James M. Kolodziej D.C.
9371-3 Cypress Lake Dr.
Ft. Myers, Fl 33919

CONFIDENTIAL PATIENT INFORMATION

NAME_____MARITAL STATUS_____SPOUSE_____
ADDRESS_____DATE OF BIRTH_____AGE_____
CITY_____ZIP_____ HOME PHONE_____
SS#_____ EMAIL:_____WORK PHONE_____CELL_____
GENDER M F #OF CHILDREN_____REFERRED BY_____
OCCUPATION_____EMPLOYER_____
METHOD OF PAYMENT: CASH_____INSURANCE_____AUTO INSURANCE_____WORK COMP_____
EMERGENCY CONTACT: _____
PURPOSE OF THIS APPOINTMENT/PRESENT COMPLAINT_____

_____

THIS AREA FOR DR. USE_____

_____

_____

_____

_____

_____

_____

WHEN DID THIS CONDITION BEGIN? _____SPECIFIC INCIDENT? _____
PLEASE EXPLAIN_____

_____

GETTING WORSE? _____PLEASE LIST ANY DR.'S SEEN FOR THIS_____
THEIR DIAGNOSIS AND TREATMENT_____

_____

THIS CONDITION INTERFERES WITH: WORK_____SLEEP_____DAILY ACTIVITIES_____
OTHER?

_____

WHAT HAVE YOU DONE TO TREAT THIS CONDITION YOURSELF?_____

_____

PAST HEALTH HISTORY
HAVE YOU EVER BEEN IN AN AUTO ACCIDENT OR HAD OTHER SERIOUS INJURIES?_____
PLEASE EXPLAIN_____

_____

_____

_____

_____

SURGERIES?_____PLEASE LIST_____

_____

_____

_____

MEDICATION YOU ARE TAKING_____

_____

PREVIOUS CHIROPRACTIC CARE?_____WHO?_____
WHEN?_____X-RAYS TAKEN?_____WHEN?_____

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PLEASE CIRCLE ALL OF THE FOLLOWING SYMPTOMS WHICH YOU NOW HAVE OR HAVE PREVIOUSLY HAD.

GENERAL SYMPTOMS
Headache
Allergic
Migraine
Tension
Fainting
Dizziness
Convulsions
Loss of sleep
Obesity
Numbness or pain in:
Arms, Hands, Legs
Allergy
Wheezing

E.E.N.T.
Failing vision
Crossed eyes
Deafness
Earache
Ear noises
Ear discharge
Nose Bleeds
Hoarseness
Hay Fever
Asthma
Frequent colds
Enlarged Thyroid
Tonsillitis
Sinus Infections
Nasal Drainage
Enlarged glands

SKIN
Skin Eruptions
Psoriasis
Eczema
Itching
Bruising easily
Dryness
Hives or allergy

RESPIRATORY
Chronic cough
Spitting up phlegm
Spitting up blood
Chest Pain
Difficulty Breathing

CARDIOVASCULAR
Rapid heartbeat
Slow heart beat
Low blood pressure
High blood pressure
Hardening of arteries
Swelling of ankles
Poor circulation
Paralytic Stroke
Heart Attack

MUSCLE & JOINTS
Arthritis
Stiff Neck
Back ache
Swollen joints
Painful Joints
Foot trouble
Hernia
Spinal curvature
Muscle Spasms
Back Spasms
Sciatica

GENITOURINARY
Frequent Urination
Painful Urination
Blood in Urine
Pus in Urine
Kidney infection or stone
Inability to control urination
Prostate trouble

GASTROINTESTINAL
Poor appetite
Belching or gas
Nausea
Vomiting
Vomiting up Blood
Pain over stomach
Distention of abdomen
Diarrhea
Colon trouble
Hemorrhoids (piles)
Liver Trouble
Gall Bladder Trouble
Colitis

WOMEN ONLY
Painful Periods
Excessive flow
Hot Flashes
Irregular cycle
Cramps or backache
Previous miscarriage
Vaginal Discharge
Lumps in breast
Menopausal symptoms

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FAMILY HISTORY: Please list the names and ages of your immediate family members. Please list any major illness or disease from both the past and present that they may have had.

NAME	AGE	AGE DECEASED	HEALTH PROBLEMS
Mother			
Father			
Brother			
Sister			
Children			
Spouse			

PLEASE READ AND SIGN:
This office offers different types of care depending on your condition. At your report of findings, on your second visit, all of your examination and X ray findings will be reviewed with you, options will be explained and recommendations will be made.

Please check the type of care you desire:

_____Initial intensive care (Temporary Relief)
_____Treatment for the spinal subluxation complex (Spinal Rehabilitative Care)
_____I prefer the Doctor select the type of care he feels is best for me.
_____I wish to have the Doctor review my findings with me before I decide.

I hereby state that the information on all pages of this form is correct and true. I authorize James M. Kolodziej, D.C. to examine, make x rays, treat me and do whatever deemed necessary in accordance with the state statutes for the care and management of my condition. I understand that insurance policies are an arrangement between the insurance carrier and myself. Should collection proceedings or other legal action become necessary I understand Dr. Kolodziej has the right to disclose to an outside collection agency all relevant personal and account information necessary to collect payment for services rendered. I understand that I am responsible for all charges whether or not paid by my insurance carrier, as well as any attorney fees and costs incurred to collect for these services.

By signing below, you agree to accept full financial responsibility as a patient who is receiving chiropractic services or as the responsible party for minor patients. Your signature verifies that you have read the above disclosure statement, understand your responsibilities, and agree to these terms.

Signature_____Date_____

ACKNOLEDGMENT 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.

List below the names and relationship of people whom you authorize the Practice to release PHI.

_____ _____

_____ _____

_____ _____