# SOUTHERN CHIROPRACTIC LIFE CENTER

Dr. David N. Migdal, D.C.
10345 Southern Boulevard
Royal Palm Beach, Florida 33411
(561) 790-6388

**Confidential patient health record**

Date _____

Name _____ Home Phone: _____

Street _____ Apt.# ____ City _____ Zip Code _____

Age _____ Birth Date _____ Marital Status: Single __ Married __ Widow(er) __ Divorced __ How Many Children _____

Occupation _____ Employer _____

Address _____ Office Phone: _____

Name of Wife or Husband _____ Occupation _____

Employer _____ Office Phone: _____

Patient's Nearest Relative _____ Phone: _____

Referred by _____ If insurance claim, name of company _____

Present family doctor _____ Address _____

Date of last physical examination _____ By Doctor _____

**List present complaints:**

1. _____ For how long _____
2. _____ For how long _____
3. _____ For how long _____
4. _____ For how long _____
5. _____ For how long _____

Cause of injury/illness _____

_____

_____

Remarks _____

_____

_____

**List other doctors consulted for this condition(s):**

Name _____ Address _____

Diagnosis _____ Results _____

Name _____ Address _____

Diagnosis _____ Results _____

Name _____ Address _____

Diagnosis _____ Results _____

**What surgery have you had:**

Type _____ When _____ Doctor _____

Type _____ When _____ Doctor _____

Type _____ When _____ Doctor _____

Type _____ When _____ Doctor _____

Type _____ When _____ Doctor _____

Remarks _____

_____

**List serious accidents and falls:**

What _____ When _____

What _____ When _____

What _____ When _____

Remarks _____

_____

**List fractures:**

What _____ When _____

What _____ When _____

Remarks _____

_____

**List medications and/or diet supplements you take:**

What _____ Frequency _____ Doctor _____

What _____ Frequency _____ Doctor _____

What _____ Frequency _____ Doctor _____

What _____ Frequency _____ Doctor _____

Remarks _____

_____

**Check any of the following diseases you have or have had:**

- ❑ Appendicitis
- ❑ Aids Virus
- ❑ Diphtheria
- ❑ Typhoid fever
- ❑ Pneumonia
- ❑ Rheumatic fever
- ❑ Polio
- ❑ Malaria
- ❑ Tuberculosis
- ❑ Whooping cough
- ❑ Anemia
- ❑ Measles
- ❑ Mumps
- ❑ Small Pox
- ❑ Chicken pox
- ❑ Diabetes
- ❑ Cancer
- ❑ Heart Attack
- ❑ Goiter
- ❑ Influenza
- ❑ Pleurisy
- ❑ Alcoholism
- ❑ Venereal infection
- ❑ Arthritis
- ❑ Epilepsy
- ❑ Mental disorder
- ❑ Lumbago
- ❑ Eczema

**Check any of the following you have or have had repeatedly in the past five years:**

## General symptoms

- ❑ Headache
- ❑ Fever
- ❑ Chills
- ❑ Sweats
- ❑ Fainting
- ❑ Dizziness
- ❑ Convulsions
- ❑ Loss of sleep
- ❑ Fatigue
- ❑ Nervousness
- ❑ Loss of weight
- ❑ Numbness or pain in arms, hands or legs
- ❑ Allergy
- ❑ Neuralgia

## Eyes, ears, nose and throat

- ❑ Failing vision
- ❑ Near sightedness
- ❑ Crossed eyes
- ❑ Eye pain
- ❑ Deafness
- ❑ Earache
- ❑ Ear noises
- ❑ Ear discharge
- ❑ Nose bleeds
- ❑ Nasal obstruction
- ❑ Sore throat
- ❑ Hoarseness
- ❑ Hay fever
- ❑ Asthma
- ❑ Dental decay
- ❑ Gum trouble
- ❑ Frequent colds
- ❑ Enlarged thyroid
- ❑ Tonsillitis
- ❑ Sinus infection
- ❑ Nasal drainage
- ❑ Enlarged glands

## Skin

- ❑ Skin eruptions
- ❑ Itching
- ❑ Bruises easily
- ❑ Dryness
- ❑ Boils
- ❑ Varicose veins
- ❑ Sensitive skin
- ❑ Hives or allergy

## Respiratory

- ❑ Chronic cough
- ❑ Spitting up phlegm
- ❑ Spitting up blood
- ❑ Chest pain
- ❑ Difficult breathing

## Cardio-vascular

- ❑ Rapid beating heart
- ❑ Slow beating heart
- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Pain over heart
- ❑ Previous heart stroke
- ❑ Hardening of arteries
- ❑ Swelling of ankles
- ❑ Poor circulation
- ❑ Paralytic stroke

## Muscle and joint

- ❑ Stiff neck
- ❑ Back ache
- ❑ Swollen joints
- ❑ Tremors
- ❑ Painful tail bone
- ❑ Foot trouble
- ❑ Pain between shoulders
- ❑ Hernia
- ❑ Spinal curvature
- ❑ Faulty posture

## Genitourinary

- ❑ Frequent urination
- ❑ Painful urination
- ❑ Blood in urine
- ❑ Pus in urine
- ❑ Kidney infection or stones
- ❑ Bed wetting
- ❑ Inability to control urine
- ❑ Prostate trouble

## Gastrointestinal

- ❑ Poor appetite
- ❑ Excessive hunger
- ❑ Belching or gas
- ❑ Nausea
- ❑ Vomiting
- ❑ Vomiting of blood
- ❑ Pain over stomach
- ❑ Distention of abdomen
- ❑ Constipation
- ❑ Diarrhea
- ❑ Colon trouble
- ❑ Hemorrhoids (Piles)
- ❑ Intestinal worms
- ❑ Liver trouble
- ❑ Gall bladder trouble
- ❑ Jaundice
- ❑ Colitis

## Female

- ❑ Painful menstrual periods
- ❑ Excessive flow
- ❑ Hot flashes
- ❑ Irregular cycle
- ❑ Cramps or back ache
- ❑ Previous miscarriage
- ❑ Vaginal discharge
- ❑ Congested breast
- ❑ Lumps in breast
- ❑ Menopausal symptoms

**IF YOURS IS AN ACCIDENTAL INJURY PLEASE COMPLETE THE INFORMATION REQUESTED ON THE REVERSE SIDE**

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's 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 the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminated my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature _____ SS# _____ Date _____

Guardian or Spouse's Signature Authorizing Care _____ Date _____

Please return this completed form to the receptionist.

**Southern Chiropractic Life Center**
**10345 Southern Boulevard**
**Royal Palm Beach, Florida 33411**
**(561) 790-6388**

**Patient Name:** _____ **Date:** _____

**Instructions:** These questions ask for your views about how your pain affects how you function in everyday activities. Please answer every question and mark **ONE** number on **EACH** scale that best describes how you feel.

**Does your pain interfere with your normal work inside and outside the home?**

Work normally — Unable to work at all

0 1 2 3 4 5 6 7 8 9 10

**Does your pain interfere with personal care (such as washing, dressing, etc.)?**

Take care of myself completely — Need help with all my personal care

0 1 2 3 4 5 6 7 8 9 10

**Does your pain interfere with your traveling?**

Travel anywhere I like — Only travel to see doctors

0 1 2 3 4 5 6 7 8 9 10

**Does your pain affect your ability to sit or stand?**

No problems — Cannot sit/stand at all

0 1 2 3 4 5 6 7 8 9 10

**Does your pain affect your ability to lift overhead, grasp objects, or reach for things?**

No problems — Cannot do at all

0 1 2 3 4 5 6 7 8 9 10

**Does your pain affect your ability to lift objects off the floor, bend, stoop, or squat?**

No problems — Cannot do at all

0 1 2 3 4 5 6 7 8 9 10

**Does your pain affect your ability to walk or run?**

No problems — Cannot walk/run at all

0 1 2 3 4 5 6 7 8 9 10

**Has your income declined since your pain began?**

No decline — Lost all income

0 1 2 3 4 5 6 7 8 9 10

**Do you have to take pain medication every day to control your pain?**

No medication needed — On pain medication throughout the day

0 1 2 3 4 5 6 7 8 9 10

**Does your pain force you to see doctors much more often than before your pain began?**

Never see doctors — See doctors weekly

0 1 2 3 4 5 6 7 8 9 10

**Does your pain interfere with your ability to see the people who are important to you as much as you would like?**

No problem — Never see them

0 1 2 3 4 5 6 7 8 9 10

**Does your pain interfere with recreational activities and hobbies that are important to you?**

No interference — Total interference

0 1 2 3 4 5 6 7 8 9 10

**Do you need the help of your family and friends to complete everyday tasks (including work outside the home and housework) because of your pain?**

Never need help — Need help all the time

0 1 2 3 4 5 6 7 8 9 10

**Do you now feel more depressed, tense, or anxious than before your pain began?**

No depression/tension — Severe depression/tension

0 1 2 3 4 5 6 7 8 9 10

**Are there emotional problems caused by your pain that interfere with your family, social, and/or work activities?**

No problems — Severe problems

0 1 2 3 4 5 6 7 8 9 10

**The PDQ scores can be divided into 5 distinct categories: no disability (score of 0), mild (scores of 1-70), moderate (scores of 71-100), severe (scores of 101-130), and extreme (scores of 131-150).**

| Pain Disability | Questionnaire Score | Grade Modifier |
|---|---|---|
| 0 | No disability | 0 |
| 1-70 | Mild disability | 1 |
| 71-100 | Moderate disability | 2 |
| 101-130 | Severe disability | 3 |
| 131-150 | Extreme disability | 4 |

# INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on 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 or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic.

I have had the opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures.

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 wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

---

To be completed by patient:

_____
Print Patient's Name

_____
Signature of Patient

_____
Date Signed

To be completed by patient's representative, if necessary
e.g. if patient is a minor or physically or legally incapacitated.

_____
Print Name of Patient

_____
Print Name of Patient's Representative

_____
Signature of Patient's Representative

As: _____
Relationship or Authority of Patient's Representative

_____
Date Signed

To be completed by doctor or staff
Name and address of clinic/office:

SOUTHERN CHIROPRACTIC LIFE CENTER
10345 Southern Boulevard
Royal Palm Beach, FL 33411
Dr. David N. Migdal, D.C.
(561) 790-6388

_____
Witness to Patient's Signature:

_____
Translated by:

Print name(s) of doctor(s) treating this patient:

DR. DAVID N. MIGDAL, D.C.

_____

Date: _____

Date: _____

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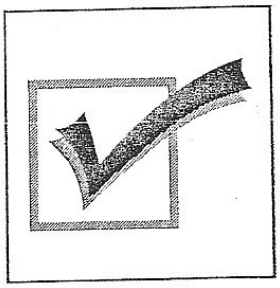
DAVID N. MIGDAL D.C.
10345 SOUTHERN BLVD.
ROYAL PALM BEACH, FL. 33411
561-790-6388



IN ORDER TO PROTECT YOU, THE PATIENT, WE NEED TO BE ASSURED THAT IF THE DOCTOR NEEDS TO ORDER X-RAYS, FOR DIAGNOSIS PURPOSES, THAT THERE IS NO POSSIBILITY OF PREGNANCY.

## PLEASE CHECK ONE:

_____There is NO possibility of me being pregnant.

_____There is a possibility of me being pregnant. (Not sure)

_____There is a definite possibility that I am pregnant.

_____
PRINT PATIENT NAME

_____
SIGNATURE & DATE

# SOUTHERN CHIROPRACTIC LIFE CENTER
## DR.DAVID N. MIGDAL D.C.

### DIRECT PAYMENT AUTHORIZATION WITHOUT ASSIGNMENT OF BENEFITS
PRIVATE AND GROUP ACCIDENT AND HEALTH INSURANCE

I hereby instruct and direct the_____Insurance Company to pay by check made out and mailed directly to:

SOUTHERN CHIROPRACTIC LIFE CENTER

**DR.DAVID N.MIGDAL D.C**
10345 SOUTHERN BOULEVARD
ROYAL PALM BEACH, FL
33411
561 790-6388

If my current policy prohibits direct payment to the doctor, then I hereby also instruct and direct you to make out the check to me and mail as follows:

c/o:
**SOUTHERN CHIROPRACTIC LIFE CENTER**
**10345 SOUTHERN BOULEVARD**
**ROYAL PALM BEACH, FL. 33411**

The professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. **THIS IS A DIRECT PAYMENT AUTHORIZATION AND NOT AN ASSIGNMENT OF BENEFITS.** This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

**A PHOTOCOPY OF THIS DOCUMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.**

I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in this case.

**Dated at_____this_____day of___200__.**

**Signature of Policyholder:_____ Witness_____**

**Signature of Claimant if other that Policyholder_____**