WELCOME

Date: _____

Patient Information

Name: _____ Date of Birth: _____ Age: _____

Phone#(H) _____ (C)_____(W)_____Email:_____

Mailing Address: _____ City_____State_____Zip_____

Sex: ❑ Male ❑ Female S ❑ M ❑ D ❑ W ❑ # of Children: _____ SS#: _____

Occupation: _____ Employer: _____ Can we call you at work? ❑ Yes❑ No

Spouse's Name: _____Spouse's Employer:_____Spouse's Occupation:_____

Emergency contact: Name: _____ Relation: _____ Phone #: _____

Medical Doctor's Name: _____ City of M.D.:_____Would you like a report sent to your M.D.? Y N

Who referred you to our office:_____Any chiropractor in the past?:Y N Name:_____

Major compliant (Please describe only your major compliant):_____

_____

How did this condition develop?(Accident?)_____

_____

When was the very first time you were aware of this problem? _____

Have you received any treatment for this condition? If yes, where/ when, and what were your results? _____

_____

How has the condition affected your life?_____

Has this problem been getting better, worse, or staying the same? _____

What makes it worse? _____What makes it better? _____

Any other condition you want examined? _____

_____

Health History

Please check to indicate if you are currently experiencing any of the following conditions:

❑ Neck Pain/Stiffness	❑ Pins/Needles in Arms	❑ Light Bothers Eyes	❑ Sudden Weight Loss	❑ Nausea
❑ Back Pain/Stiffness	❑ Pins/Needles in Legs	❑ Depression	❑ Loss of Taste	❑ Cold Feet
❑ Arm/Hand Pain	❑ Fatigue	❑ Nervousness	❑ Loss of Memory	❑ Chest Pain
❑ Leg/Knee Pain	❑ Sleeping Difficulties	❑ Tension	❑ Jaw Problems	❑ Fever
❑ Headaches	❑ Loss of Smell	❑ Cold Sweats	❑ Constipation	❑ Fainting
❑ Dizziness	❑ Allergies	❑ Stomach Problems	❑ Shortness of Breath	❑ Skin lesions/Warts/Skin tags
❑ Asthma	❑ Blurred Vision	❑ Night Pain	❑ Bowel/Bladder Changes	

Please check to indicate if you have ever had any of the following:

❑ Aids/HIV	❑ Cancer	❑ Hepatitis	❑ Osteoporosis	❑ Stroke
❑ Alcoholism	❑ Cataracts	❑ Hernia	❑ Pacemaker	❑ Suicide Attempt
❑ Allergy Shots	❑ Chemical Dependency	❑ Herniated Disc	❑ Parkinson's Disease	❑ Thyroid Problems
❑ Anemia	❑ Chicken Pox	❑ Herpes	❑ Pinched Nerve	❑ Tonsillitis
❑ Anorexia	❑ Diabetes	❑ High Cholesterol	❑ Pneumonia	❑ Tuberculosis
❑ Appendicitis	❑ Emphysema	❑ Kidney Disease	❑ Polio	❑ Tumors/Growths
❑ Arthritis	❑ Epilepsy	❑ Liver Disease	❑ Prostate Problems	❑ Typhoid Fever
❑ Asthma	❑ Fractures	❑ Measles	❑ Prosthesis	❑ Ulcers
❑ Bleeding Disorders	❑ Glaucoma	❑ Migraines	❑ Psychiatric Care	❑ Vaginal Infections
❑ Breast Lump	❑ Goiter	❑ Miscarriage	❑ Rheumatoid Arthritis	❑ Venereal Disease
❑ Bronchitis	❑ Gonorrhea	❑ Mononucleosis	❑ Rheumatic Fever	❑ Whooping Cough
❑ Bulimia	❑ Gout	❑ Multiple Sclerosis	❑ Scarlet Fever	
	❑ Heart Disease	❑ Mumps	❑ Other _____	

Are you currently under drug and/or medical care? ❑ Yes ❑ No If yes, explain _____

Please list any medications you are currently taking (**Be sure to include dosage and frequency**)_____

_____

Please list any surgeries/ hospitalizations and/or fractures you have had (**type & date**): _____

_____

_____

Please list any allergies: _____

Please list any supplements you are currently taking (vitamins/herbs/minerals): _____

Is there a family history of any of the following conditions? (**Indicate family member including parents, grandparents & siblings**)

❑ Heart Disease _____ ❑ Diabetes _____
❑ Cancer _____ ❑ Arthritis _____ ❑ Other _____

Do you exercise: ❑Never ❑Daily ❑ Weekly ❑Walks ❑Runs ❑Swims

Do your work activities mostly involve: ❑ Sitting ❑ Standing ❑ Light Labor ❑ Heavy Labor

What is your daily/weekly intake of the following:

Water_____cups/day Caffeine_____ cups/day Alcohol_____drinks/week Cigarettes _____ packs/day

X-Ray Information **for female patients only:**

☐ There is a possibility that I may be pregnant at this time.

☐ Yes, I am definitely pregnant

☐ No, I am definitely not pregnant at this time

Spinal Healthcare & Physical Medicine
Physical Therapy Relative Contraindications

Name:_____

The following list consists of conditions which may contraindicate using certain physiotherapeutic modalities we have in our Physical Therapy/Rehabilitation room. Please read through this list carefully and circle any of the following that you may have. Also, list the year or date that you first had the disorder or procedure/implant and any details that you can provide.

Yes No Tumor_____

Yes No Tuberculosis_____

Yes No Pregnancy_____

Yes No Pacemaker_____

Yes No Blood Clots or Phlebitis_____

Yes No Problems with Circulations_____

Yes No Use of an anticoagulant (blood thinner) _____

Yes No Metallic Implant or Joint Replacement_____

Yes No Surgical Clips, Shrapnel, or other metal fragments_____

Yes No Skin diseases or rashes_____

Yes No Hypersensitivity to hot/cold_____

Yes No Intrauterine device or I.U.D_____

Yes No Vasculitis/Raynaud's Syndrome_____

Yes No Impaired sensation or loss of feeling_____

I hereby certify that the above statements are true to the best of my knowledge.

_____ _____

Signature **Date**

_____

Witness (Office Staff)

SPINAL HEALTHCARE & PHYSICAL MEDICINE

ALCAT Food Tolerance Survey

NAME:_____DATE_____

Please complete the following food and chemical sensitivity questionnaire. Mark each symptom based upon your experiences over the last 60 days. Some of these symptoms may have been repeated previously in this paperwork. Answer YES or NO (If you answered YES to any of the questions, please include details and frequency of your condition)

Digestive Symptoms

Yes No Stomach Pains, Cramping, Bloating or Gas_____

Yes No Constipation or Diarrhea_____

Yes No Reflux or Heartburn, Nausea or Vomiting_____

Weight Yes No

Inability to lose weight or Water Retention_____

Yes No Food Cravings or Binge Eating_____

Sinus/ Respiratory Yes No

Stuffy/Runny Nose_____

Yes No Asthma or Wheezing_____

Yes No Chest Congestion or Chronic Cough_____

Yes No Frequent Sneezing_____

Head & Ears

Yes No Migranes/Headaches_____

Yes No Ear Aches, Ear Infections, Ringing in Ears_____

Eyes & Throat Yes No

Itchy Eyes/Watery Eyes_____

Yes No Sore Throat/Persistent Canker Sores_____

Emotional/Mental/Energy Yes No

Depression/Anxiety_____

Yes No Mood Swings/Irritability/Poor Concentration_____

Yes No Fatigue/Lethargy or Hyperactivity_____

Yes No Restlessness &/or Insomnia_____

Skin Disorders Yes No

Eczema, Dermatitis, Rashes or Hives_____

Yes No Excessive Sweating_____

Other Symptoms Yes No

Joint Pain, Muscle Aches &/or Arthritis_____

Yes No Irregular Heartbeat or Chest pains_____

Please list any symptoms not mentioned above:

SPINAL HEALTHCARE & PHYSICAL MEDICINE CONSENT TO CARE

A patient coming to the doctor gives him/ her permission and authority to care for them in accordance with appropriate test, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases underlying physical defects, deformities or pathologies, may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/ she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/ she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the physician.

I agree to settle any claim or dispute I may have against or with any of these persons or entities, whether related to the prescribed care or otherwise, will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

I have read and understand the foregoing.

_____ _____

Patient's Signature Date

FINANCIAL POLICY

Payment is expected at time of service unless prior arrangements have been made

Assignment and Release (insured patients)

I certify that I (or my dependent) have insurance coverage with _____ and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PHYSICIAN/MEDICAL PRACTICE, INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I FURTHER AGREE THAT IN THE EVENT ANY CHARGES MADE BY MY PHYSICIAN ARE NOT PAID AND THIS MATTER IS REFERRED TO AN ATTORNEY FOR COLLECTION, I AGREE TO BE RESPONSIBLE FOR ALL COSTS OF COLLECTION, INCLUDING REASONABLE ATTORNEY FEES.

Disclaimer

It should be understood that any information regarding insurance coverage provided to our office is to the best of our knowledge complete and accurate. However, because insurance policies are open to interpretation and/or insurance companies may not give complete disclosure of terms and conditions over the phone, it is in your best interest to contact your insurance company yourself to verify information coverage.

- I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.
- I authorize Spinal Healthcare and Physical Medicine to release any information to any insurance company, adjuster, or attorney as requested.

SIGNATURE: _____ **DATE** _____

WITTNESS: _____

PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR INSURANCE CARD(S)

PATIENT AKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____ DOB: _____

I acknowledge that I have reviewed the Notice of Privacy Practices of *Spinal Healthcare & Physical Medicine.*

PLEASE INITIAL ONE OF THE FOLLOWING OPTIONS AND SIGN BELOW:

_____ I wish to receive a paper copy of the Privacy Notice

_____ I do not request a copy of the Privacy Notice at this time. I acknowledge that I can request a copy at any time and the Privacy Notice will be posted in the office.

PLEASE INITIAL BELOW:

_____I acknowledge that it is the policy of *Spinal Healthcare & Physical Medicine* to leave a reminder messages on my answering machine or with another person in my home. I may make request of alternative means of communication (within reason) in writing.

_____ I acknowledge that if I should have a problem or question in regards to my right, I may speak with the Privacy Officer, Brenda Berry OM, about my concerns.

_____ _____

Signature of Patient/Guardian **Date**

_____ _____

Witness (Office Staff) Date

Who would you like to have access to information regarding your records/account?

NAME	RELATIONSHIP TO PATIENT	DATE OF BIRTH

***No information will be shared with anyone not on your list

Meaningful Use 2017

Patient Name: _____ **DOB**: _____

Gender: M F **Height**: _____ **Weight**: _____

Preferred Language: _____ **Ethnicity**: _____

Race: (Circle One) White African American American Indian/Alaska Native

Hawaiian/Pacific Islander Asian Other Declines to Specifiy

Smoking History: (Circle One:

- ○ Never Smoked
- ○ Current Smoker Number of years smoking: _____
- ○ Former Smoker How long ago did you stop smoking? _____

How many years did you smoke? _____

Allergies YES NO **Medication Allergies** YES NO

Please list allergies:

_____

_____

Medications YES NO

Please list all medications with dosage:

_____

_____

_____

_____

For Doctors Use

Diagnoses:

_____
_____
_____
_____

BP:_____R/L