# 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 complaint** (Please describe only your major complaint):______________________________________________

_____________________________________________________________________________________________

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 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

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

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 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 UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. I HEREBY AUTHORIZE THE DOCOTR TO REALEASE ALL INFORAMTIONNECESSARY, INCLUDING THE DIAGNOSIS AND THE RECORDS OF ANY EXAM OR TREATMENT RENDERED TO ME, IN ORDER TO SECURE THE PAYMENT OF BENEFITS. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURANCE CLAIMS, INCLUDING ELECTRONIC SUBMISSIONS. 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.

___________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.

### Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by *Spinal Healthcare & Physical Medicine* or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

### Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. I have received a copy of the Notice of Patient Privacy Policy. _________

### Requesting a Restriction on the use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.

) If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

**Notice or Treatment in Open or Common Areas**

Describe and Notify private areas available upon request

**Revocation of Consent**

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation o f consent is received will not be affected.

***By my signature below I give my permission to use and disclose my health information.***

_________________________________________ ___________________________

**Signature of Patient/Guardian** **Date**

_________________________________________ ___________________________

**Printed Patient's Name** **Date**

_________________________________________ ___________________________

**Witness (Office Staff)** **Date**

## Meaningful Use

**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**

**Updated 2/22/2019**