PATIENT INTRODUCTION

□ Mr.
□ Mrs.
□ Miss _____ Date _____

First Middle Maiden Last Age____

□ Single □ Married □ Separated □ Divorced □ Widowed

Address _____
STREET CITY ZIP

Home Phone _____ Cell Phone _____

DATE OF BIRTH _____ REFERRED BY_____

ARE YOU MEDICARE ELIGIBLE? ☐ YES ☐ NO

Social Security No. _____

Place of Employment_____Occupation _____

Business Address _____
STREET CITY ZIP

Business Phone _____ E-mail Address _____

Name of person legally and financially responsible (*If patient is a minor, name of parent, guardian, etc.*)

_____

Name of spouse _____Date of Birth _____Occupation_____

Spouse's employer _____ Business Phone _____

Cell _____
STREET CITY ZIP

Name of nearest relative not living with you _____

_____
ADDRESS PHONE

MEDICAL HISTORY

Previous Injuries _____
Previous Back Pain _____
Illnesses _____
Operations _____
Medication(s) _____
Other Physicians _____
Known Abnormalities _____
PURPOSE OF THIS APPOINTMENT _____
When did your current symptoms begin? _____
Other doctors seen for this condition _____
Have you been treated by a physician for any health condition in the last year?
□YES □NO If yes, please describe _____

Have you ever suffered from:

□ Dizziness
□ Backaches
□ Heart Trouble
□ Diabetes
□ Tuberculosis
□ Arthritis
□ Headaches
□ Numbness
□ Asthma
□ Neuritis
□ Digestive Disorders
□ Nervousness
□ Sinus Trouble
□ Anemia
□ Rheumatic Fever
□ Cancer

REGENERATIVE WELLNESS OF ORLANDO, LLC

Marvin R. Terry, D.C.
7600 Dr. Phillips Blvd. #52, Orlando, FL 32819
Phone: (407)298-3090/Fax: (321)293-0111

INFORMED CONSENT FOR TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, to include, but not limited to, various modes of physical therapy and diagnostic x-rays, on me (or the patient named below for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working, or associated with, serving as a back up for the chiropractor below.
I have had the opportunity to discuss with the doctor of chiropractic named below the nature and purpose of chiropractic adjustments and other procedures. I understand the results are not guaranteed.
I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts known, is in my best interest.
Alternative treatment may include: medication, surgery, or physical therapy procedures. As with any procedure there are risks associated with these alternative procedures. If no treatment is sought your condition could get worse, remain the same, or improve.

According to the Federal Food, Drug, and Cosmetic Act, as amended, Section 201 (g) (1), the term "drug" is defined to mean:
Articles intended for use in the diagnostics, cure, mitigation, treatment or prevention of disease. A vitamin, mineral, trace element, enzyme, amino acid, herb, or homeopathic remedy is not a drug. Although, a vitamin, mineral, trace mineral, enzyme, amino acid, herb, or homeopathic remedy may have an effect on any disease process or symptoms, this does not mean that it can be misrepresented, or classified as a drug by anyone.
Therefore, please be advised that any suggested nutritional advice or dietary advice is not intended as any primary treatment and/or therapy for any disease or particular bodily symptom.
Nutritional counseling, vitamin recommendations, nutritional advice, and the adjunctive schedule of nutrition is provided solely to upgrade the quality of foods in the patient's diet in order to supply good nutrition supporting the physiological biomechanical process of the human body.
Evaluation of current nutritional status may employ various techniques including, but not limited to, symptom surveys, physical exam, case history, and reflex muscle testing. These methods of evaluation are not intended to diagnose or rule out any disease or condition but merely to analyze the body's nutritional status.

By signing below, I agree that I have read and understand the above statements and agree to the above named procedures. I have had an opportunity to ask questions about its content and by signing below I agree to the above named procedures. I intend for this consent form to cover the entire course of treatment for my present condition and any future conditions for which I seek treatment.
To be completed by patient's representative, if patient is a minor or is physically or mentally incapacitated.

Patient's Signature Date	Name of Patient
Witness Signature Date	Signature of Patient's Representative
Preliminary Diagnosis	Relationship to Patient

Regenerative Wellness of Orlando, LLC is not a provider of any one insurance. It is important that there be a clear understanding of this, and as a result, a clear understanding of what our procedures are regarding insurance.

You will always be informed of what procedures will be performed before they occur, and you will be informed of the fees associated with those procedures. You are responsible for payment on the date of services.

We do not process insurance forms at this office, nor do we have interactions with insurance companies. Each visit or periodically, we can provide you with an itemized receipt (a "Superbill") with all of the necessary codes and information for you to submit to your insurance company. Your insurance company may reimburse you for a portion of your office visit if you have out-of-network benefits. You assume sole responsibility for obtaining the receipt from us, interacting with your insurance company, and pursuing reimbursement. We do not guarantee reimbursement, although some of our patients do have success.

Ultimately your health choices are yours alone, not any insurance company, their representatives, or a policy manual.

By signing this form, you acknowledge that you are responsible for payment of services rendered and there is no guarantee that your insurance company will reimburse you for any procedures and treatment.

_____ _____

Patient Name Date

_____

Patient Signature

4 Key Stressors Questionnaire

Patient Name: _____ **Date:** _____

Please circle **yes** or **no** for each of the following questions. Please fill in the Other sections for any unlisted issues related to each category.

After identifying and reviewing your primary stressor(s) with your health care provider, please refer to the corresponding chapter **(Chapter 1: Blood Sugar Control, Chapter 2: Mental and Emotional Stress, Chapter 3: Overcoming Insomnia, Chapter 4: Reducing Inflammation)** in the SOS Stress Recovery Program Patient Handbook for lifestyle, dietary and nutrient therapy recommendations.

Blood Sugar Imbalance

- Do you experience symptoms of hypoglycemia such as dizziness, shakiness or brain fog between or following meals? Y N
- Do you frequently miss or delay meals? Y N
- Do you frequently crave sugar or carbohydrates? Y N
- Do you consume excessive sugar or refined carbohydrates? Y N
- Are you diabetic or pre-diabetic? Y N
- Do you regularly consume alcohol or caffeine? How much per day? _____ Y N
- Do you consume food within two hours before bedtime? Y N
- Other _____

Mental and Emotional Stress

- Do you frequently experience anxiety? Y N
- Do you suffer from depression? Y N
- Do you suffer from mood swings? Y N
- Do you have difficulty getting motivated? Y N
- Do you frequently experience feelings of agitation, anger, fear or worry? Y N
- Do you consider your job, relationships or finances stressors in your daily life? Y N
- Are you a caregiver for a parent or disabled child? Y N
- Other _____

Sleep Cycle Disturbances

- Are you experiencing problems falling asleep? Y N
- Are you experiencing difficulty staying asleep? Y N
- Are you sleeping less than 7-9 hours each night? Y N
- Do you awaken not feeling well-rested in the morning? Y N
- Do you work 2nd or 3rd shift or keep late night hours? Y N
- Do you use electronic devices within two hours before bed? Y N
- Do you eat within two hours of bedtime? Y N
- Do you frequently feel drowsy throughout the day? Y N
- Do you snore? Y N
- Other _____

Inflammatory Imbalance or Chronic Pain

- Musculoskeletal: Do you suffer from headaches, muscle, back or joint pain? Y N
- Gastrointestinal: Do you suffer from IBS, Crohn's disease or diverticulitis? Y N
- Dermatological: Do you suffer from hives, eczema or psoriasis? Y N
- Respiratory: Do you suffer from asthma, bronchitis, seasonal allergies or hay fever? Y N
- Autoimmune: Do you suffer from any autoimmune condition such as MS, lupus or rheumatoid arthritis? Y N
- Immunological: Do you suffer from food allergies, chronic infections or frequent Illness? Y N
- Other _____