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

CONFIDENTIAL PATIENT INFORMATION

NAME_____MARITAL STATUS_____LAST 4 SS_____
ADDRESS_____DATE OF BIRTH_____AGE_____
CITY_____STATE_____ZIP_____HOME PHONE_____
EMAIL:_____CELL_____
GENDER__M__F__#OF CHILDREN_____REFERRED BY_____
OCCUPATION_____EMPLOYER_____
METHOD OF PAYMENT: SELF PAY_____INSURANCE_____AUTO INSURANCE_____
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, take 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 me. Not all services offered are covered by every insurance contract and some insurance companies arbitrarily select certain services they will not cover. I understand that I am responsible for all charges not covered by my insurance carrier (this includes Medicare and all Medicare plans).** Should the balance become delinquent, the patient agrees to pay any and all cost in the recovery of said balance including but not limited to collection agency fees, attorney fees, and or court cost. 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.

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_____

James M. Kolodziej, D.C.

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.

By **initialing** the lines below I authorize being contacted for office news and practice reminders by:
Mail _____; _____;

Email_____; at email address:

_____;

Telephone numbers_____; home: _____

cell: _____work:_____;
By voice mail _____;

By **initialing** this line _____, I authorize Dr. Kolodziej to personally discuss with me products that may benefit my health or condition.

REQUEST FOR SPECIAL CONFIDENTIAL COMMUNICATIONS PROCEDURES

I hereby authorize James Kolodziej, D.C. to release all written communications to me be mailed only to the following address: _____.
I hereby authorize all phone calls placed by James Kolodziej, D.C to me only be placed to: _____.
I hereby request that no voice mail be left by James Kolodziej, D.C. on the above listed or any other telephone listings related to me. ☐

9371 Cypress Lake Drive, Suite 3
Fort Myers, FL 33919
Phone (239) 433-9189 • Fax (239) 433-4672
www.southfortmyerschiro.com

James M. Kolodziej, D.C.

Patient Name (please print) _____ Date _____

Name of Parent, Guardian or Patient's legal representative _____

Signature of Patient, Parent, Guardian or Patient's legal representative _____

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

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

_____ _____

_____ _____

_____ _____

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