

## **Dr. Charles W. Rice, Jr.**

Chiropractic Physician

Diplomate American Chiropractic  
Board of Nutrition

Certified Clinical Nutritionist

### **Dear Friend:**

We would like to welcome you to Total Health Chiropractic Center! Our goal is to provide you with thorough and efficient service. In order to provide you and our other patients with the best care, we request that you follow our guidelines regarding broken and/or cancelled appointments. Please remember that we have reserved appointment times especially for you. Therefore, we request at least 24 hours notice in order to reschedule your appointment. This will enable us to offer your cancelled time to other patients that desire to get their treatment completed. When you cancel your appointment at the last minute, everyone loses – you, the doctor and other patients that would like to have utilized your appointment time.

Since our office does not charge for broken or cancelled appointments, please realize how important it is to keep your reserved time. If you arrive late you may have to wait as we see others that arrived on time. Thank you for your consideration of our policies and for the opportunity to be your chiropractic office of choice.

Your first visit with the doctor begins the process of determining your individual needs and takes 45 minutes to 1 hour. The doctor will first review your health history and then conduct a physical examination that will include neurological, orthopedic and spinal tests. The doctor will use the information collected to compose a nutrition plan to address your specific needs. The doctor will review the nutrition plan with you on the second visit, which typically takes 30 minutes.

Please complete the attached forms as completely as possible. This information will help the doctor attend to your needs. You will not be able to see the doctor until this information has been collected. If you have any questions please call the office at 813-269-0437.

Remember to thank the person who referred you to our office.

**Yours in Good Health,**

**The Staff of Total Health Chiropractic Center**

Total Health Chiropractic  
Center, PA.  
13129-A N Dale Mabry Hwy.  
Tampa, FL 33618

Phone: 813-269-0437  
Fax: 813-963-5557  
totalhealthchiro@verizon.net

# CONFIDENTIAL INFORMATION

Name \_\_\_\_\_ Preferred Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ E-mail \_\_\_\_\_

Your Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Work Address \_\_\_\_\_

Work Phone \_\_\_\_\_ Social Security # \_\_\_\_\_

Spouse/Guardian \_\_\_\_\_ Occupation \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

We would like your permission to keep your primary care physician up to date on your condition and treatment here at Total Health Chiropractic Center.

Primary Care Doctor \_\_\_\_\_

## Agreement to Pay

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this chiropractic office will prepare any necessary report and forms to assist me in making collections from the insurance company. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment at the time of the visit. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable and that I am responsible for any costs incurred in collection of said balance. I have read and understand the above and agree to comply.

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

\_\_\_\_\_  
Date

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

Please answer the questions below concerning your health history. Be sure to list all conditions or symptoms, both past or present.

**An understanding of your health history will help us to determine appropriate care.**

FULL NAME \_\_\_\_\_ DATE \_\_\_\_\_  
AGE \_\_\_\_\_ RACE \_\_\_\_\_ GENDER \_\_\_\_\_ HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_

**Review of Systems**

1. Do you have skin, hair or nail problems?  Yes  No \_\_\_\_\_
2. Do you have mouth and/or throat problems?  Yes  No \_\_\_\_\_
3. Do you have nose and/or sinus problems?  Yes  No \_\_\_\_\_
4. Do you have ear problems?  Yes  No \_\_\_\_\_
5. Do you have eye problems?  Yes  No \_\_\_\_\_
6. Do you have chest or lung (breathing) problems?  Yes  No \_\_\_\_\_
7. Do you smoke?  Yes  No Amount per day \_\_\_\_\_ How Long? \_\_\_\_\_
8. Do you have heart and/or blood vessel problems?  Yes  No \_\_\_\_\_
9. Do you have blood or lymph node problems?  Yes  No \_\_\_\_\_
10. Do you have digestive problems?  Yes  No \_\_\_\_\_
11. Do you have genital problems (e.g. prostate, testicular, vaginal)?  Yes  No \_\_\_\_\_
12. Do you have urinary (including kidney or bladder) problems?  Yes  No \_\_\_\_\_
13. **Females**, have you had menstrual problems?  Yes  No \_\_\_\_\_  
 Have you ever taken birth control pills?  Yes  No For how long? \_\_\_\_\_  
 Is there any chance that you are currently pregnant?  Yes  No  
 Do you have any breast problems?  Yes  No \_\_\_\_\_
14. Do you have any nervous system diseases and/or mental health problems?  Yes  No \_\_\_\_\_
15. Do you have any gland and/or hormone problems?  Yes  No \_\_\_\_\_
16. Do you have allergy or immunity problems?  Yes  No \_\_\_\_\_
17. Do you have any muscle, tendon or ligament problems?  Yes  No \_\_\_\_\_
18. Do you have any bone or joint diseases (examples: bone = osteoporosis, joint = arthritis)?  Yes  No \_\_\_\_\_

**Past History**

19. List any diseases which you have had in the past, including childhood diseases: \_\_\_\_\_  
\_\_\_\_\_
20. Tell us if you have ever been diagnosed as having a particular condition such as diabetes, cancer, AIDS, etc.: \_\_\_\_\_  
\_\_\_\_\_
21. Have you suffered any physical injuries such as falls or blows, automobile accidents, whiplash, concussion or head injury, lacerations, sprains, strains, dislocations, broken or cracked bones?  Yes  No  
\_\_\_\_\_  
\_\_\_\_\_
22. List any surgeries you have had (don't forget appendix, tonsils, ear tubes, wisdom teeth):  
 \_\_\_\_\_ Date \_\_\_\_\_  
 \_\_\_\_\_ Date \_\_\_\_\_  
 \_\_\_\_\_ Date \_\_\_\_\_  
 \_\_\_\_\_ Date \_\_\_\_\_

(OVER PLEASE)

FULL NAME \_\_\_\_\_

DATE \_\_\_\_\_

23. Have you ever been hospitalized for any reason other than surgery?  Yes  No \_\_\_\_\_
24. **Medications:** Please list all medications (prescription & non-prescription) you are currently taking or take on an occasional basis: \_\_\_\_\_

25. Your diet is:  Balanced  Fair  Poor  Excessive  Restricted

**Family History**

26. Are there any diseases or conditions that are common among your family members (i.e. inherited diseases or conditions)?  Yes  No \_\_\_\_\_

**Social History**

27. In what position do you usually sleep, and how well? \_\_\_\_\_
28. Do you exercise on a regular basis?  Yes  No How? \_\_\_\_\_
29. How do you spend your spare time (hobbies, etc)? \_\_\_\_\_
30. Do you use:  Caffeine?  Tobacco?  Nicotine?  Recreational Drugs?  Alcohol?
31. Please describe your work.  
 Type:  Professional  Physical Labor  Driver  Clerical  Factory  Homemaker  
 Physical Demands:  Heavy  Moderate  Mild  Sedentary  
 Stress Level:  High  Medium  Low

**Additional Questions**

32. Do you have problems with recurring headaches?  Yes  No \_\_\_\_\_
33. Are you losing weight without trying?  Yes  No \_\_\_\_\_
34. Does your pain wake you up at night?  Yes  No \_\_\_\_\_
35. Have you had a change in bowel or bladder habits?  Yes  No \_\_\_\_\_
36. Have you had a sore that doesn't heal?  Yes  No \_\_\_\_\_
37. Have you recently had any unusual bleeding or discharge?  Yes  No \_\_\_\_\_
38. Do you have a thickening/lump in the breast or elsewhere?  Yes  No \_\_\_\_\_
39. Do you have indigestion or difficulty swallowing?  Yes  No \_\_\_\_\_
40. Have you had an obvious change in a wart or mole?  Yes  No \_\_\_\_\_
41. Do you have a nagging cough or hoarseness?  Yes  No \_\_\_\_\_
42. In the space below, please explain or give additional details regarding the information you have given above. Also, if there is any information about your health history which was not requested, please fill it in below.
- \_\_\_\_\_
- \_\_\_\_\_

43. Please describe your current complaint. In other words, what brought you here? \_\_\_\_\_
- \_\_\_\_\_
44. Who is your:  
 Medical Doctor? \_\_\_\_\_  
 OB/GYN? \_\_\_\_\_  
 Dentist? \_\_\_\_\_

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

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

## Body Temperature

Please record your temperature according to the instructions below for 3 to 5 days. This must be completed before your visit.

### ***How To Measure Your Temperature.***

The Temperature is taken,

- By mouth
- With a Mercury/glass thermometer (a **new** digital thermometer can be used if you can't get a mercury thermometer)
- Every 3 hours, 3 times a day, starting 3 hours after waking, for several days (not the 3 days prior to the period in women since its higher then). For example, if one wakes at 7am, then the temp. should be measured at around 10am, 1pm, and 4pm.
- For each day, add the temperatures together and divide by 3 to get the average.

Use the table below to record your readings.

Date					
Time					
<b>Average</b>					

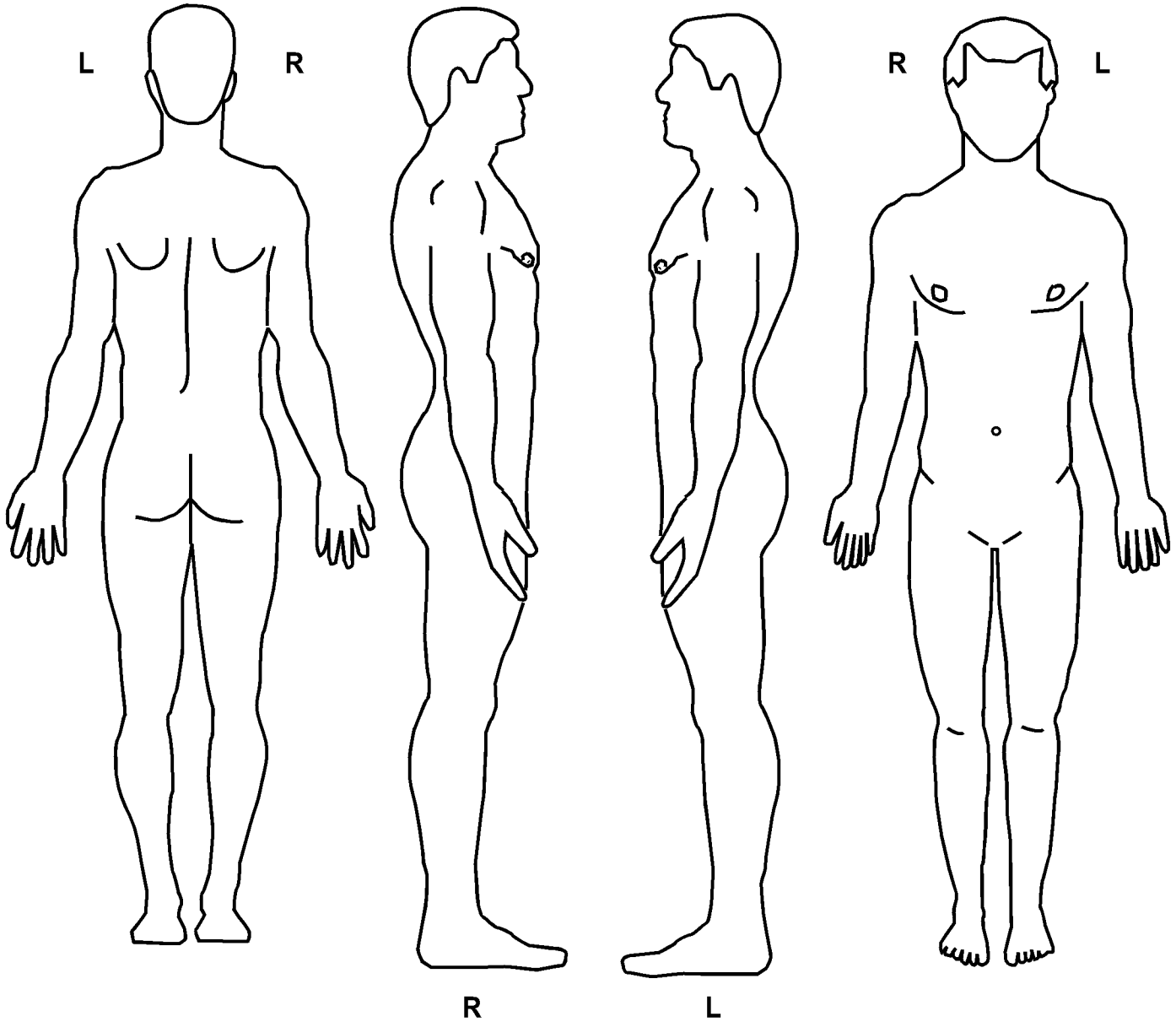
**Diet Log**

**Please write down what you eat and drink for a week! This includes juice, coffee, alcohol. If you're attempting to follow any particular diet, please indicate that in the space below the table, IE Swank diet, Atkins.**

	<b>Monday</b>	<b>Tuesday</b>	<b>Wednesday</b>	<b>Thursday</b>	<b>Friday</b>	<b>Saturday</b>	<b>Sunday</b>
Breakfast							
Snack							
Lunch							
Snack							
Dinner							
Snack							

# PAIN DRAWING

Name \_\_\_\_\_ Date \_\_\_\_\_



**Mark as follows:**

**A - Ache B - Burning N - Numbness P - Pins & Needles**

**S - Stabbing O - Other - Describe \_\_\_\_\_**



# Authorization for the Release of Medical Records

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
(also list maiden name/other names used)

I hereby request and authorize:

Dr. Charles W. Rice, Jr.  
Total Health Chiropractic Center, PA.  
13129A N Dale Mabry Hwy.  
Tampa, FL 33618

\_\_\_\_\_ To Disclose information to:  \_\_\_\_\_ To Receive Information from:

Provider: \_\_\_\_\_

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

City/State/Zip \_\_\_\_\_

Information to be disclosed include copies of:

<input type="checkbox"/> Entire Record	<input type="checkbox"/> X-ray Reports
<input type="checkbox"/> Progress Notes	<input type="checkbox"/> X-ray Films
<input type="checkbox"/> Physical Exam forms	<input type="checkbox"/> Other, specify: _____
<input type="checkbox"/> Daily chart notes	

Purpose for disclosure:

Treatment, Payment OR  Other (Specify) \_\_\_\_\_

This authorization will be effective for six months after the date signed, unless cancelled in writing. I understand that the cancellation will have no effect on information released prior to receiving the cancellation. A copy of this authorization is as valid as the original.

\_\_\_\_\_  
Signature of Patient Date: \_\_\_\_\_

OR

\_\_\_\_\_  
Signature of Legal Representative/Relationship Date: \_\_\_\_\_

If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law.

Notice to recipient of information: This information has been disclosed to you from confidential records, which are protected by law. Unless you have further authorization, laws may prohibit you from making any further disclosures of this information without the specific written consent of the patient or legal representative.

Dear friend:

In order to properly evaluate your condition, the doctor will need to review any diagnostic tests that have been performed on you in the past 6 months. This includes laboratory tests and X-rays. So that we may serve you quickly and efficiently, please collect these records before your visit. If you do not have copies of these records, please complete the attached Release of Medical Records to allow the ordering doctor to send them to us. We appreciate your co-operation. If you have any questions regarding the completion of this form please call the office at 813-269-0437.

Sincerely,

The Staff of Total Health Chiropractic Center, PA.