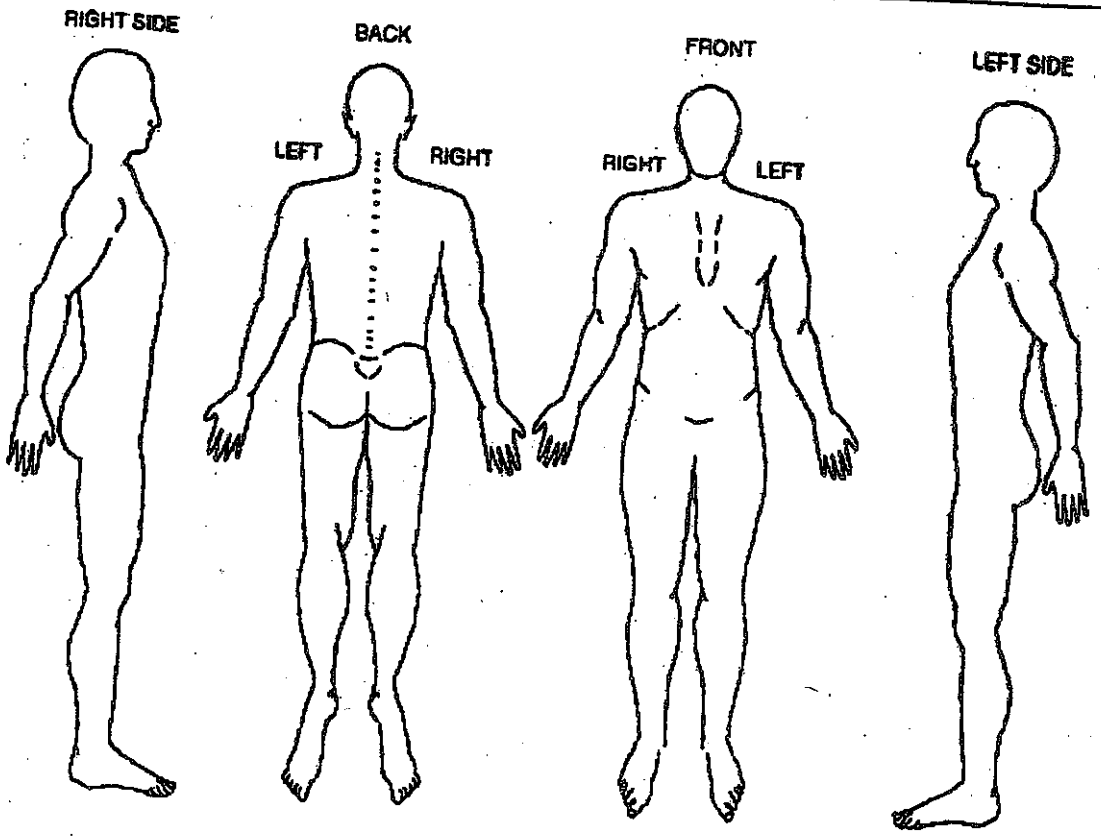
Pain Scale

Name: _____ Date _____

Please use the symbols provided to mark the areas where your current complaints are located.

Aching	Burning	Stabbing	Pins & Needles	Numbness
XXXXX	^^^^^	//////	OOOOO	- - - - -
XXXXX	^^^^^	//////	OOOOO	- - - - -



Pain Scales: Please circle the number that describes the pain you have experienced over the last week with (0) being NO pain and (10) being the worst imaginable pain.

0	1	2	3	4	5	6	7	8	9	10

Affordable Chiropractic Care Center Dr. John T. Hoehn, D.C., F.A.C.O

WELCOME

PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

_____

Employer/School Phone (____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

_____
Name of Insurance Company(ies) and assign directly to

Dr. _____ all insurance 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 authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

PHONE NUMBERS

Home Phone (____) _____

Cell Phone (____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Home Phone (____) _____

Work Phone (____) _____

ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No

Date _____

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?
☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable)

_____

PATIENT CONDITION

Reason for Visit _____

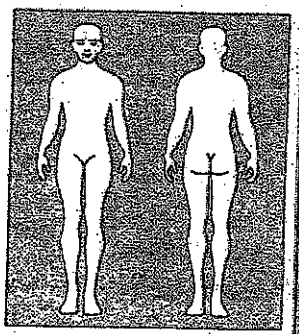
When did your symptoms appear? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other



How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ None ☐ Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____

Spinal Exam _____ Chest X-Ray _____ Urine Test _____

Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Alcoholism	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Measles	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Allergy Shots	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Migraine Headaches	☐ Yes ☐ No	Sexually Transmitted Disease	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Fractures	☐ Yes ☐ No	Miscarriage	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Anorexia	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Mononucleosis	☐ Yes ☐ No	Suicide Attempt	☐ Yes ☐ No
Appendicitis	☐ Yes ☐ No	Goiter	☐ Yes ☐ No	Multiple Sclerosis	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Gonorrhea	☐ Yes ☐ No	Mumps	☐ Yes ☐ No	Tonsilitis	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Gout	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Bleeding Disorders	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Tumors, Growths	☐ Yes ☐ No
Breast Lump	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Parkinson's Disease	☐ Yes ☐ No	Typhoid Fever	☐ Yes ☐ No
Bronchitis	☐ Yes ☐ No	Hernia	☐ Yes ☐ No	Pinched Nerve	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Bulimia	☐ Yes ☐ No	Herniated Disk	☐ Yes ☐ No	Pneumonia	☐ Yes ☐ No	Vaginal Infections	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Polio	☐ Yes ☐ No	Whooping Cough	☐ Yes ☐ No
Cataracts	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Prostate Problem	☐ Yes ☐ No	Other _____	
Chemical Dependency	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No	Prosthesis	☐ Yes ☐ No		
Chicken Pox	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No		
				Rheumatoid Arthritis	☐ Yes ☐ No		

EXERCISE

☐ None
☐ Moderate
☐ Daily
☐ Heavy

WORK ACTIVITY

☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

HABITS

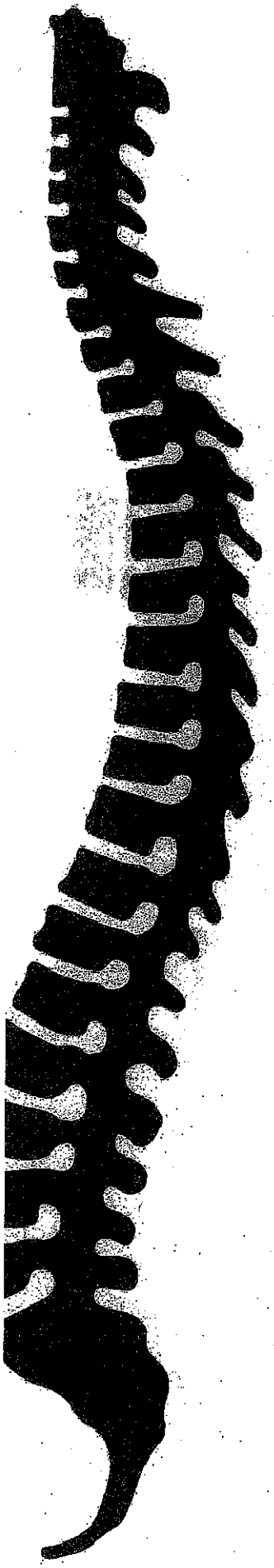
☐ Smoking Packs/Day _____
☐ Alcohol Drinks/Week _____
☐ Coffee/Caffeine Drinks Cups/Day _____
☐ High Stress Level Reason _____

Are you pregnant? ☐ Yes ☐ No Due Date _____

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS
Pharmacy Name _____		
Pharmacy Phone (____) _____		

Affordable Chiropractic Care Center



Patient Name: _____

Height: _____ **Weight:** _____ **BP:** _____/_____

Right Handed: _____ **Left Handed:** _____

Please answer the following questions:

Preferred Language: Circle One

Patient Declined
Dutch
English
French
French Canadian
German
Greek Italian
Japanese
Portuguese
Russian
Spanish

Race: Circle One

Patient Declined
American Indian or Alaska Native
Asian
Black or African American
Native Hawaiian or Other Pacific Island
White

Ethnicity:

Patient Declined
Hispanic or Latino
Not Hispanic or Latino

Smoking Status:

Current every day smoker
Current some day smoker
Former Smoker
Never Smoked

Communication Preference:

Mail
Phone
Email: _____

AFFORDABLE CHIROPRACTIC
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JOHN T. HOEHN, D.C., F.A.C.O.
Chiropractic Physician
Board Certified Chiropractic Orthopedist

Tower Hill
330 N.W. 76th Drive
Gainesville, Fl 32607
Phone: (352) 332-7400

CREATION OF HEALTHVAULT ACCOUNT FOR RECEIPT OF SECURE EMAIL MESSAGING

In response to governmental reporting requirements for secure patient email messaging, we are required to create a HealthVault email account for each patient, which the patient can then choose to initiate or not. To that end, please (1) provide an email address; (2) select one of the following security questions; and (3) provide the answer to the security question you selected. Once you have completed this process, an email (from PayDC Support) will be sent to the email address you provided, along with a code, and you will be asked to answer the security question you selected here with the answer you have provided. This process will allow you the option of initiating secure email messaging with our office. You do NOT have to set up secure email messaging. If you choose NOT to initiate, simply ignore the email and do NOT follow the initiation process instructions. Even if you choose NOT to set up secure messaging with our office, we still must report that you have provided our office with an email address; selected one of the below security questions; and provided the answer to the security question you selected. Therefore, please complete the following and return to an Office Staff Member.

We appreciate your assistance in complying with this governmental mandate.

Email address: _____

Please select and answer one of the following security questions:

1. In what city or town was your first job? _____
2. In what city or town did you meet your spouse/partner? _____
3. What is the middle name of your oldest child? _____
4. What is the name of the first beach you visited? _____
5. What is your father's middle name? _____
6. What was the last name of your favorite teacher? _____
7. What was the make and model of your first car? _____
8. What was the name of the company where you had your first job? _____
9. What was the name of your high school? _____
10. What is your mother's maiden name? _____

Date: _____ Patient Signature: _____

Print Name: _____

Thank you

Pain & Disability Questionnaire/ Function Rating Index

For Neck and Back Complaints

Patient Name:_____ Date:_____

These Questions ask your views about how your pain now affects how you function in everyday activities. Please answer **EVERY** question by circling **ONE** number on each scale that describes how you feel.

1. Does your pain interfere with your normal work inside and outside the home?
   0 1 2 3 4 5 6 7 8 9 10

2. Does your pain interfere with your personal care (such as washing, dressing, ect...)?
   0 1 2 3 4 5 6 7 8 9 10

3. Does your pain interfere with your traveling?
   0 1 2 3 4 5 6 7 8 9 10

4. Does your pain affect your ability to sit or stand?
   0 1 2 3 4 5 6 7 8 9 10

5. Does your pain affect your ability to lift overhead, grasp objects, or reach for things?
   0 1 2 3 4 5 6 7 8 9 10

6. Does your pain affect your ability to bend over, stoop, or squat?
   0 1 2 3 4 5 6 7 8 9 10

7. Does your pain affect your ability to walk or run?
   0 1 2 3 4 5 6 7 8 9 10

8. Does your pain affect your ability to sleep?
   0 1 2 3 4 5 6 7 8 9 10

9. What is your pain intensity (**0- no pain, 5-mild pain, 10-severe pain**)?
   0 1 2 3 4 5 6 7 8 9 10

10. What is your pain frequency (**0- No pain, 5- Occasional/Intermittent, 10- Frequent/Constant**)?
    0 1 2 3 4 5 6 7 8 9 10

Patient Signature:_____ Date:_____ Dr. Hoehn Signature_____

AFFORDABLE CHIROPRACTIC
Care Center of Gainesville, P.A.

Specializing in State of the Art Testing, Physical/Manual Medicine, Rehabilitation, Acupuncture & Massage Therapy

Tower Hill
330 N.W. 76th Drive
Gainesville, Fl 32607
Phone: (352) 332-7400

JOHN T. HOEHN, D.C., F.A.C.O.
Chiropractic Physician
Board Certified Chiropractic Orthopedist

Revised Oswestry Assessment (Low Back)

Name_____ Date_____

1. **Pain Intensity (choose the single best statement)**
   - __ The pain comes and goes and is very mild
   - __ The pain is mild and does not vary much
   - __ The pain come and goes and is moderate
   - __ The pain is moderate and does not vary much
   - __ The pain comes and goes and is severe
   - __ The pain is severe and does not vary much

2. **Personal Care (choose the single best statement)**
   - __I would not have to change my way of washing or dressing in order to avoid pain.
   - __I do not normally change my way of washing or dressing even though it causes some pain.
   - __Washing and dressing increases the pain, but I manage not to change my way of doing it.
   - __ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
   - __ Because of the pain, I am unable to do some washing and dressing without help.
   - __ Because of the pain, I am unable to do any washing or dressing without help.

3. **Lifting (choose the single best statement)**
   - __ I can lift heavy weights without extra pain
   - __I can lift heavy weights but it causes extra pain.
   - __Pain prevents me from lifting heavy weights off the floor.
   - __Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on a table.
   - __Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
   - __I can only lift very light weights, at the most.

4. **Walking (choose the single best statement)**
   - __ Pain does not prevent me from walking any distance.
   - __ Pain prevents me from walking more than one mile.
   - __ pain prevents me from walking more than ½ mile.
   - __ Pain prevents me from walking more than ¼ mile.
   - __ I can only walk while using a can or on crutches.
   - __ Pain prevents me from sitting at all.

5. **Sitting ("Favorite chair" includes a recliner.) (choose the single best statement)**
   - __ I can sit in any chair as long as I want without pain.
   - __ I can only sit in my favorite chair as long as I like.
   - __ Pain prevents me from sitting for more than one hour.
   - __ Pain prevents me from sitting more than ½ hour.
   - __ Pain prevents me from sitting more than 10 minutes.
   - __ Pain prevents me from sitting at all.

6. **Standing (choose the single best statement)**
   - __ I can stand as long as I want, without pain.
   - __ I have some pain while standing but it does not increase with time.
   - __ I cannot stand for longer than one hour without increasing pain.
   - __ I cannot stand for longer than ½ hour without increasing pain.
   - __ I cannot stand for longer than 10 minutes without increasing pain.
   - __ I avoid standing because it increases the pain straight away.

7. **Sleeping (choose the single best statement)**
   - __ I get no pain in bed.
   - __ I get pain in bed, but it does not prevent me from sleeping well.
   - __ Because of my pain, my normal night's sleep is reduced by less than one quarter.
   - __ Because of pain, my normal night's sleep is reduced by less than one half.
   - __ Because of pain, my normal night's sleep is reduced by less than three-quarters.
   - __ Pain prevents me from sleeping at all.

8. **Social life (choose the single best statement)**
   - __ My social life is normal and gives me no pain.
   - __ My social life is normal, but increased the degree of my pain.
   - __ Pain has no significant effect on my social life, apart from limiting my more energetic interests, e.g. dancing, ect.
   - __ Pain has restricted my social life and I do not go out very often.
   - __ pain has restricted my social life to my home.
   - __ I have hardly any social life because of the pain.

9. **Traveling (choose the single best statement)**
   - __ I get no pain while traveling
   - __ I get some pain while traveling but none of my usual forms of travel make it any worse.
   - __ I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
   - __ I get extra pain while traveling which compels me to seek alternative forms of travel.
   - __Pain restricts all forms of travel.
   - __ Pain prevents all forms of travel except that done lying down.

10. **Changing degree of pain (choose the single best statement)**
   - __ My pain is rapidly getting better.
   - __ My pain fluctuates, but overall is definitely getting better.
   - __ My pain seems to be getting better, but improvement is slow at present.
   - __ My pain is neither getting better nor worse.
   - __ My pain is gradually worsening.
   - __ My pain is rapidly worsening.

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Neck Disability Index

Name_____ Date_____

1. Pain Intensity (choose the single best statement)
   - __ I have no pain at the moment.
   - __ The pain is very mild at the moment.
   - __ The pain is moderate at the moment.
   - __ The pain is fairly severe at the moment.
   - __ The pain is very severe at the moment.
   - __ The pain is the worst imaginable at the moment.

2. Personal Care (washing, dressing, ect.. choose the single best statement)
   - __ I can look after myself normally without causing extra pain.
   - __ I can look after myself normally but it causes extra pain.
   - __ It is painful to look after myself, and I am slow and careful.
   - __ I need some help but manage most of my personal care.
   - __ I need help every day in most aspects of self-care.
   - __ I do not get dressed. I was with difficulty and stay in bed.

3. Lifting (choose the single best statement)
   - __ I can lift heavy weights without extra pain .
   - __ I can lift heavy weights but it gives extra pain.
   - __ Pain prevents me from lifting heavy weights off the floor, but I can manage if items are conveniently positioned ie. on a table.
   - __ Pain prevents me from lifting heavy weights, but I can manage light weights if they are conveniently positioned.
   - __I can lift only very light weights.
   - __ I cannot lift of carry anything at all.

4. Reading (choose the single best statement)
   - __ I can read as much as I want with no neck pain.
   - __ I can read as much as I want with slight neck pain.
   - __ I can read as much as I want with moderate neck pain.
   - __ I can't read as much as I want because of moderate neck pain.
   - __ I can't read as much as I want because of severe neck pain.
   - __ I can't read at all.

5. Headaches (choose single best statement)
   - __ I have no headaches at all.
   - __I have slight headaches that come infrequently.
   - __ I have moderate headaches that come infrequently.
   - __ I have moderate headaches that come frequently.
   - __ I have severe headaches that come frequently.
   - __ I have headaches all the time.

6. Concentration (choose single best statement)
   - __ I can concentrate fully without difficulty.
   - __ I can concentrate fully with slight difficulty.
   - __ I have a fair degree of difficulty concentrating.
   - __ I have a lot of difficulty concentrating.
   - __ I have a great deal of difficulty concentrating.
   - __ I can't concentrate at all.

7. Work (choose the best single statement)
   - __ I can do as much work as I want to.
   - __ I can only do my usual work, but work no more.
   - __ I can do most of my usual work, but no more.
   - __ I can't do my usual work.
   - __ I can hardly do any work at all.
   - __ I can't do any work at all.

8. Driving (choose the single best statement)
   - __ I can drive my car without neck pain.
   - __ I can drive as long as I want with slight neck pain.
   - __ I can drive as long as I want with moderate neck pain.
   - __ I can't drive as long as I want because of my moderate neck pain.
   - __ I can hardly drive at all because of severe neck pain.
   - __ I can't drive my car at all because of neck pain.

9. Sleeping (choose the single best statement)
   - __ I have no trouble sleeping
   - __ My sleep is slightly disturbed for less than 1 hour.
   - __ My sleep is mildly disturbed for up to 1-2 hours.
   - __ My sleep is moderately disturbed for up to 2-3 hours.
   - __ My sleep is greatly disturbed for up to 3-5 hours.
   - __ My sleep in completely disturbed for up to 5-7 hours.

10. Recreation (choose the single best statement)
   - __ I have no neck pain during all recreational activities.
   - __ I have some neck pain with a few recreational activities.
   - __ I have some neck pain with all recreational activities.
   - __ I have neck pain with most recreational activities.
   - __ I can hardly do recreational activities due to neck pain.
   - __ I can't do any recreational activities due to neck pain.

AFFORDABLE CHIROPRACTIC
DR. JOHN T. HOEHN, D.C, F.A.C.O.

Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. 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.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, our office has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Name of Patient _____ Date _____

Signature _____

Affordable Chiropractic

Dr. John T. Hoehn, D.C., F.A.C.O.

ASSIGNMENT & RELEASE, LEIN & AUTHORIZATION, INSURANCE BENEFITS & ATTORNEY, MASSAGE THERAPY

I certify that I, and/or my dependent(s), have insurance coverage with_____ and assign directly to Dr. John T. Hoehn/Affordable Chiropractic all insurance benefits that may be due and owing this office for services rendered to me, both by reason of accident or illness, and by reason of any other bills that are due, and to withhold such sums from any disability benefits, medical payment benefits, or No-Fault benefits, health and accident benefits, workers compensation benefits, or any other insurance benefits obligated to reimburse me or from any settlement, judgment or verdict on my behalf as may be necessary to adequately protect said office. I hereby further give a lien to said office against any and all insurance benefits named herein, and any and all proceeds to any settlement, judgment or verdict which may be paid to me as a result of the injuries or illness for which I have been treated by said office. This is to act as an assignment of my rights and benefits to the extent of the office's services provided.

In the event my insurance company obligated to make payment to me upon charges made by this office for the services and refuses to make such payments, upon demand by this office or me. I hereby assign and transfer to this office any and all causes of action that I might have or that might exist in my favor against such company and authorize this office to prosecute said cause of action either in my name or in the office's name and further I authorize this office to compromise, settle of otherwise resolve said claim or cause of action as they see fit.

I understand that I remain personally responsible for the total amount due to this office for their services. I further understand and agree that this ASSIGNMENT, LEIN and AUTHORIZATION do not constitute any consideration for this office to await payments and they may demand payments from me immediately upon rendering services at their option.

I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above-named insurance company (ies), their agents, adjuster or attorney for the purpose of obtaining payment for services and determining insurance benefits payable for related services. I also agree that the above-named office be given power of attorney to endorse/sign my name on any and all checks for payment of my doctor bill.

<u>Massage Therapy:</u> You will be charge a $10.00 NO-SHOW fee if you do not show up for your massage appointment or cancel it 24 hours in advance.

Signature_____

Printed Name_____

Date_____Relationship to Patient_____

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What to expect from massage therapy

There are several techniques used in massage therapy. Most people think of massage as a "feel good" therapy. This is generally known a Swedish Massage and is used to massage the muscles and make you feel relaxed. The massage that is prescribed in our office is a therapeutic massage, with techniques used for deep tissue work and muscle rehabilitation, including myofascial release, neuromuscular re-education and stretching techniques. This type of massage does not necessarily make you "feel good" the first visit or two, because of deep tissue work. When muscles have been injured due to an accident or to a sprain/strain-type injury, they will be very tight and knotted up and will require direct work to loosen up the tissues and release built up toxins that contribute to the persistence of symptomatology, which may cause some discomfort and, in some cases, even some flu-like symptoms. It is important to drink plenty of water following massage therapy in order to flush the released toxins out of the system. If symptoms persist for more than a week, or if they worsen, please let your doctor and the massage therapist know. Massage therapy is a very effective therapy, but it is not the only therapy. If you have any questions regarding massage, or any other therapy, please feel free to discuss this with your doctor. Our primary concern is to get you well and communication is vital to your care.

CONTRAINDICATIONS:

As with any therapy, there are some conditions for which massage therapy is contraindicated. Please inform the doctor and therapist, if you have not already done so, if you have any of the following conditions. (Many of these conditions benefit from massage therapy, but require specific techniques).

Fever
Viral infection (cold or flu)
Osteoporosis
Varicose veins, phlebitis, hematoma
Pitting edema
High blood pressure
Cancer
Areas of abnormal sensation
Diabetes
Heart or lung disease
Scoliosis
Hernia
Skin problems or diseases
Psychosis
Chronic fatigue syndrome
Lupus
Pregnancy (1st trimester)
Aneurysm, heart attack
Fibromyalgia
Recent surgery
Phlebitis, thrombosis, thrombophlebitis
Severe asthma

MISSED APPOINTMENTS

Our massage schedule is very carefully put together and time slots available accommodate only one patient at a time in order to give each patient their prescribed massage and keep unnecessary waiting to a minimum. If you are late for your massage, your time will be cut short so that the next patient will have their scheduled time. If you do not show up for your appointment, or if you fail to give at least 24 hours notification prior to your appointment time, you will be charged a $10 no show fee, which will be due before your next massage. Also, if you come for your scheduled massage appointment and decide you do not want massage, you will be charged the $10 no show fee.

The no show fee is not billable to your insurance if you have it, so please, as soon as you know that you will not be able to keep your appointment, give us a call so that someone else might use the time. And because of the value of the massage slots, if you miss three (3) massage appointments without giving the required notice, you will be changed to another therapy modality.

Insurance companies have specific guidelines regarding massage therapy. If we are billing your insurance for massage, please understand that a script, either from your primary care physician or Dr. Hoehn, may be required. If you have any questions regarding your coverage, please talk to our insurance coordinator.

I _____ attest that I have had the opportunity to ask any questions I may have in regards to massage therapy and by signing this I am stating that I understand I will be charged a $10 no-show fee if I don't show for my scheduled massage or call 24 hours prior to cancel.

_____ Date: _____
Signature

Specializing in State of the Art Testing, Physical, Manual Medicine, Rehabilitation and Massage Therapy

JOHN T. HOEHN, D.C., D.A.C.O.
Chiropractic Physician
Board Certified Chiropractic Orthopedist

Tower Hill
330 N.W. 76th Drive
Gainesville, FL 32607
Phone: (352) 332-7400

RECORD RELEASE AUTHORIZATION

To: _____

_____

_____

I, _____, hereby authorize the
(Print Patient Name)

release of my medical reports, diagnosis, treatment, prognosis and recommendations, as well as other data pertinent to my treatment with your office.

Dr. John T. Hoehn, DC, FACO
Affordable Chiropractic
330 NW 76th Drive
Gainesville, FL 32607
(352) 332-7400 Phone
(352) 331-0902 Fax

_____
Patient Signature Date

_____
Patients Date of Birth