Chery Chiropractic Center
1900 Crystal drive Suite 1
Fort Myers, FL 33907
239-936-6566

CHERY CHIROPRACTIC CENTER
CARINE CHERY, D.C.
1900 CRYSTAL DRIVE, STE.1
FORT MYERS, FL 33907
TELEPHONE: (239) 936 6566
FAX: (239) 936 6442

Welcome,

I would like to take a moment and welcome you to our office. You have choices as to where you seek healthcare and I appreciate and feel honored you would choose this office to address your most important asset-your health.

Our goal today is to determine whether chiropractic is a good option for your condition. If it is, then I would love to help you. If it is not, I will refer you to the appropriate provider. Please complete the attached paperwork. It is lengthy and for that, I apologize. Thoroughness offers few "shortcuts". If you have any questions, please ask.

The kind referrals of our patients have allowed us to successfully treat many patients. It is my sincere hope that my unique experience and expertise will help lead you to better health as well.

Thanks again for choosing Chery **Chiropractic Center.** I look forward to serving you.

Respectfully,

Dr. Carine Chery D.C.
Chiropractic Physician

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PERSONAL INJURY INTAKE

Patient Name:______________________________ Birth Date: ____________ Age:_______ Sex: M / F

Address:_____________________________________ City:_________________ State:_____ Zip:_______

Phone: (_____)_____________ Work Phone: (_____)________________ Cell Phone: (_____)__________

Email: ______________________________ Occupation:____

Employer:_____________________ Years Employed: ________ D.L. #:__________________________

SS #:_______________ Marital Status:______________

In Case of Emergency, Please Contact: __________________ Phone:(___)_________ Relation:__________

If telephone correspondence is needed is it okay to leave a message with either a person/machine in regard to your treatment **(please check yes or no).** ☐ **YES** ☐ **NO**

Please fill out personal insurance info, if applicable and hand insurance card to the front desk to copy.

Your Ins. Co.:__________________________ Policy/ID #:________________ Agent's Name:___________

Ins. Co. Phone #:___________________________ Insurance Claim #:______________________________

Name on Policy (if other than self):______________________________ Policy #:____________________

Please fill out responsible party's insurance info., if applicable

Responsible Party's Name:____

Address:____________________________ City:______________________ State:_______ Zip:_________

Responsible Party's Insurance Carrier: ________________________ Phone #: (____)_________________

Responsible Party's Policy #:_________________________________ Claim #:________________________

INFORMATION ABOUT YOUR ACCIDENT

1. Name:___________________________________ Phone:(____)_____________ Fax:(_____)_________
2. Were You: ( ) Driver ( ) Passenger ( ) Front Seat ( ) Back Seat
3. Number of people in your vehicle? _______________ Were you wearing a seat belt? (Yes) (No)
4. What direction were you headed? ( ) North ( ) East ( ) South ( ) West
5. What direction was the other vehicle headed? ( ) North ( ) East ( ) South ( ) West

   Name of street _____________________________
6. Were you struck from: ( ) Behind ( ) Front ( ) Left Side ( ) Right Side
7. Approximate speed of you car _______ mph. Other car _______ mph
8. Were you knocked unconscious? ( ) Yes ( ) No If yes, for how long? ______________________
9. Were police notified? ( ) Yes ( ) No
10. In your own words, please describe the accident: ____

____

____

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11. Did you have any physical complaints BEFORE THE ACCIDENT ( ) Yes ( ) No

If yes, describe:____

12. Please describe how you felt:

a. DURING the accident: ____

b. IMMEDIATELY AFTER the accident: _______________________________

c LATER THAT DAY: ____

d. THE NEXT DAY: ____

13. What are your present complaints and symptoms?

____

____

14. Do you have any previous illnesses which relate to this case? ( ) Yes ( ) No

If yes, please describe:____

15. Have you ever been involved in an accident before? ( ) Yes ( ) No

If yes, please describe, including date(s) and type(s) of accidents as well as injuries received:

____

16. Where were you taken after your current accident?______________________________

17. Have you been treated by another doctor since the accident? ( ) Yes ( ) No

If yes, names:____

18. Since this injury occurred, are your symptoms: ( ) Improving ( ) Getting Worse ( ) Same

19. Check symptoms you have noticed SINCE the ACCIDENT:

( ) Headache	( ) Irritability	( ) Numbness-Toes	( ) Face Flushed	( ) Feet Cold	( ) Neck Pain
( ) Chest Pain	( ) Shortness-Breath	( ) Buzzing in Ear	( ) Hands Cold	( ) Neck Stiff	( ) Dizziness
( ) Fatigue	( ) Loss of Balance	( ) Stomach Upset	( ) Sleeping Problem	( ) Head is Heavy	( ) Depression
( ) Fainting	( ) Constipation	( ) Back Pain	( ) Pins/Needles Arms	( ) Light Sen. Eyes	( ) Loss of Smell
( ) Cold Sweats	( ) Nervousness	( ) Loss of Memory	( ) Pins/Needles Legs	( ) Loss of Taste	( ) Fever
( ) Tension	( ) Ears Ring	( ) Diarrhea	( ) Numbness-Finger	( ) ______________________	

20. Have you lost time from work as a result of this accident? ( ) Yes ( ) No

a. Last day worked: ____

b. Type of employment: ____

c. Present Salary: ____

d. Are you being compensated for time lost from work? ( ) Yes ( ) No

If yes, type of compensation you are receiving: ____________________________

21. Do you notice any activity restrictions as a result of this injury? ( ) Yes ( ) No

If yes, please describe:____

22. Other pertinent information: ____

____

I agree to the following: All services rendered to me are charged directly to me and that I am personally responsible for payment. If I suspend or terminate my care and treatment, fees for services rendered to me will be immediately due and payable. All cancellations must be made 24 hours in advance. "No Show" and Late Cancellations will be assessed a $25 fee.

______________________________ ______________________________ ____________________

Patient's Signature | Print Patient Name | Date

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IMPORTANT: Please check (X) all present symptoms

Head:

- ☐ Headache
  - Sinus (allergy)
  - Entire Head
  - Back of Head
  - Forehead
  - Temples
  - Migraine
- ☐ Head feels heavy
- ☐ Loss of memory
- ☐ Light-Headedness
- ☐ Fainting
- ☐ Light bother eyes
- ☐ Blurred vision
- ☐ Double vision
- ☐ Loss of vision
- ☐ Loss of taste
- ☐ Loss of balance
- ☐ Dizziness
- ☐ Loss of hearing
- ☐ Pain in ears
- ☐ Ringing in ears
- ☐ Buzzing in ears

Neck:

- ☐ Pain in neck
- ☐ Neck pain with movement
  - Forward
  - Backward
  - Turn to left
  - Turn to right
  - Bend to left
  - Bend to right
- ☐ Pinched nerve in neck
- ☐ Neck feels out of place
- ☐ Muscle spasms in neck
- ☐ Grinding sounds in neck
- ☐ Popping sounds in neck
- ☐ Arthritis in neck

Arms and Hands;

- ☐ Pain in upper arm/elbow
- ☐ Loss of grip strength
- ☐ Aggravated by movement
- ☐ Tennis elbow
- ☐ Pain in forearm
- ☐ Pain in hands
- ☐ Pain in fingers
- ☐ Sensation of pins and needles in arms
- ☐ Sensation of pins and needles in fingers
- ☐ Numbness in arms (R / L)
- ☐ Fingers go to sleep
- ☐ Hands cold
- ☐ Swollen joints in fingers
- ☐ Sore joints in fingers

Shoulders:

- ☐ Pain in shoulder joint (R / L)
- ☐ Pain across shoulders
- ☐ Bursitis (R / L)
- ☐ Arthritis (R / L)
- ☐ Can't raise arm above shoulder
- ☐ Can't raise arm over head
- ☐ Tension in shoulders
- ☐ Pinched nerve in shoulder (R / L)
- ☐ Muscle spasms in shoulders

Mid Back:

- ☐ Mid-back pain
- ☐ Location ________________
- ☐ Pain between shoulder blades
- ☐ Sharp stabbing
- ☐ Dull ache
- ☐ Pain from front to back
- ☐ Muscles spasms
- ☐ Pain in kidney area

Chest:

- ☐ Chest Pain
- ☐ Shortness of breath
- ☐ Pain around ribs
- ☐ Breast pain
- ☐ Irregular heartbeat

Abdomen:

- ☐ Nervous stomach
- ☐ Can't eat certain food
- ☐ Nausea
- ☐ Gas
- ☐ Constipation
- ☐ Diarrhea
- ☐ Hemorrhoids

Low Back:

- ☐ Low back pain
- ☐ Slipped disc
- ☐ Low back feels out of place
- ☐ Muscle spasm
- ☐ Arthritis
- ☐ Worse when working
- ☐ Worse with lifting
- ☐ Worse with standing
- ☐ Worse with sitting
- ☐ Worse with bending
- ☐ Worse with coughing
- ☐ Worse with lying down/sleeping
- ☐ Worse with walking

Hips, Legs, and Feet:

- ☐ Pain in buttocks
- ☐ Pain in hip joint
- ☐ Pain down leg(s)
- ☐ Knee pain
- ☐ Leg cramps
- ☐ Cramps in feet
- ☐ Pins/needles
- ☐ Leg numbness
- ☐ Toes numbness
- ☐ Cold feet
- ☐ Swollen ankles
- ☐ Swollen feet

Women Only:

- ☐ Menstrual pain where __________
- ☐ Cramping
- ☐ Irregularity
- ☐ Cycle _____days
- ☐ Birth control type ____________
- ☐ Hysterectomy
- ☐ Genital cancer
- ☐ Discharge
- ☐ Menopause
- ☐ Tumors
- ☐ Abortions
- ☐ Pregnant

Men Only:

- ☐ Urinary freq.
- ☐ Difficulty w/start
- ☐ Night urination
- ☐ Prostate prob.

General:

- ☐ Nervousness
- ☐ Irritable
- ☐ Depressed
- ☐ Fatigue
- ☐ Normal sleep
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Gain weight
- ☐ Coffee________
- ☐ Tea __________
- ☐ Cigarettes _____
- ☐ Other ________
- ☐ Diabetes
- ☐ Hypoglycemia

List any Surgeries: ____
____
____
____

Patient's Signature: ____ Date:__________________________

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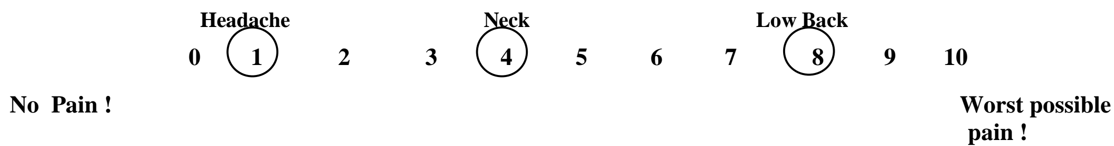
QUADRUPLE VISUAL ANALOGUE SCALE

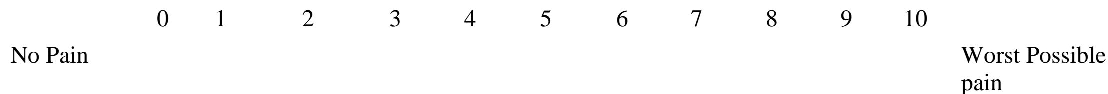
_______________________________________ ________________
Patient Name Date

Please read the instructions carefully:
Please circle the number that best describes the question being asked.

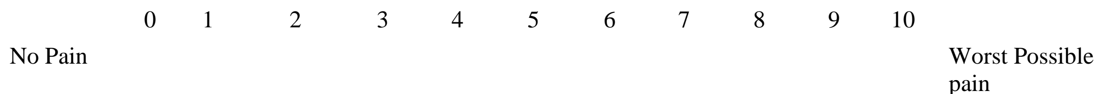
Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint.
Example:



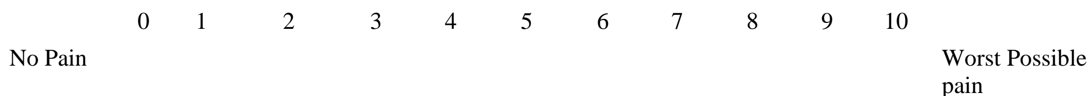
1. **What is your pain RIGHT NOW?**



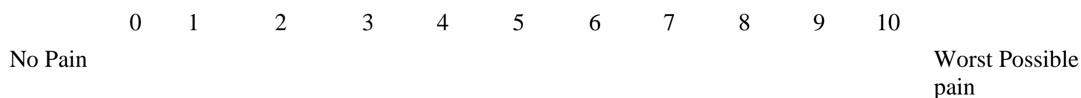
2. **What is your TYPICAL or AVERAGE pain?**

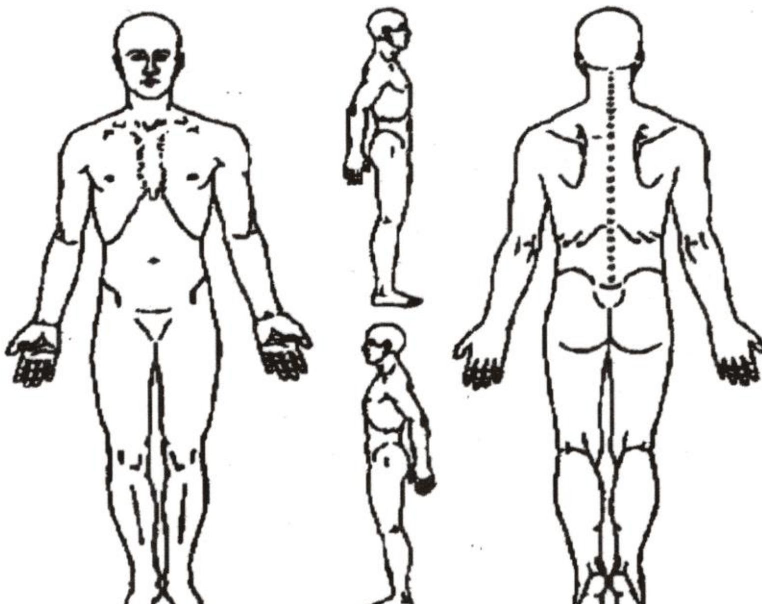


3. **What is your pain level AT ITS BEST (How close to “0” does your pain get at its best)?**



4. **What is your pain level AT ITS WORST (How close to “10” does your pain get at its worst)?**





On the diagram to the left, please indicate where you are experiencing pain **right now.** Please illustrate using the legend below.

A = ACHE B = BURNING

N = NUMBNESS P = PINS & NEEDLES

S = STABBING S = SHOOTING

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PERSONAL INJURY FINANCIAL AGREEMENT

I would like to take a moment to welcome you to our office and to assure you that you will receive the very best care available for your injury. In order to familiarize you with the financial policy of our office, I would like to explain how your medical bills will be handled.

PARTY RESPONSIBLE:

If you were involved in an auto accident in your own vehicle, we will bill the medical payments portion or Personal Injury Protection portion of your insurance policy to cover the treatment charges incurred in our office.

MEDPAY: If you were a passenger in another vehicle, the insurance company which ensures the automobile may be billed for your medical services incurred.

PIP (Personal Injury Protection): If you were a passenger in another vehicle, and you own a car that has PIP coverage, the insurance company which carries your policy will be responsible to pay your medical bills.

3rd PARTY: If another vehicle has caused the accident, they will first bill your automobile MedPay or PIP. If the third party is being billed and awaiting payment, payment will be due upon settlement and closing of the case.

ATTORNEY LIENS:

If you hire an attorney to represent you in a lawsuit, it is our policy to have your attorney sign a Doctor's Lien. This will guarantee direct payment to our office for any undid balance upon the settlement of your lawsuit. We retain the right to first submit all charges to your private and/or auto insurance policy for payment. Further, this office does not discount or reduce the amount of your balance based upon the outcome of your settlement.

RESPONSIBILITY FOR PAYMENT:

As a courtesy to you, we will gladly submit your charges to your insurance company and/or your attorney; however, all services rendered by this office are charged directly to you, and ultimately, you are personally responsible for payment of these charges, regardless of any insurance reimbursement or settlement you may or may not receive.

Once again, I welcome you to our office. I hope that this has answered any questions that you might have about our financial arrangement. If, at any time, you have further questions about your care, please do not hesitate to ask.

I have read and agree to the above.

____________________________________ ________________
Patient's Signature Date

____
Printed Patient Name

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NOTICE OF DOCTOR'S LIEN

Patient:______________________________________ Date of Accident:________________

I do hereby authorize Dr. Carine Chery DC to furnish you, my attorney and/or third-party insurance, with a full report of her examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was recently involved.

I hereby authorize and direct you, my attorney and/or third-party insurance, to pay directly to said doctor such sums as may be due and owing her for the medical services rendered me both by reason of this accident and by reason of any other bills that are due to her office and to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect and fully compensate said doctor. And I hereby further give a Lien on my case to said doctor against any and all proceeds of my settlement, judgment, or verdict which may be paid to you, my attorney, or myself, as a result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by her for service rendered to me and that this agreement is made solely for said doctor's additional protection and in consideration of her awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover said fee.

I agree to promptly notify said doctor of any change or addition of attorney(s) and/or third-party insurance used by me in connection with this accident, and I instruct my attorney and/or third-party insurance to do the same and to promptly deliver a copy of this lien to any such substituted attorney(s).

Please acknowledge this letter by signing below and returning to the doctor's office. I have been advised that if my attorney and/or third-party insurance does not wish to cooperate in protection the doctor's interest, the doctor will not await payment and may declare the entire balance due and payable.

________________ ____

Dated Patient's Signature

The undersigned being an attorney and/or third-party insurance of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment, or verdict, as may be necessary to adequately protect and fully compensate said doctor above-named. Attorney and/or third-party insurance further agrees that in the event this lien is litigated, that the prevailing party will be awarded attorney fees and costs.

________________ ____

Dated Attorney and/or third-party Signature

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ASSIGNMENT OF BENEFITS/DIRECT PAYMENT AUTHORIZATION/ MEDICAL RELEASE AND POWER OF ATTORNEY

I, ____ hereinafter ASSIGNOR, hereby authorize
(Name of Insured Patient)

__________________________________ To pay directly to _____________________________________
(Name of Medical Provider)

Hereinafter ASSIGNEE, the medical benefits otherwise payable to me for their services, but not to exceed the charges for those services. I hereby ASSIGN any benefits or causes of action under any policy of insurance, indemnity agreement, or any other collateral source as defined in Florida Statutes for any services and or charges provided ASSIGNEE agreeing to await payment from the above-named insurance carrier for all payments due and payable pursuant to the ASSIGNOR'S contract of insurance. This ASSIGNMENT OF BENEFITS is IRREVOCABLE unless subsequent revocation is in writing.

By way of the original or copy hereof, I, the undersigned patient herby direct the applicable personal injury protection and/or medical payments insurance carrier to make payment directly to the above-named health care provider for services/supplies which were necessitated by a motor vehicle accident. Additionally, I hereby authorize and direct the applicable personal injury protection and/or medical payments insurance carrier to make any checks payable to **Dr. Chery** only and to forward it to its place of business. This authorization for direct payment should not be deemed an assignment of benefits in that, I, the patient, at this time retain all rights to enforce my applicable insurance contract. Furthermore, this payment authorization transfers no right, title or interest in a said contract other than the ability to receive direct payment as specified hereinabove. I authorize **Dr. Chery** to sign my name to any check written in my name or both our names where such checks are in payments for services regarding my injury.
As part of this direct payment authorization without assignment or rights or benefits, I hereby instruct the insurance carrier that in the event the subject medical benefits are disputed for any reason, including medical reasonableness and or necessity, that the amount of benefits claimed by **Dr. Chery**, is to be set aside and not disbursed until the dispute is resolved. This assignment of benefits serves as appropriate notice to gain priority in the distribution of benefits. I further authorize the release of any and all insurance benefits information and/or medical benefits information necessary to process this claim.

IN WITNESS WHEREOF of undersigned ASSIGNOR and ASSIGNEE have hereunto set their hands, this ________ day of _______________, 20____.

______________________________ ___________________________________
Patient's Signature Date

________________________________ __________________ ________________
Patient's Name (print) Patient's DOB Patient's SS#

______________________________ ___________________________________
Insurance Company Claim Number

____ ____________________________________
Date of Accident Authorized Representative of ASSIGNEE

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INFORMED CONSENT TO CHIROPRACTIC CARE

CHERY CHIROPRACTIC CENTER
CARINE CHERY, D.C.
1900 CRYSTAL DRIVE, STE.1
FORT MYERS, FL 33907
TELEPHONE: (239) 936 6566
FAX: (239) 936 6442

Patient: Please discuss any questions or concerns with the Doctor before signing this consent.
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 above.
I have had the opportunity to discuss with the doctor and/or with other office or clinic personnel the purpose and benefits of the chiropractic adjustments and other treatments outlined below. Alternatives to treatment have been reviewed.

Through chiropractic adjustments and treatments that are usually beneficial and seldom cause any problem, I understand and am informed that there are some risks to treatment. Risks include, but are not limited to fractures, disc injuries, strokes, dislocations, and sprains.
I understand that I will be receiving the following treatment:

- Chiropractic Adjustment
- Electrical Muscle Stimulation
- Therapeutic Exercises
- Manual Therapy

Extremity Manipulation
Ultrasound
Hot Pack/Cold Pack
Mechanical Traction

I understand that chiropractic is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the chiropractic treatment that I have requested and authorized, I have had the opportunity to read this form and this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

Signature of Patient ____________________________________ Date _______________

Signature of Patient/Guardian _____________________________ Date ______________

(If patient is a minor)
Witness Signature _____________________________________ Date ______________