

Michael A. Haley, D.C.  
500 S. Cypress Road #4  
Pompano Beach, Florida 33060  
(954) 969-8800



## ENTRANCE FORM

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Referred by: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone #: \_\_\_\_\_ Cell / Work #: \_\_\_\_\_ Occupation: \_\_\_\_\_

e-mail address: \_\_\_\_\_ Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: *M F* Marital Status: *M S W D Sep* No. of Children: \_\_\_\_\_

### **PAST HISTORY** When answering the following questions, please give applicable dates and details.

Have you had any surgeries? *yes no* \_\_\_\_\_

Have you ever been hospitalized? *yes no* \_\_\_\_\_

Have you had any illnesses? *yes no* \_\_\_\_\_

Have you had any traumas or injuries in the past? *yes no* \_\_\_\_\_

Have you been in automobile accidents? *yes no when?* \_\_\_\_\_

Describe your diet (food and vitamin/supplement intake): \_\_\_\_\_

Do you drink alcohol? *yes no* Number of drinks per week: \_\_\_\_\_ Smoke Cigarettes? *yes no* Packs per week: \_\_\_\_\_

Do you use any medications or drugs? *yes no* \_\_\_\_\_

Hours of sleep per night: \_\_\_\_\_ Quality of sleep: *excellent good ok poor terrible*

Sports, exercises, and common physical activities: \_\_\_\_\_

\_\_\_\_\_ Hours per week? \_\_\_\_\_

What is your Chief Complaint? \_\_\_\_\_

What caused it? \_\_\_\_\_ When did it begin? \_\_\_\_\_

Have you had this problem before? \_\_\_\_\_

Other Physicians: \_\_\_\_\_ Known Abnormalities: \_\_\_\_\_

### **FAMILY HISTORY**

Have your parents, brothers and sisters, or grand parents had any significant illnesses? *yes no*

If yes, please describe: \_\_\_\_\_

My signature below implies consent for treatment. (If under the age of 18, a parent or guardian's signature is required.) I understand that chiropractic may cause severe injury or death. This authorization or photocopy hereof will authorize this office to release any information pertinent to my condition or case to any insurance company, adjustor, or any attorney involved in this case and hereby releases this office of any consequence thereof.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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## **ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

\_\_\_\_\_  
**Patient Name (please print)**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Parent, Guardian or Patient's legal representative**

\_\_\_\_\_  
**Signature**

**THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.**



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I am committed to providing the best joint care possible with your current physicians. This requires open communication between this office and your physicians. I would like to keep your family physicians up to date with your progress. Please provide contact information and sign the records release below that gives me your authorization to do so.

Patient Name: \_\_\_\_\_

### **YOUR PHYSICIANS:**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Office Address: \_\_\_\_\_ Suite: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Office Address: \_\_\_\_\_ Suite: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Office Address: \_\_\_\_\_ Suite: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

This office is authorized to submit copies of the patient's records to other physicians to the patient and the patient's responsible insurance company. A photocopy of this document shall be sufficient to authorize any person, corporation, insurance agent, insurance company, physician or entity whatsoever having the undersigned's medical records or insurance policy/contract to release true copies of same to the above-named medical provider. A photocopy of this document shall be considered the same as an original for the purposes herein stated.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## 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 but may be performed by handheld instruments. 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.

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.

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Print Name

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Signature

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Date

### Consent to evaluate and adjust a minor child:

I, \_\_\_\_\_ being the parent or legal guardian of \_\_\_\_\_ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

### 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: \_\_\_\_\_

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Signature

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Date