

Total Health of Wesley Chapel, Inc.

20433 Bruce B Downs Blvd
Tampa Florida 33647
(813) 994-0151

38111 5th Ave
Zephyrhills, FL 33541
(813) 355-4818

INFORMED CONSENT FOR CHIROPRACTIC TREATMENT

Based on your medical history, physical examination, and diagnostic studies, the doctor at Total Health of Wesley Chapel Inc. is recommending a trial course of chiropractic therapy. This may include chiropractic manipulation and physical therapy treatment for your complaint. There are many types of treatment options available in your case and as such, alteration in your treatment may be employed. **While it's true that many patients respond quickly, I anticipate your care to last from one to three months.**

While the doctor believes this recommended treatment to be reasonable and necessary and the anticipated benefits to far outweigh their risks, some patients understandably wonder what complications might occur. The doctor thinks you should be made aware of these risks before beginning your treatment.

For the vast majority of patients, there are few, if any, risks. Most of the risks are minimal; such as increased muscle, spinal or extremity pain. If you notice any increase in symptoms please inform the doctor as soon as possible, (alterations in your care may be required). In some patients, more serious complications have occurred; such as broken bones, disc injuries and/or exacerbation, paralysis of the legs or arms; injuries to organs and/or tissue (burns) and/or a vascular accident causing stroke. While none of these complications had ever occurred in this office, nor is it the intent to inflict said complications; should they occur in your case, you would be referred immediately to the appropriate health care provider for treatment, intervention and/or surgery.

This consent is designed to inform you and not scare you. Thus, if you have any questions the doctor will be glad to discuss them with you before beginning treatment.

Sincerely,

Dr. Thomas A. Ladanyi, D.C
Dr. Nathan A. Jones, D.C.

I have read and understand the above consent form and understand the risks of the recommended treatment. The treatment and the risks of the treatment, along with the alternatives to treatment including but not limited to one of the following options (orthopedic or neurosurgical evaluation and/or alternative medical doctors, o\and/or do nothing) have also been fully verbally explained to me by the doctor. I understand and consent to treatment being delivered by Dr. Ladanyi and/or (whomever he may designate as his assistants). I nonetheless do consent for Total Health of Wesley Chapel Inc. to provide their recommended chiropractic therapy. **I also certify that no guarantee or assurance of results has been made.**

Date:_____

Patient's signature:_____

Witness signature: _____

TOTAL HEALTH OF WESLEY CHAPEL

20433 Bruce B. Downs Blvd.
Tampa, FL 33647

Dr. Thomas A. Ladanyi
Chiropractic Physician

38111 5th Avenue
Zephyrhills, FL 33541

PATIENT INFORMATION:

(Please Print)

Date _____ 201__

Name _____ SS# _____ - _____ - _____
First Middle Initial Last

Address: _____
Street City State Zip Code

Phone: Home # _____ Work # _____ Cell# _____

E-mail Address: _____@_____.com

Female Male DOB / / Age _____ Whom may we thank for referring you to us? _____

(Please check one)

Minor Married Divorced Widowed Single Separated

SYMPTOMS:

Are you: Right-handed Left-handed Ambidextrous

Describe your symptoms _____

How often? Constantly (76-100%) Frequently (51-75%) Occasionally (26-50%) Intermittently (0-25%)

When did you first notice the symptoms (or date of accident)? _____

Is this condition getting progressively worse? _____

Where specifically is the problem located? _____

How did your symptoms begin? _____

What describes the nature of your symptoms?

Sharp Shooting Dull ache Burning Numb Tingling Other _____

How are your symptoms changing? Getting better Not changing Getting Worse

Whom have you seen for your symptoms?

No one Other chiropractor _____ Medical Doctor Other _____

What treatment and/or test did you receive and when?

X-rays /CT Scan/ MRI/ Other: _____

Medication (*circle*) Aspirin Tylenol Ibuprofen Other _____

Which activities are difficult to perform? Sitting Standing Walking Bending Laying down

Rising Other: _____

Rate the severity of your pain (1 mild pain or discomfort to 10 severe pain): 1 2 3 4 5 6 7 8 9 10

Is the pain constant or does it come and go? _____

HEALTH HISTORY: *(check only those conditions which are applicable)*

- | | | | | |
|---|-------------------------------------|---|---|--|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Prostate Problems |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cancer | <input type="checkbox"/> Hernia | <input type="checkbox"/> Measles | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Herniated Disc | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fractures | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Tumors, Growths |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Polio | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Other _____ | | | | |

Previous Surgeries and Dates: _____

Dates of last exams _____ (Women) Date of last menstrual cycle: _____

Please list ALL medications you are currently taking: _____ Allergies: _____

Blood Pressure _____

Diabetes _____

Other _____

(Please use back of sheet for additional space)

DAILY HABITS:

What type of exercise do you perform on a daily basis? None Moderate Heavy

What do your daily work habits include? (ex: sitting, standing, light labor, heavy labor, computer work)

What vitamins do you currently take? _____

What other nutritional supplements do you take (if any)? _____

Do you smoke? Yes No How much per day? _____

How much liquor do you consume on a weekly basis? _____

How much coffee or caffeinated beverages do you consume on a daily basis? _____

Receipt of Notice of HIPPA Privacy Practices Written Acknowledgement form

I have been given a copy, and/or been asked by the staff of Total Health of Wesley Chapel to read a copy of their Notice of HIPPA Patient Privacy Practices and as it pertains to Total Health of Wesley Chapel.

**Signature of Patient or Parent
Or Legal Guardian**

Date

AUTHORIZATION:

I certify that the information provided is accurate to the best of my knowledge. I further understand that giving incorrect information can be dangerous to my health. I authorize this office to release any information, including the diagnosis and the records of any treatment or examination rendered to me during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company pay directly to TOTAL HEALTH OF WESLEY CHAPEL, INC.; I further understand that my chiropractic insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependants.

X _____

Signature of Patient (or parent if a minor child)

Date