New Patient Information

Name _____ ☐Female ☐Male Date _____

What you prefer to be called _____ Age _____ Date of birth _____

Preferred Language ☐English ☐Other _____ Race: ☐White ☐African American ☐ Other _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Email Address _____ SS# _____

Preferred Method of Contact _____

Employer _____ Occupation _____ Work Phone _____

Emergency Contact _____ Relation _____ Phone _____

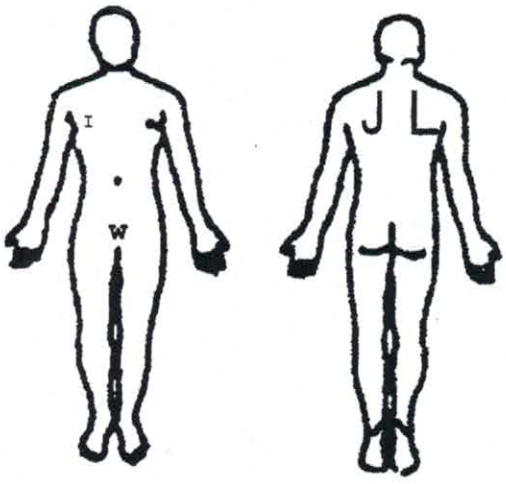
How did you hear about our office? _____

When did your condition begin? _____

Other Doctors seen for this condition? _____

Have you had the same or similar symptoms before? ☐ Yes ☐ No Date of prior condition _____

Mark Areas of Pain on Figures Below



List chief symptoms in order of severity:

(1) _____

(2) _____

(3) _____

Have you had chiropractic care before? ☐ Yes ☐ No

Family Physician _____

May we forward our findings to your doctor? ☐ Yes ☐ No

Current Medications _____

_____

_____

_____

Allergies (Medicine, Food, Environment) _____

_____

Previous Surgeries _____

Do you have a PERSONAL history of: ☐ Cancer ☐ Diabetes ☐ Heart Disease ☐ Stroke

Other serious illnesses _____

Check all symptoms that apply to you:

☐ Headache	☐ Tingling/numbness in arms/hands	☐ Chest Pain	☐ Unexplained weight loss
☐ Neck Pain/Stiffness	☐ Tingling/numbness in legs/toes	☐ Knee Pain	☐ Fatigue
☐ Back Pain/Stiffness	☐ Loss of balance/dizziness	☐ Hip Pain	☐ Night Sweats
☐ Shoulder Pain	☐ Shortness of breath	☐ Fever	☐ Blood in Urine
☐ Other _____		☐ Night Pain	☐ Pain unrelieved by rest

For women: Are you pregnant? ☐ Yes ☐ No Are you taking birth control? ☐ Yes ☐ No

Health History & Assessment

Patient Name_____ Date_____

Vitals BP _____ Temp _____ Height _____ Weight _____

Current Pain Level (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worse)

Social/Lifestyle history:
Marital status: M S W D
Occupation_____
Do you smoke? No Yes How much?_____
Do you drink alcohol? No Yes How much on a typical day?_____
Do you take; blood thinners (heparin, coumadin, warfarin), birth control pills, steroids
Do you have any family history of; rheumatoid arthritis, gout, ankylosing spondylitis, lupus, stroke

Please (CIRCLE) **Any That May Apply To Your Health History:**

General
Cancer, diabetes, thyroid disease, AIDS or HIV Fatigue, recent unexplained weight loss, decreased energy, loss of appetite, night sweats, fever or chills, recurrent infections, skin ulcers or rashes, excessive thirst

Neuromusculoskeletal
Stroke, paralysis, seizures, mental disorders, fractures, dislocations, orthopedic problems, arthritis, rheumatoid arthritis, gout, lupus, osteoporosis, scoliosis
Change in vision, smell, hearing or taste, light headedness, dizziness/ vertigo, loss of consciousness, difficulty speaking or swallowing, headaches, numbness or tingling, difficulty walking, change in mood or behavior

Cardiovascular
Pacemaker, defibrillator, high blood pressure, heart disease, irregular heart beat, heart attack, congestive heart failure,TIA, peripheral vascular disease, blood clotting or bleeding disorder, anemia Chest pain, shortness of breath, nose bleeds, swollen ankles, redness or swelling of a limb, unusual bruising, bleeding gums, swollen lymph nodes

Respiratory
Asthma, emphysema, tuberculosis, COPD, Cough or change in cough, blood in sputum, wheezing, difficulty breathing

Digestive
Liver disease, hepatitis, ulcers, gall stones, appendicitis, pancreatitis, reflux disease
stomach pain, pain or difficulty swallowing, indigestion, nausea, vomiting, diarrhea, constipation, bloating, excessive gas or belching, blood in stool, black stools, jaundice

Genitourinary
Kidney disease, kidney stones, prostate enlargement, burning with urination, blood in urine, increased frequency of urination, difficulty with urination, loss of bladder or bowel control, change in menstrual bleeding

Initial _____

Health Insurance

Policyholder Name _____ Date of Birth _____

Workers Compensation

Is your condition due to an Employment Related Injury? Yes ☐ No ☐ Have you reported it? Yes ☐ No ☐

Date of accident _____

Supervisor _____ Supervisor # _____

Auto Accident

Is your condition due to Automobile Accident? Yes ☐ No ☐ Date of accident _____

Auto Accident Insurance Name _____ Claim # _____

Adjuster Name _____ Phone # _____

Attorney Name _____ Phone # _____

CONSENT OF PROFESSIONAL SERVICES AND RELEASE OF INFORMATION

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are changed directly to me and that I am personally responsible for payment. I also understand if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

I hereby authorize Dr. Pearson and his affiliated providers to administer treatment, physical examination, X-ray studies, laboratory procedures, chiropractic care, physical therapy, or any clinic services that they deem necessary in my case; I do hereby give my consent for the performance of conservative non-surgical treatment, including, but not limited to manipulation, physical therapy modalities, soft tissue massage and therapeutic exercises. I am aware there are possible risks and complications associated with these procedures, ranging from soreness to stroke. I understand there is no certainty that I will achieve benefits and acknowledge that no guarantee has been made regarding the outcome of these procedures. I am aware there are alternatives to these procedures, including medication and/or surgery. I further authorize them to disclose all or any part of my (patient's) record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or a family member or employer of the patient for all or part of the clinic's charge, including, and not limited to hospital or medical services companies, insurance companies, workers compensation carriers, welfare funds, or the patient's employer.

We invite you to discuss any questions you might have with us. The best health services are based on a friendly mutually understood relationship.

Patient's or Guardian's Signature _____ Date _____

CONSENT TO TREAT A MINOR

I (we) being the parent, guardian or custodian of the minor being _____, age _____, do hereby authorize, request & direct Dr. Pearson and staff to perform examinations, diagnostic x-rays, laboratory tests, and any treatment that in their judgment, is deemed advisable or required.

It is the understanding of the undersigned that the physicians and their staff will have full authority from me as legal parent/guardian to continue with examinations, diagnostic tests, and treatments as will be needed while said minor shown above is under care in this office until legal age is attained.

As legal parent/guardian, I realize full responsibility for all charges and payments due.

Parent/Guardian or Custodian Signature _____ Date Signed _____

Witness _____

Informed Consent for Medical Cannabis

I understand that Medical Cannabis is offered as treatment for specific medical conditions and/or symptoms as designated by the Florida Department of Health, Office of Compassionate Use.

I understand that Dr. Pearson is a qualified physician who is registered with the Office of Compassionate Use and may order medical cannabis for my medical use if he feels I qualify as a patient who could benefit from this medical decision.

I understand that I must be re-certified with the State of Florida at a minimum every thirty (30) weeks and that Dr. Pearson may increase the frequency of visits at his discretion.

I understand that Dr. Pearson is not implying or suggesting that medical cannabis should be a substitute for any other treatment prescribed by another physician.

I understand that I may not seek medical cannabis from any other physician while being a patient registered with Dr. Pearson.

I understand that Dr. Pearson will register my case with the Florida Department of Health, Compassionate Use Registry and he will also submit the treatment plan quarterly to the University of Florida, College of Pharmacy for research purposes on the efficacy of medical cannabis to help treat Patients.

I understand that I may fill the order placed by Dr. Pearson at any qualified dispensing organization. The dispensary will verify identity of the patient as well as the existence of an order in the Registry of Compassionate Use. A maximum of a thirty (30) week supply is allowed, however dispensaries will only distribute seventy (70) days at a time.

I understand that when treatment is discontinued, Dr. Pearson will deactivate my registration with the Compassionate Use Registry.

By signing this document, I voluntarily agree that all my questions have been addressed, benefits and risks have been discussed. I understand that **NO** fees associated with care or obtaining medical cannabis can be applied to any insurance plan, according to Florida State law. All fees will be paid by myself or my legal representative.

Print name_____

Or legal guardian _____

Signature_____ Date_____

Financial Office Policies – Medical Cannabis Program

I understand my initial visit/consult will cost $200.00 and $100.00 must be paid prior to my visit/consult with the doctor. I further understand that no showing or multiple (more than 2) reschedules for an appointment will cause me to be discharged from this office and forfeits the initial $100.00 or current charge(s) for that visit.

I acknowledge that, should the Doctor be unable to qualify me under the expanded language within Amendment 2, I am entitled to a refund the day of my initial visit/consult.

Currently under Florida law, Dr. Pearson may recommend a 30 week supply of Medical Cannabis/CBD Oil – Low THC. I understand that my follow up visits to re-certify my recommendation with the State of Florida is $200.00. I understand that office visits in between these certifications are $100.00.

I understand that because Cannabis is still prohibited at the Federal level, we are unable to accept Medical Insurance.

I further acknowledge that should future legislation disqualify me as a patient at a date after I've already completed my initial appointment, no refund will be made.

Print name_____

Or legal guardian _____

Signature_____ Date_____