Dr. James Valcarcel
136 N Orchard St #3,
Ormond Beach, FL 32174
p. 386.310.8096

Today's Date: ___________________

Patient Information

First Name: _______________________ Middle Initial: ___ Last Name: _____________________________

Home Phone: ___________________ Mobile Phone: ________________

E–mail: ____ (Required)

Address: _________________________________ City: _______________________ State __ Zip: _______

Social Security: _______________________

Date of Birth: ___/___/______ Age: _______ Male / Female Married / Single

Employment Status: Employed / Unemployed / Student / Other: _______________________________

Occupation: ________________________________ Employer / School: _____________________________

Emergency Contact

Contact Name: __________________________________ Relation: __________________________________

Contact Home Phone: ________________________ Mobile Phone: ________________________________

Primary Care Physician: ____ Contact: ______________

Are you currently insured by Medicare? Yes / No

Is this a Worker's Comp or Car Accident Case? Yes / No

How Did you hear about our office? **Facebook** **Google** **Referral** **Other**

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Initial ________

Patient Name: ______________________________ Today's Date:_____________________

What brings you in to Aligned Integrative Healthcare?

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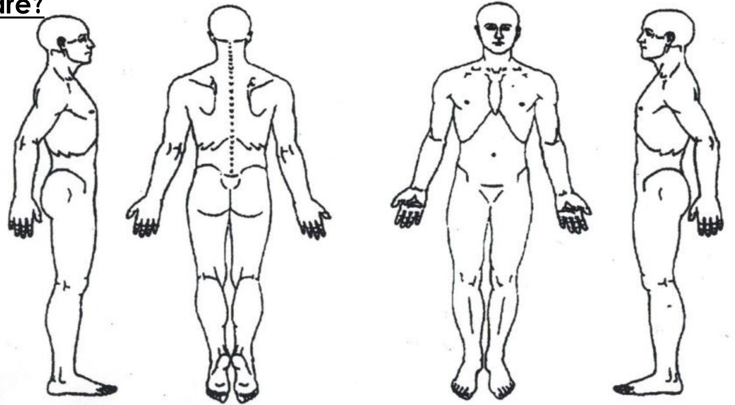

By using the key below, please indicate on the body diagram where you are experiencing pain.

– Numbness XXX – Burning /// – Stabbing
+++ – Dull Ache OOO – Pins and Needles

Describe your symptoms: ____

____

When did your symptoms start?: ____

How did your symptoms begin?: ____

What makes it better?: ______________________ Worse?: ______________________

Rate your pain from 1 to 10 (10 being the worst): 1 2 3 4 5 6 7 8 9 10

Have you ever experienced this issue before?: **YES** **NO** If so when?: ______________________

Did you seek medical/chiropractic attention?: **YES** **NO** Who did you see?: ______________________

Is this worse at certain times of the day? **YES** **NO** If so when?: ______________________

Does this wake you up at night? **YES** **NO** Any changes in your bowel or bladder habits?: **YES** **NO**

Have you lost weight without trying?: **YES** **NO** Any unusual lumps, worts, moles or swelling? **YES** **NO**

Any other symptoms you have noticed since this started? **YES** **NO** If so what?: ______________________

Past Medical History

Prior Surgeries: ____

Current or Recent Illnesses: ____

Traumas or Accidents: ____

Allergies: ____

Current Medications/ Supplementation: ____

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____

Do you use Tylenol, Aleve or other OTC pain medications regularly?: **YES** **NO**
Date of Last: X–ray: ____________ MRI: ____________ CT: ____________ Physical: ____________

Initial ________

Patient Name: ______________________________ Today's Date:_______________________

Please CIRCLE all that you have or are being treated for:

Heart Disease High Cholesterol High Blood Pressure Low Blood Pressure Heartburn Diabetes

Anemia Heart Attack Shortness of Breathe Asthma Lung Conditions Eye disorders/Glaucoma

Neurological Problems Headaches/Migraines Stroke Depression/Anxiety Arthritis Cancer

Ulcer/Colitis Liver Problems Kidney/Bladder Problems Seizures Sinus Problems Thyroid Problems

Multiple Sclerosis Osteoporosis STD Psoriasis Eczema Joint Replacement Surgery Alcoholism

Others not listed: ____

____

Family History

Any significant medical conditions?
Mother: ______________________________ Father: ______________________________

Grandmother (M): ________________________ Grandfather (M): ________________________

Grandmother (P): ________________________ Grandfather (P): ________________________

Siblings: ______________________________ Children: ______________________________

Social History

Describe your diet: **Stand American Paleo Low Carb Vegan/Vegetarian Low Fat Other**

How often do you exercise?: **2+/week 1+/week 1+/month Never** ______________________

How often do you drink alcoholic beverages a week?: **1–3 4–7 8+ Beer Wine Liquor**
What is your occupation?: ____________________ Work Activity Level: **Low Moderate Heavy**

Stress level : **Low Average High Very High**
What stresses you? ________________________ Hobbies?: ________________________

Do you smoke or have you smoked?: **YES NO** When did you quit?: __________ How often?: _____/wk

Do you or have you participated in Recreational Drugs?: **YES NO** Which ones?: ______________

Do you currently take pain killers?: **YES NO** If so for how long?: ________________________

How many hours per night do you sleep?: **8+ 6–8 less than 6** Feel rested? **YES NO**

Caffeine Intake: **Less than 2 more than 2** per day Of: **Coffee Soda Tea Pills Energy Drink** Are

you married?: **YES NO** Divorced?: **YES NO** Children?: **YES NO**

Has your condition affected your intimate life?: **YES NO**

Do you ever feel Depressed?: **YES NO** Explain: ____________________________________

Initial ________

Patient Name: ______________________________ Today's Date:______________________

Review of Systems

Please CIRCLE all that apply to you:

Weakness	Memory Trouble	Hernia
Fatigue/Malaise/Lethargy	Neck Pain	Testicular Pain or Swelling
Fever/Chills	Neck Stiffness	Painful Menstruation
Weight Gain	Breast Lumps	Menopausal Symptoms
Wight Loss	Breast Pain or Discharge	Leg Cramps
Sleeping Trouble	Chest Pain or Discomfort	Varicose Veins
Change in Appetite	Palpitations	Muscle or Joint Pain
Night Sweat	Breathing Difficulties	Joint Stiffness
Itching or Rashes	Swelling	Backache
Lumps or Sores	Cough or Coughing Sputum	Redness
Skin Color Change	Wheezing	Muscle or Joint Tenderness
Changes in Nails or Hair	Trouble Swallowing	Decreased Motion
Headache	Heartburn	Fainting
Dizziness	Nausea	Paralysis
Head Injury	Pregnant	Numbness or Loss of Sensation
Vertigo	Rectal Bleeding	Tingling
Ringing in the Ears	Diarrhea	Radiating Pain
Vision Changes	Abdominal Pain	Tremors
Nasal Congestion/Discharge	Frequent Urination	Heat or Cold Intolerance
Sinus Problems	Difficulty Urinating	Increased Sweating
Hoarseness	Burning or Painful Urination	Excessive Thirst
Nervousness	Kidney Stones	Excessive Hunger
Depression	Bowl or Bladder Changes	Change in Glove/Hat/Shoe Size

Initial ________

Informed Consent Form

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. If anything is unclear, please ask questions before you sign.

The nature of the chiropractic rehabilitation

Doctors of Chiropractic utilize spinal manipulative therapy and other hands on techniques. The doctor may use their hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement. Also, rehabilitation exercises may be required. These exercises may include moving around on the table or floor, with or without stretchy bands, kettlebells or other apparatuses.

Analysis / Examination / Treatment

As a part of the analysis, examination, and treatment, you are consenting to the chiropractic procedures.

This may consist of the following procedures:

Spinal Manipulative Therapy Range of Motion Orthopedic, Muscle Strength Testing

Vital signs Neurological Exam Posture and Functional Testing Hot/Cold Therapy

Palpation Electrical Muscle Stimulation Vibration Therapy Laser Others (Can Explain)

The material risks inherent in chiropractic treatment

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
- Hospitalization
- Surgery

If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Symptoms may increase and over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW

I have read [ ] or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Valcarcel and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Patient or Guardian's Name: ______________________________ Date: ___________________________

Signature: ____ Date: ___________________________

OFFICE POLICIES

HIPAA/PRIVACY: The patient understands and agrees to allow Aligned Integrative Healthcare, LLC to use their Patient Health Information for the sole purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

FINANCIAL POLICY: It is the policy of Aligned Integrative Healthcare, LLC that all balances be paid in full at the time of service unless other arrangements have been made. We accept cash, check, Visa, MasterCard. HSA and FSA cards are also accepted.

CANCELLATION POLICY: We value your time, and appreciate you showing value for ours as well. We real- ize that sometimes emergencies arise, and canceling an appointment might be necessary. We do, however, require a 24-hour notice for cancellations. If you miss an appointment, or cancel with less than the 24-hour notice required, you will be charged a $50 cancellation fee.

ASSIGNMENT AND RELEASE: I assign directly to Aligned Integrative Healthcare, LLC all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic. Furthermore, I authorize the release of my medical records to secure payment and/or to receive medical information pertaining to my case in the facility.

I hereby certify that I understand and agree to the policies set forth by Aligned Integrative Healthcare, LLC.

Date: ______________________

Patient / Legal Guardian Name: ________________________________

Patient Signature: ____ Date: ______________________