11270 Pines Blvd, Pembroke Pines, FL 33026 PH) 954.441.7246 FX) 954.441.7241

ABOUT YOU

TODAY'S DATE:	PATIENT NAME:		
SEX: ☐MALE ☐FEMALE	DOB:	AGE:	SS#:
ADDRESS:	CITY/STATE/ZIP:		
HOME/CELL #:	WORK #:		
E-MAIL: @			
EMPLOYER:	OCCUPATION:		
STATUS: ☐MINOR ☐SINGLE ☐MARRIED ☐DIVORCED ☐SEPARATED ☐WIDOWED			
SPOUSE:	CHILDREN: ___Y___N	IF SO, HOW MANY? ___________	

EMERGENCY CONTACT NAME: **RELATIONSHIP:** **PHONE #:**

IF A FAMILY MEMBER/FRIEND ASKS TO SPEAK TO YOU, CAN WE TELL THEM YOU ARE HERE: ☐YES ☐NO

REASON FOR VISIT

REASON FOR THE VISIT: ☐AUTO ☐WORK ☐SPORTS ☐TRAUMA ☐CHRONIC		
EXPLAIN WHAT HAPPENED:		
PLEASE DESCRIBE THE PAIN AND LOCATION:		
DATE THE CONDITION BEGIN:	GETTING WORSE? ___Y___N	CONSTANT: ______COMES AND GOES:_____
IS THE CONDITION INTERFERRING WITH YOUR: ☐WORK ☐SLEEP ☐DAILY ROUTINE		
HAVE YOU HAD A SIMILAR CONDITION IN THE PAST? ☐YES ☐NO		
HAVE YOU BEEN TREATED BY A MEDICAL PHYSICIAN FOR THIS CONDITION? ☐YES ☐NO		
HAVE YOU BEEN TREATED BY A CHIROPRACTOR BEFORE? ☐YES ☐NO		
IF SO, WHOM?		

Multi-Care Medical

HEALTH HISTORY

ARE YOU TAKING ANY OF THE FOLLOWING MEDICATIONS?			
☐BLOOD PRESSURE	☐PAIN KILLERS (ASPIRIN)	☐MUSCLE RELAXERS	☐BLOOD THINNERS

DO YOU HAVE OR EVER HAVE ANY OF THE FOLLOWING DISEASES OR CONDITIONS?

☐HEART ATCK/STROKE	☐HEART SURG/PACEMAKER	☐HEART DISEASE	☐ASTHMA
☐ALCOHOL ABUSE	☐DRUG ABUSE	☐HIV/AIDS	☐HEPATITIS
☐SHINGLES	☐VENEREAL DISEASE	☐DIABETES	☐FAINTING/SEIZURES
☐CANCER (TYPE)______________________		☐GLAUCOMA	☐ARTIFICIAL LIMBS
☐RESPIRATORY ISSUES	☐SINUS PROBLEMS	☐ARTHRITIS	☐ULCER/COLITIS
☐ANEMIA	☐KIDNEY PROBS.	☐HIGH/LOW BLD PRESSURE	
☐OTHER____________________________		☐PSYCHIATRIC PROBLEMS	

DO YOU HAVE ANY METAL IN YOUR BODY (LIKE SHRAPNEL, BULLETS OR IMPANTS)?

□YES □ NO IF YES, PLEASE EXPLAIN :_______________________________________

LIST ANY SERIOUS MEDICAL CONDITION (S) YOU HAVE/HAD:

PLEASE LIST ANYTHING YOU MAY BE ALLERGIC TO:

LIST PREVIOUS SURGERIES/TREATMENTS WITH DATES:

LIST ANY PAST SERIOUS ACCIDENTS WITH DATES:

FAMILY HEALTH HISTORY:		
	DO YOU TAKE SUPPLEMENTS OR VITAMINS?	□YES □ NO
	EXERCISE?	□YES □ NO
	SPECIAL DIET?	□YES □ NO
	DO YOU SMOKE?	□YES □ NO

WOMEN: PREGNANT □YES □ NO LAST MENSTRUAL CYCLE: ______________________

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AUTHORIZATION FOR MEDICAL TREATMENT

I the undersigned, patient in this office hereby authorize **Multi Care Medical, LLC** and/or the physicians of **Multi Care Medical, LLC** (and whomever they designate as their assistants) to administer such treatments as is necessary and to perform the following therapy and manipulation and such additional therapy or procedures as are considered therapeutically necessary on the basis of findings during the course of said treatment.

I hereby certify that I have read and fully understand the above Authorization for Medical Treatment, the reason why the above named treatment is considered necessary, its advantages and possible complications, if any as well as possible alternative modes of treatment which are explained to me by **Multi Care Medical, LLC** and/or the physicians of **Multi Care Medical, LLC**.

I also certify that no guarantee or assurance has been made as to the result that may be obtained.

______________________________ ______________________

Print Name Date

____

Patient's Signature

____

Witness

11270 PINES BLVD. PEMBROKE PINES, FL 33026

NOTICE OF PRIVACY PRACTICES ACKNOWLEDEGMENT

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

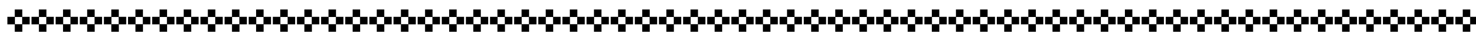
I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclose to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: ____

Relationship to Patient: ____ Self ____Other ______________________

Signature: ____Date: ______________________



OFFICE USE ONLY

WITNESS: ______________________________________