENT TO RECEIVE MAIL AND /OR TELEPHONE MESSAGES

PATIENT NAME: _____

DO WE HAVE YOUR PERMISSION TO:

Send a appointment reminder to your home? Yes No

Send test results to your home? Yes No

Leave the following information on your home answering machine/voice mail:

Appointment Information: Yes No

Billing Information: Yes No

Medical Information: Yes No

I give permission to share appointment information with the person(s) named below:

Name: _____

Name: _____

I give permission to share medical information with the person(s) named below:

Name: _____

Name: _____

I give permission to share billing information with the person(s) named below:

Name: _____

Name: _____

Signature of Patient _____

Date: _____



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PLEASE COMPLETE THE FOLLOWING INFORMATION FOR OUR RECORDS

Name: _____

Employer: _____

Do you smoke cigarettes, cigars, pipe or chew tobacco? Y N How much per day? _____

Do you drink alcoholic beverages? Y N How many per week? _____

Do you exercise daily? Y N What areas of your body? _____

Name of your medical doctor? _____

Have you been treated for any health condition other than this accident in the past year?
If yes, please explain _____

List any operation you have had for any reason: _____

Have you been treated by a chiropractor for any reason prior to this accident? _____

Have you had any previous automobile accidents? Y N If yes, when and were any
injuries sustained, who treated you and for how long? _____

Have you been diagnosed with any of the following: (Please circle any appropriate answer)

Alcoholism Anemia Arthritis Cancer Depression Diabetes Eczema

Epilepsy Hear Disease Mental disorder Sexually Transmitted disease

Patient's Signature _____ Date: _____

AUTOMOBILE ACCIDENT HISTORY FORM
PLEASE FILL OUT ALL QUESTIONS TO THE BEST OF YOUR ABILITY
PLEASE PRINT ALL ANSWERS and SIGN EACH FORM AT THE BOTTOM

Your Name: _____ Today's Date: _____

Date of Accident: _____ Time of Accident: _____ AM/PM

City of Accident: _____ Street of Accident: _____

Please describe to the best of your knowledge, what happened during this accident: _____

Did the police come to the accident scene? Y N Is there a report on file? Y N

Did you go to the hospital Y N If yes, which hospital? _____

How did you get there? _____ Were x-rays or scans done Y N If yes, which areas of the body? _____

What did the hospital do for your injuries? _____

How long did you stay in the hospital? _____

What bleeding cuts did you sustain during the accident? _____

What bruises did you sustain during the accident? _____

Did you receive any injury or bruises from the seat belt? Y N If yes, please describe: _____

On what part of the vehicle did your following body parts hit?

- | | |
|-----------------------------------|-----------------------------|
| a. head hit _____ | b. chest hit _____ |
| c. right/ left shoulder hit _____ | d. right/left arm hit _____ |
| e. right/left hip hit _____ | f. right/left leg hit _____ |
| g. right/left knee hit _____ | h. other _____ |

Were you aware of the approaching collision prior to impact, or did impact catch you by surprise?
AWARE SURPRISED

Did you lose consciousness (black out) upon impact? Y N; How long? _____

Did you experience a flash of light or explosion in your head? Y N

Patient's Signature _____ Date: _____

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Dr. Abraham I. Kozma
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Check the symptoms you have noticed since the accident:

- | | | | |
|---------------------------|------------------|------------------------------|--------------------------|
| Headache | neck pain | neck stiffness | sleeping problems |
| Shoulder pain | arm pain | mid back pain | low back pain |
| Nervousness | tension | irritability | chest pain |
| Dizziness | arms tingle | legs tingle | hands numb |
| Feet numb | shortness/breath | fatigue | depression |
| Ears ringing | fainting | anxiety | panic attacks |
| Jaw pain | memory loss | loss of taste | loss of smell |
| Diarrhea | face flushed | cold hands | cold feet |
| Fever | stomach upset | cold seats | flu-like symptoms |
| Constipation | loss of balance | pain after meals | leg pain |
| Nausea | restlessness | forgetful | difficulty concentrating |
| Reduced tolerance to heat | | reduced tolerance to alcohol | |
| Lightheaded | blurred vision | confusion | disoriented |

Other (describe) _____

Just prior to the accident in question, did you have nay of the above symptoms? If so, please write here which symptoms you had: _____

Please describe how you felt:

- A. During the accident _____
- B. Immediately after the accident: _____
- C. The following day: _____

Since the accident have your symptoms become: a. better b. worse c. same

Do you notice any restrictions in your activity as a result of this injury? _____

Patient's Signature: _____ Date: _____

Have you retained an attorney? Y N If yes, who: _____

Have you contacted your Insurance Company? Y N

Were there any witnesses? Y N (names) _____

Have you been treated by another doctor since the accident? Y N, If yes, who? _____

What type of treatment did you receive? A. chiropractic b. medical c. massage d. physical therapy
e. psychological counseling f. exercise g. other _____

Have you ever been in an automobile accident before? Y N If yes, please describe, including any injuries received: _____

Have you lost time from work due to this injury? Y N If yes, please complete the type of employment ____
_____ last day worked _____

Are you being compensated for the time lost from work? Y N If yes, what type of compensation?

AUTO: Number of people in your automobile: _____

What direction were you headed N S E W on (name of street) _____

Were you struck from: a. behind b. front c. left side d. right side OR did you strike the other
vehicle with you're: a. front end b. rear end

Give the year, make, and model of the vehicle **you** were in: Year _____ Make _____ Model _____

What is the estimated cost of damage to the vehicle you were in? \$ _____

What was the year, make, and model of the **other** vehicle? Year _____ Make _____ Model _____

Road conditions at the time of the accident: WET DRY ICY OTHER _____

Was your car stopped at the time of the impact? YES NO

Patient's Signature: _____ Date: _____

