Florida Functional Neurology Group

WWW.FFNG.ORG

ALEXANDER C. FRANK, DC, DACNB, FABES
BOARD CERTIFIED CHIROPRACTIC NEUROLOGIST
DIPLOMATE, AMERICAN CHIROPRACTIC NEUROLOGY BOARD
FELLOW, AMERICAN BOARD OF ELECTRODIAGNOSTIC SPEICALTIES

Welcome to our office,

Please take your time in filling out your intake documents. The documents were designed to be filled-out on your computer. You can move from field to field via the TAB key, or you can use your mouse and cursor to select a specific field. You can also print off the documents and fill them in by hand, *neatly*. *PLEASE* return your documents 1 day prior to your initial office visit.

Please wear/bring loose/athletic clothing for the examination. Bring warm clothing such as a sweat suit & socks, if you tend to get cold. Please call the office for specific directions to our location and arrive *at least* 20 minutes prior to your scheduled initial appointment to enter the necessary information into our paperless documentation system.

We look forward to being a part of your health care team.

Cordially,

Dr. Frank

Florida Functional Neurology Group

WWW.FFNG.ORG

Confidential Pediatric Patient Information

Patients Name: _____ Chief Complaint: _____

Address: _____ Home Phone: _____

_____ Cell: _____Work:_____

Email: _____ SSN: _____ _____

Date of Birth: _____ Favorite Color: Select One

Occupation: _____ School: _____

Referred by: _____

Are your present systems or condition related to, or the result of an auto collision, work-related injury or other personal injury? (Someone else might be responsible for payment?) ◯ Yes ◯ No

Please proivde any infrmation you feel may help expedite your child's care.

Family Physician: _____ (Note: We may send your health information to this provider)

Person to contact in case of emergency (Name and Phone): _____

What operations have you had? _____ When? _____

_____ When? _____

Serious Illness: _____ When? _____

Accidents/Injuries: _____ When? _____

_____ When? _____

Infectious Diseases: _____ When? _____

History of: ADHD Y____ N____ Blood Sugar/DM Y____ N____ Concussion Y____ N____ Thyroid Issues Y____ N ____

Psychological Issues Y____ N____ Tics/OCD Y____ N____ Headaches Y____ N____ Food Sensitivities Y____ N____

Sleep Issues Y____ N ____ Poor Balance & Corrdiantion Y____ N____ Childhood Developmental Delay Y____ N____

Medications ? (check those that apply): Pain Killers ____ Insulin _____ ADHD, etc.☐ Asthma____ Thyroid☐

Muscle Relaxers _____ Birth Control _____ Allergy_____ Other: _____

_____ _____

Signature of Parent / Guardian **Date**

P: 954-825-5832 info@ffng.org

Florida Functional Neurology Group

WWW.FFNG.ORG

A patient, in coming to the chiropractic physician, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course will not give any treatment or care if he is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures whatever he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The board certified chiropractic neurologist provides a specialized, non-duplicating health care service. Your doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a patient, I am authorizing FFNG and its' staff to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

To the best of my knowledge I am pregnant_____ __ I am NOT pregnant_____

I give my permission to X-ray_____ I DO NOT give my permission to x-ray me for diagnostic interpretation. _____

Missed Appointments:

There is a possible $25 fee charged for all appointments that are not canceled prior to scheduled visit.

Consent to Evaluate and Treat a Minor:

_____being the parent or legal guardian of_____, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Communications:

In the event that we would need to communicate your healthcare information, to whom may we do so?

Spouse: _____

Children: _____

Others: _____

_____ None

May we mail postcards or leave messages on any answering device, i.e. home answering machines or voicemails? Yes_____ No_____

Acknowledgement:

I have reviewed the notice of privacy practices (HIPAA) and have been provided an opportunity to discuss my right to privacy. Upon reques I will be given a copy.

I, _____, have read and fully understand the above statements.

Signature: _____ Date_____

Florida Functional Neurology Group

WWW.FFNG.ORG

Patient:_____

Date:_____/_____/2015

Review of Systems

Please check all that apply

General-
□ Weight loss or gain
□ Fatigue
□ Fever or chills
□ Weakness
□ Trouble sleeping

Skin-
□ Rashes
□ Lumps
□ Itching
□ Dryness
□ Color changes
□ Hair and nail changes

Head-
□ Headache
□ Head injury
□ Neck Pain

Ears-
□ Decreased hearing
□ Ringing in ears
□ Earache
□ Drainage

Eyes-
□ Vision Loss/Changes
□ Glasses or contacts
□ Pain
□ Redness
□ Blurry or double vision
□ Flashing lights
□ Specks
□ Glaucoma
□ Cataracts
□ Last eye exam

Nose-
□ Stuffiness
□ Discharge
□ Itching
□ Hay fever
□ Nosebleeds
□ Sinus pain

Throat-
□ Bleeding
□ Dentures
□ Sore tongue
□ Dry mouth
□ Sore throat
□ Hoarseness
□ Thrush
□ Non-healing sores

Neck-
□ Lumps
□ Swollen glands
□ Pain
□ Stiffness

Breasts-
□ Lumps
□ Pain
□ Discharge
□ Self-exams
□ Breast-feeding

Respiratory-
□ Cough
□ Sputum
□ Coughing up blood
□ Shortness of breath
□ Wheezing
□ Painful breathing

Cardiovascular-
□ Chest pain or discomfort
□ Tightness
□ Palpitations
□ Shortness of breath with activity
□ Difficulty breathing lying down
□ Swelling
□ Sudden awakening from sleep with shortness of breath

Gastrointestinal-
□ Swallowing difficulties
□ Heartburn
□ Change in appetite
□ Nausea
□ Change in bowel habits
□ Rectal bleeding
□ Constipation
□ Diarrhea
□Yellow eyes or skin

Urinary-
□ Frequency
□ Urgency
□ Burning or pain
□ Blood in urine
□ Incontinence
□ Change in urinary strength

Vascular-
□ Calf pain with walking
□ Leg cramping

Musculoskeletal-
□ Muscle or joint pain
□ Stiffness
□ Back pain
□ Redness of joints
□ Swelling of joints
□ Trauma

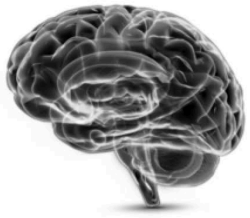
Neurologic-
□ Dizziness
□ Fainting
□ Seizures
□ Weakness
□ Numbness
□ Tingling
□ Tremor

Hematologic-
□ Ease of bruising
□ Ease of bleeding

Endocrine-
□ Head or cold intolerance
□ Sweating
□ Frequent urination
□ Thirst
□ Change in appetite

Psychiatric-
□ Nervousness
□ Stress
□ Depression
□ Memory loss

Signature_____



Florida Functional Neurology Group

WWW.FFNG.ORG

AUTHORIZATION TO RELEASE & RECEIVE X-RAYS & INFORMATION

TO:_____
(NAME OF HEALTH CARE PROVIDER, CLINIC, HOSPITAL, ETC.)

ADDRESS:_____

I, _____ DOB:_____ SSN:_____
(PATIENT'S NAME)

REQUEST THE FOLLOWING INFORMATION:

☐ X-RAYS ☐ HISTORY ☐ RECORDS ☐ DIAGNOSIS ☐ REPORTS ☐ TREATMENT

CONCERNING MY: ☐ ILLNESS ☐ ACCIDENT ☐ INJURY ☐ OTHER_____

TO BE RELEASED TO: FLORIDA FUNCTIONAL NEUROLOGY GROUP

_____

_____

FOR THE PURPOSE OF:_____
(REVIEW, EVALUATION, INSURANCE CLAIM PROCESSING, OR ANY PURPOSE REASONABLY RELATED TO THE ABOVE)

I UNDERSTANT THAT I HAVE A RIGHT TO RECEIVE A COPY OF THIS AUTHORIZATION UPON MY REQUEST.

SIGNATURE:_____DATE:_____

◯ PATIENT ◯ PARENT ◯ GUARDIAN

NOTICE OF PRIVACY PRACTICES

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1966 (HIPPA). I HAVE REVIEWED THE ACT OF HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY AND ACKNOWLEDGE THE FEDERAL RULES TO PROTECT THE RIGHTS OF PERSONAL HEALTH INFORMATION.

PATIENT NAME: _____ DATE: _____

PATIENT SIGNATURE: _____