BACK&JOINT REHAB CENTER

Date _____/_____/_____

Patient Name _____ **Preferred Name** _____

Home Phone (_____) _____ **Work Phone # (_____)** _____ **Cell Phone (_____)** _____

Social Security #_____ **E-Mail Address** _____

Address_____ **City**_____ **State**_____ **Zip Code**_____

Date of Birth _____/_____/_____ **Age**____ **Sex: M F Height**_____ **Weight** ____ Patient Employer _____

Work Address_____ City_____ State_____ Zip Code_____

Occupation / Job Description _____

Marital Status (circle one): Single / Married / Widowed / Divorced / Separated / Domestic Partner / Other: _____

Number of Children/Ages: _____

Emergency Contact _____ **Relationship** _____ **Phone # (_____)** _____

Note: (Only fill out this section if the patient is different from the insured) **Insured Name**: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Social Security #: _____ Home Phone #: _____ Date of Birth: ___/___/_____

Insured Employer: _____ Work Phone: _____

Work Address: _____City: _____ State: _____ Zip Code: _____

HOW DID YOU FIND US?

□ Existing Patient Name: _____ □ Family Doctor Name: _____ □ Friend/Family Name: _____

□ If referred by a person, is it okay for us to use your name when thanking them for referring you? □ **Yes** □ **No**

□ Google Reviews □ Mailer □ Chamber of Commerce □ Co-Worker □ Yelp Reviews □ Facebook

□ Clinic Website □ Billboard □ Other: _____

PRIMARY COMPLAINT: _____ **OTHER COMPLAINTS:** _____

Date of Injury: _____

How did your symptoms begin? (i.e. lifting, driving, sports, no apparent reason, etc.) _____

Family Doctor / Primary Care Physician (PCP) Name:_____

It is our policy to keep your family doctor and/or referring doctor informed regarding your care in the office.

□ **Yes** □ **No** Do we have your permission to inform your family doctor or referring physician regarding progress about your condition?

Health & Wellness Goals

Please share your health goals so we can help you in pursuit of your best quality of living**.**

In the next 4-6 weeks, I'd like to… (i.e. work without pain and return to playing golf, exercise, tennis, running,etc.)

1. _____

In the next year, I'd like to … (i.e. lose 20 pounds by my birthday and train for a marathon / return to lifting weights, etc.)

1. _____

Are you interested in Preventative Health Programs to keep you at your best? □ **Yes** □ **No**

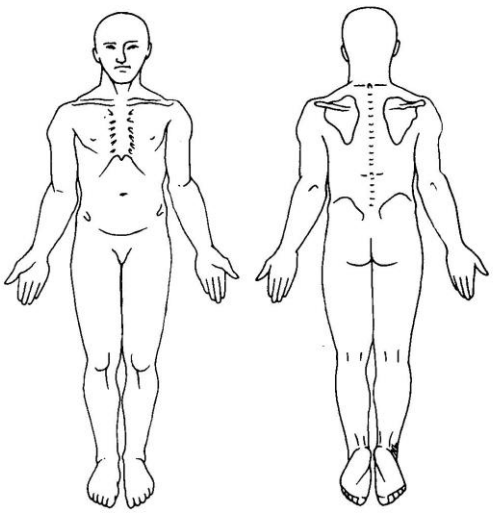
Legibly Print the Email Address you would like to receive our newsletter and health information:

Email Address: _____

What do you hope to enjoy better when you regain your health?

_____

_____



Mark the affected areas on the diagram (pain, numbness, weakness, etc.)

PLEASE CIRCLE YOUR LEVEL OF PAIN BELOW:
(1=minimal pain; 10=worst pain imaginable)

PAIN CURRENTLY
1 2 3 4 5 6 7 8 9 10

PAIN AT ITS WORST
1 2 3 4 5 6 7 8 9 10

PAIN TYPICALLY
1 2 3 4 5 6 7 8 9 10

Review of Systems: *Please write in a number .1 – PRESENTLY HAVE 2 – PREVIOUSLY HAD 3 – RELATED TO ACCIDENT*

GENERAL
___Allergy
___Chills
___Convulsions
___Dizziness
___Fainting
___Fatigue
___Fever
___Headache
___Sleep Loss
___Weight Loss/Gain
___Nervousness/Depression
___Neuralgia
___Numbness
___Sweats
___Tremors
___Anxiety/Depression

EYE, EARS, NOSE THROAT
___Asthma
___Colds
___Sore Throat
___Deafness
___Dental decay
___Ear aches/ringing in ear
___Ear Discharge
___Sinus Infection
___Enlarged Thyroid
___Enlarged Glands
___Nose Bleeds
___Vision problems
___Far sighted
___Near Sighted
___Hoarseness
___Nasal Obstruction

MUSCULOSKELETAL
___Arthritis
___Bursitis
___Neck Pain
___Disc Herniation
___low back pain
___Mid-Back Pain
___Carpal Tunnel
___shoulder blade pain
___TMJ/ Jaw Pain
___Elbow Pain
___Shoulder Pain
___Hand/Wrist Pain
___Hip Pain
___Knee Pain
___Ankle/Foot Pain
___Poor Posture
___Sciatica
___Spinal Curvature
___Muscle Spasms
___Numbness
___Weakness

GENITOR-URINARY
___bedwetting
___blood in urine
___frequent urination
___inability to control bladder
___kidney infection or stones
___Painful urination
___prostate trouble
___pus in urine
___painful menstruation
___hot flashes
___irregular cycle
___ lumps in breasts

CARDIOVASCULAR
___Hardening of arteries
___high blood pressure
___low blood pressure
___pain over heart
___poor circulation
___rapid heart beat
___slow heart beat
___swelling of ankles

RESPIRATORY
___chest pain
___chronic cough
___difficult breathing
___spitting up blood
___spitting up phlegm
___wheezing

GASTROINTESTINAL
___belching or gas
___colitis
___colon trouble
___constipation
___diarrhea
___difficult digestion
___distention of abdomen
___excessive hunger
___heartburn/reflux
___gall bladder trouble
___hemorrhoids
___intestinal worms
___jaundice
___liver trouble
___nausea
___Pain over stomach
___Vomiting
___Vomiting blood

Current Medication: (Include all vitamins, herbal supplements, and over-the-counter medications.)

1._____ 5._____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

Allergies (medication, food, other substance) Please list and state the reaction you had:

_____

_____

Hospitalizations / Surgeries (please list procedures, dates and locations): _____

_____

_____

Imaging (X-RAYS, MRI'S, ULTRASOUNDS, etc.)_____

_____

Previous Injuries (sprains, fractures, auto or other accidents, etc.) _____

_____

Family History: Check any diseases which your relatives have had (if known):

Relatives	Arthritis	Cancer	Diabetes	Heart Disease/Stroke	Kidney Disease	Neurological Disease	Thyroid Disease	Deceased
Father								
Mother								
Brother								
Sister								
Maternal Grandparents								
Paternal Grandparents								

Personal Habits – Please answer honestly. *All information is confidential.*

Please rate your answer on a scale of 1 to 5, with 1 being No/Never and 5 being Yes/Often.

	1	2	3	4	5	Elaborate
Exercise Regularly (3-4 x week)						
Wear Seat Belts						
Recreational Drugs						
Drink Alcohol						
Smoke						
Chew Tobacco						
Experience Stress						
Other						

Women Only:

Menstrual Periods: Age of Onset: ___ Regular? Yes ☐ No ☐ Length of Period: _____

Date last Period Began: ___/___/____ Average Cycle Length: _____

Difficulty with Periods: Yes ☐ No ☐ Specify: _____

Age at Menopause (if applicable): _____ Date of last Pap Smear/Pelvic Exam? ____/____/_____

Number of Children: Born Alive____ Cesarean_____ Premature_____ Stillborn____ Miscarriages _____

Describe Pregnancy or Other Complications (if applicable):_____

_____

INFORMED CONSENT

Medical doctors, chiropractic doctors, osteopaths, and physical therapists who perform manipulation are required by law to obtain your informed consent before starting treatment.

I do hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/adjustments involving movement of the joints and soft tissues. Physical therapy exercises may also be used. Although spinal and extremity manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows:

Soreness/Bruising: I am aware that, like exercise, it is common to experience muscle soreness and occasionally bruising in the first few treatments.

Dizziness: Temporary symptoms like dizziness and nausea can occur, but are relatively rare.

Fractures/Joint Injury: I further understand that in isolated cases, underlying physical defects, deformities or pathologies, like weak bones from osteoporosis, may render the patient susceptible to injury. When osteoporosis, degenerative disc, or other abnormality is detected, this office will proceed with extra caution.

Stroke: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage including stroke is reported to occur once in a million to once in ten million treatments. To put these occurrences in perspective, once in a million is about the same chance as getting hit by lightning. Once in ten million is about the same chance as a normal dose of aspirin or Tylenol causing death.

PhysioTherapy Burns: Some of the therapies used in this office generate heat and may rarely cause a burn. Despite precautions, if a burn is obtained, there will be a temporary increase in pain and possible blistering. This should be reported to the doctor.

Tests have been or will be performed on me to minimize the risk of any complication from treatment and I freely assume these risks.

TREATMENT RESULTS

I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits. I realize that the practice of medicine, including chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures. I agree to the performance of these procedures by my doctor and such other persons of the doctor's choosing.

ALTERNATIVE TREATMENTS AVAILABLE

Reasonable alternatives to these procedures have been explained to me including rest, home applications of therapy, prescription or over-the-counter medications, exercises, physical therapy and possible surgery.

Medications: Medication can be used to reduce pain or inflammation. I am aware that long-term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks.

Rest/Exercise: It has been explained to me that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat or other home therapy. Prolonged bed rest contributes to weakened bones and joint stiffness. Exercises are of limited value but are not corrective of injured nerve and joint tissues.

Surgery: Surgery may be necessary for joint instability or serious disc rupture. Surgical risks may include unsuccessful outcome, complications, pain or reaction to anesthesia, and prolonged recovery.

Non-treatment: I understand the potential risks of refusing or neglecting care may include increased pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

I have read or had read to me the above explanation of chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely.

To attest to my consent to these procedures, I hereby affix my signature to this authorization for treatment.

Signature of Patient:_____ **Date:**_____

Signature of Parent or Guardian (if a minor):_____ **Date:** _____

Financial/Privacy Policy and Disclaimer

Returned Checks: It is our policy to collect $25.00 for returned checks. This is to cover any fees that apply from the transaction.

Financial Policy Questions: We are happy to address questions regarding your account at any time. Please direct account questions to our billing administrator.

HIPAA Privacy Policy: Attached to the patient information packet at the back of these forms is the HIPAA Notice of Privacy Practices Policy for you. By signing below, you acknowledge that you have received the HIPAA Privacy Policy and that you understand and will comply with our financial policies.

Collection of Patient Balance ***Please initial the following to acknowledge that you have read each statement.

_____**Payment is expected at the time of service.**

_____Your insurance company can and will be billed, determined by your preference and our current status as in-network or out-of-network with that company. **We cannot guarantee your coverage**, even if our office attempts to confirm your benefits and eligibility. Final approval of coverage is based on the explanation of benefits after the claim has been filed.

_____Any balance remaining after insurance benefits are obtained is the responsibility of the patient. Any non-covered services are the responsibility of the patient at the rate determined by in-network or out-of network rates as determined by the insurance company's explanation of benefits.

_____If payment is not rendered at the time of service, the patient is expected to remit payment within 30 days of the patient visit.

_____All balances remaining unpaid after 30 days may be turned over to a collection agency.

_____ **It is the patient's responsibility to understand his/her insurance policy and the intricacies of coverage.** Back & Joint Rehab Center cannot guarantee exact details at any given time.

_____ If unable to make your appointment, please notify our office at least 24 hours' notice out of respect and courtesy to other patients.

Missed Appointments or failure to reschedule without 24 hours' notice will result in a $35 charge. You will be responsible for this payment.

Designation of Authorized Representative

I do hereby designate Back & Joint Rehab Center to the full extent permissible under the Employee Retirement income Security Act of 1974 ("ERISA") and as provided in 29 CFR 2560-503-1(b)4 to otherwise act on my behalf to pursue claims and exercise all rights connected with my employee health care benefit plan, with respect to any medical or other health care expense(s) incurred as a result of the services I receive from Back & Joint Rehab Center. These rights include the right to act on my behalf with respect to initial determinations of claims, to pursue appeals of benefit determinations under the plan, to obtain records, and to claim on my behalf such medical or other health care service benefits, health care benefit plan reimbursement and to pursue any other applicable remedies.

I do hereby authorize Back & Joint Rehab Center to act on my behalf to pursue claims and exercise all rights in order to collect payments with respect to any medical or other health care expense(s) incurred as a result of the services I receive from Back & Joint Rehab Center.

Signature of Patient:_____ Date:_____

Release of Protected Health Information

I give my consent to allow the transfer and/or discussion of my protected health information to be released to this office. I understand that as a patient, my health information is confidential, and will be treated as such by this office, Back & Joint Rehab Center. I understand that any information collected by this office will be for the benefit of care provided, and will remain confidential between this office and the providing practitioner. To attest to my consent to the release of my information, I hereby affix my signature to this authorization. RPHI expires 3 years after date of signature below.

Signature of Patient:_____ Date:_____
Signature of Parent or Guardian (if a minor):_____ Date:_____

IF COMPLETED BY A PATIENT'S PERSONAL GUARDIAN OR REPRESENTATIVE, PLEASE PRINT AND SIGN YOUR NAME IN THE SPACE BELOW.

_____
PERSONAL REPRESENTATIVE (PRINT)

_____
PERSONAL REPRESENTATIVE SIGNATURE

_____
RELATIONSHIP

FOR BACK & JOINT REHAB CENTER USE ONLY

Complete this section if this form is not signed and dated by the patient or patient's guardian or personal representative.

I have made a good faith effort to obtain a written acknowledgement of receipt of Back & Joint Rehab Center Notice of Privacy Practices but was unable to for the following reason:

□ Patient refused to sign
□ Patient unable to sign
□ Other _____

Back & Joint Rehab Center Representative Signature: _____ Date: _____