Today's Date: ___/___/___

Welcome To Physicians Sports and Injury Center, LLC

Name _____
Last First MI

Nature of Complaint

_____

_____

Cause of Condition

What caused your symptoms? ☐ Auto Accident ☐ Work Accident ☐ Other/Unknown: _____

Personal Information

Address _____ **City** _____ **State** _____ **Zip** _____

Home Phone (____) _____ **Cell Phone** (____) _____ **Email:**_____

Birth Date: _____/_____/_____ **Social Security:** _____-_____-_____ **Age:** _____

Gender: ☐ Male ☐ Female **Race:** _____ **Ethnictiy:** _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Occupation: _____ **May we call you at work?** ☐ Yes ☐ No **Work Phone** (____) _____

Emergency Contact: _____ **Relationship to patient:** _____

Phone number: Home: (_____) _____ **Work:** (_____) _____**Cell:** (_____) _____

Financial Information

Cash (cash/check/credit card)

☐ **Check here if you will settle your payments privately rather than through a third party.**

Major Medical/Medicare **WE WILL NEED A COPY OF YOUR INSURANCE CARD.**

Auto Injury Insurance Medpay **WE WILL NEED A COPY OF THE POLICE REPORT.**

This information should reflect your personal Medpay policy

Were you the: ☐ Driver ☐ Passenger ☐ Other_____

Owner of the vehicle: _____

Relationship to patient: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insured's Address_____ **Insured's SSN**_____-_____-_____

Name of Insurance Carrier_____ **ID**_____ **Claim**_____ **Phone**_____

Is an attorney representing you? ☐ Yes ☐ No **Attorney's name**_____ **Law Firm**_____

Phone_____ **Fax**_____ **Address**_____

FINANCIAL AGREEMENT

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

Explanation of Insurance Coverage

Many insurance policies do cover chiropractic care but this office makes no representation that yours does. Insurance policies may vary greatly in terms of deductible and percentage of coverage for chiropractic care. Because of the variance from one insurance policy to another, we require that you, the patient, be personally responsible for the payment of your deductibles, as well as any unpaid balances in this office. We will do our best to verify your insurance coverage, and will bill your insurance in a timely manner as a courtesy to you.

Assignment of Benefits

Attached is an "Assignment of Benefits" form which we would like you to sign. This form directs your insurance company to send payments directly to this office. If your insurance carrier sends payment to you for services incurred in this office, you agree to send or bring those payments to this office upon receipt. If you pay for your visits in full the assignment need not be signed and the payments will be sent directly to you from the insurance.

Release of Information

If your insurance company requires medical reports or records to document your treatment or progress, your signature below authorizes this office to release the medical information necessary to process your claim.

Voluntary Termination of Care

If you suspend or terminate your care at any time, your portion of all charges for professional services is immediately due and payable to this office. All services rendered by this office are charged directly to you, and you, ultimately will be personally responsible for payment regardless of your insurance coverage.

We hope this answers any questions you might have concerning the financial policy of this office. Once again we welcome your to our office, and will be glad to answer any further questions that you might have.

Authorization to Communicate

I give PSIC permission to communicate with me (including emails). I understand I am not required to sign this agreement to receive treatment. I can choose to opt-out of this agreement at any time.

I have read and agree to the above.

_____ _____

Signature **Date**

Authorization to Treat a Minor

I hereby request and authorize Physicians Sports and Injury Center, LLC physicians to perform diagnostic tests and render chiropractic adjustments and other treatment to MY MINOR SON/DAUGHTER[1]. This authorization also extends to all other providers and office staff members.

_____ _____

Signature of Parent/Guardian **DATE OF BIRTH**

As of the date, I have the legal right to select and authorize health care services for the minor child named above.

(If applicable) Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse / former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

Office Financial Policy

It is our policy that following a preliminary exam, any services which are rendered by this office on the initial visit shall be paid for at that time, unless other arrangements have been made in writing. Our office is pleased to accept your insurance assignment, as soon as your exact coverage is verified by the responsible party. However, it must be fully understood that the contract is between you and your insurance company, and you are fully responsible for any and all amounts not paid by your insurance.

Our office policy is as follows:

1. Since by taking your insurance assignment, we have to await payment, this courtesy may be withdrawn if warranted.
2. Insurance payments should be made every 30 days. The maximum time limit we extend is 60 days, then fees must be paid in full by the patient.
3. You are required to sign the "Authorization to Pay Physician" section of Welcome to Our Clinic form and any other documents required by your insurance company.
4. Our office WILL NOT guarantee that your insurance company will pay. At the beginning of your healthcare, we will make every attempt to receive verification of your policy coverage. However, if for any reason your claim is denied, you are responsible for the total amount due this office.
5. This office will not enter into a dispute with your insurance company over your claim. This includes Workmen's Comp and Personal Injury cases. This is your responsibility and obligation. We will, however, assist you in any way that we can.
6. You the patient must keep current with your insurance co-payment.
7. We reserve the right to charge a 50% finance charge to all accounts over 90 days old that require additional collection attention.
8. In the event you do not meet your financial obligation for services provided in this office, we will have no choice but to send your account to collections. We will make every attempt to work with you in the event of financial hardship. However if collections become necessary then you agree to be responsible for any and all fees required by our office to collect payment.
9. If the insurance company sends you payment for our services, it is your responsibility and obligation to bring to us payment in full.
10. A Cancellation Fee of $35 may be assessed if you do not provide us with 24 hours notice of your cancellation.

I have fully read, and agree to this financial policy as written:

Signed: _____

Date: _____

Witness: _____

PATIENT CONSENT
FOR USE AND/OR DISCLOSURE OF
PROTECTED HEALTH INFORMATION
TO CARRY OUT TREATMENT, PAYMENT
AND HEALTHCARE OPERATIONS

_____, hereby states that by signing this Consent, I acknowledge and agree as follows:

1. The Practice's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out is health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.

2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

3. I understand that, and consent to, the following appointment reminders that will be used by the Practice: a) a postcard mailed to me at the address provided by me; and b) telephoning my home and leaving a message on my answering machine or with the individual answering the phone.

4. The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.

5. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.

6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all *future* transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.

7. I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.

8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

_____
Name of Individual (Printed)

_____
Signature of Individual

_____
Signature of Legal Representative

_____
Relationship
(e.g., Attorney-In-Fact, Guardian, Parent if a minor):

Date Signed ____/____/____

Witness: _____

PRACTICE'S REQUIREMENTS

1. The Practice:

(a) Is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.

(b) Is required by State law to maintain a higher level of confidentiality with respect to certain portions of your medical information that is provided for under federal law. In particular, the Practice is required to comply with the following State statutes: 'Not applicable at this time'

(c) Is required to abide by the terms of this Privacy Notice.

(d) Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for all of your PHI that it maintains.

(e) Will distribute any revised Privacy Notice to you prior to implementation.

(f) Will not retaliate against you for filing a complaint.

EFFECTIVE DATE

This Notice is in effect as of January 1, 2009.

_____ _____

Name of Individual (Printed) Signature of Individual

_____ _____

Signature of Legal Representative Relationship

(e.g., Attorney-In-Fact, Guardian, Parent if a minor)

Date Signed ____/____/____ Witness:_____

QUADRUPLE VISUAL ANALOGUE SCALE

Please list your <u>PRIMARY</u> symptom (i.e. neck pain) _____

Instructions: Please **<u>circle</u>** the number that best describes the question being asked for the primary symptom listed above

1. What is your pain RIGHT NOW?

No Pain _____ worst possible pain
0 1 2 3 4 5 6 7 8 9 10

2. What is your TYPICAL or AVERAGE pain?

No Pain _____ worst possible pain
0 1 2 3 4 5 6 7 8 9 10

3. What is your pain level AT ITS BEST (how close to "0" does your pain get at its best)?

No Pain_ _____ _ worst possible pain
0 1 2 3 4 5 6 7 8 9 10

4. What is your pain level AT ITS WORST (how close to "10" does your pain get at its worst)?

No Pain _____worst possible pain
0 1 2 3 4 5 6 7 8 9 10

DOCTOR SIGNATURE: _____ PATIENT SIGNATURE: _____

CONFIDENTIAL PATIENT HEALTH RECORD

Name: _____ **Date:** _____/_____/_____

Current Age: _____ **Gender:** ☐ Male ☐ Female

HEALTH HISTORY

Please describe the reason for your visit:

How long have you had this problem? _____

Have you ever had this problem before? ☐ Yes ☐ No **If Yes, how many times?** _____

What do you think caused this problem?

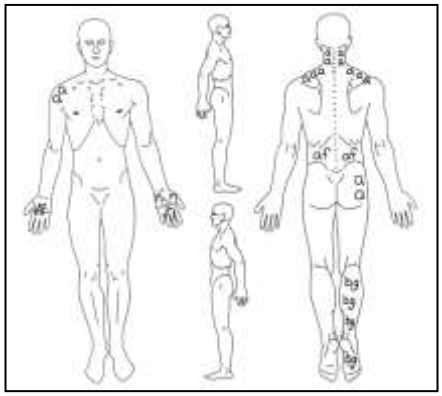
PAIN DIAGRAM

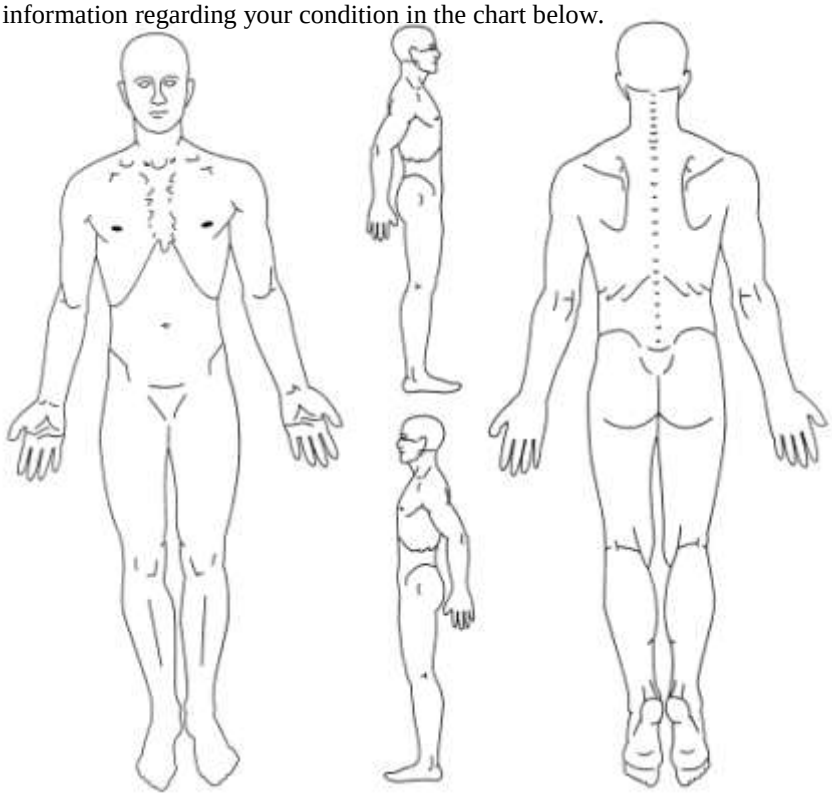
Report here the symptoms you feel at the present time. Mark the body area(s) with the type of symptoms, using the symbols in the key below. Then please fill in the additional information regarding your condition in the chart below.

SYMPTOM SYMBOLS

Aching	=	a
Burning	=	b
Numbness	=	n
Sharp	=	s
Stiffness	=	f
Tingling	=	g
Weakness	=	w

Example





REGION	Side: Left Side (L) Right Side (R) or Both (B)	Pain Type: Aching (a), Burning (b) Numbness (n), Sharp (s) Stiff (f), Tingling (g) Weakness (w)	Pain Rating: Choose 0 (no pain) to 10 (intolerable pain)	Pain Frequency: Constantly (C) (76-100% of the time) Frequently (F) (51-75% of the time) Occasionally (O) (26-50% of the time) Intermittently (I) (1-25% of the time)	What aggravates the pain? Lifting, walking, etc. Include time of day as appropriate: Morning, Mid-day, Evening, At night while sleeping	What relieves the pain? Lying down, heat, ice, etc. Include time of day as appropriate: Morning, Mid-day, Evening, At night while sleeping
Low Back	*L*	*a , b*	*8*	*C*	*Bending forward, cough*	*Lying down, Ibuprofen*

DOCTOR SIGNATURE: _____ PATIENT SIGNATURE: _____

SECONDARY COMPLAINT

Please describe the secondary complaint:

How long have you had this problem? _____

Have you ever had this problem before? ☐ Yes ☐ No **If Yes, how many times? _____**

What do you think caused this problem?

THIRD COMPLAINT

Please describe the third complaint:

How long have you had this problem? _____

Have you ever had this problem before? ☐ Yes ☐ No **If Yes, how many times? _____**

What do you think caused this problem?

FOURTH COMPLAINT

Please describe the fourth complaint:

How long have you had this problem? _____

Have you ever had this problem before? ☐ Yes ☐ No **If Yes, how many times? _____**

What do you think caused this problem?

DOCTOR SIGNATURE: _____ PATIENT SIGNATURE: _____

PERSONAL HEALTH HISTORY

PLACE A "C" NEXT TO ALL SYMPTOMS/PROBLEMS YOU HAVE CURRENTLY
AND PLACE A "P" NEXT TO ALL SYMPTOMS/PROBLEMS YOU HAVE HAD IN A PAST

☐ I have not had, nor do I presently have, any of the following symptoms.

____ Burning, tingling, or numbness into the shoulders, arms, or hands (upper extremities)
____ Burning, tingling, or numbness into the hips, legs, or feet (lower extremities)
____ Recent loss or blurring of vision
____ Cancer:
Type(s): _____
Date diagnosed: ____/____/_____
____ Diabetes:
___ Type I
___ Type II (adult onset)

____ Condition aggravated by coughing, sneezing, or grunting
____ Loss of sexual function
____ Recent onset of:
___ Urinary retention
___ Increased urinary frequency
___ Inability to control bladder
____ Constant pain unrelated to movement
____ Night pain unrelated to movement
____ Unexplained weight loss greater than 10 lbs.
____ History of malaise/generalized weakness
____ History of fever or chills

____ Osteoporosis
____ Bacterial infection
Date it began: ___/___/___
____ Abdominal pain
____ Blood in urine
____ Rectal bleeding
____ Hemorrhoids
____ Urethral discharge
____ Prolonged steroid use
____ IV drug abuse

____ Abdominal pain
____ Allergies
Type:
_____
_____
_____
____ Angina
____ Back pain
____ Blurred vision
____ Chemical dependency
____ Chest pain
____ Chronic back problems
____ Cold feet
____ Cold sweats
____ Constipation
____ Depression
____ Dermatitis
____ Digestive problems
____ Dizziness
____ Fainting
____ Fatigue
____ Hair loss
____ Headaches
____ Heart attacks
____ Hormone replacement
____ Jaw problems
____ Joint swelling
____ Kidney stones
____ Loss of smell
____ Loss of memory
____ Loss of taste
____ Menstrual cramps
____ Migraines
____ Miscarriage
____ Muscular incoordination
____ Nausea
____ Nervousness
____ Painful urination
____ Pinched nerve
____ PMS
____ Prostate problems
____ Ringing/buzzing in the ears
____ Shortness of breath
____ Sleeping difficulties
____ Stomach problems
____ Tension
____ Tooth Pain
____ Ulcer/gastrointestinal bleeding
____ Unexplained excessive thirst
____ Unexplained loss of appetite
____ Vaginal infections

____ Alcoholism
____ Anemia
____ Anorexia
____ Appendicitis
____ Arteriosclerosis
____ Arthritis
____ Asthma
____ Bleeding disorders
____ Blindness
____ Bulimia
____ Cancer
____ Cataracts
____ Chicken Pox
____ Chronic lung disease
___ Bronchitis
___ Emphysema
____ Congestive heart failure
____ Connective tissue disease
____ Type: _____
____ Date diagnosed: ___/___/___
____ Deafness or reduced hearing
____ Drug/alcohol dependency
____ Epilepsy
____ Fibromyalgia
____ Fractures
____ Gall Bladder Problems
____ Glaucoma
____ Goiter
____ Gout
____ Heart Disease
____ Hepatitis
____ Hernia
____ Herniated disc
____ Herpes
____ High Blood Pressure
____ High Cholesterol
____ HIV/AIDS
____ Hypertension
____ Kidney Disease
____ Liver Disease
____ Low Blood Pressure
____ Low Blood Sugar
____ Measles
____ Menopause
____ Mononucleosis
____ Multiple Sclerosis
____ Mumps
____ Pacemaker
____ Parkinson's Disease
____ Pneumonia
____ Polio
____ Pregnancy
____ Prostate Disease
____ Prosthesis
____ Psychiatric Care
____ Psoriasis
____ Rheumatic fever
____ Rheumatoid arthritis
____ Scarlet fever
____ Sciatica
____ Scoliosis
____ Sinus problems
____ SLE (Lupus)
____ Spinal Disc Disorder
____ STDs (venereal, etc.)
____ Stroke
____ Tendonitis
____ Thyroid Disorder
____ Tumor(s)
____ Visual disturbances
____ Whooping cough

Please tell us about any major injuries, hospitalizations, serious illnesses or surgeries:

Year	Reason	Hospital	Outcome

List your prescribed medications, over-the-counter medications, herbs, vitamins and inhalers:

Product	**Reason**	**Dosage** (Example: 500mg)	**Frequency** (Example: 2x/day)	**Is it helping?**

DOCTOR SIGNATURE: _____ PATIENT SIGNATURE: _____

Please provide details of any known allergies. (eg., latex, medications, foods)

Allergy	Reaction

HEALTH HABITS

EXERCISE: How often do you exercise? ☐ **Never** ☐ **Rarely** ☐ **Occasionally** ☐ **Moderately** ☐ **Regularly**

Type of exercise: _____

If you exercise, what is the intensity? ☐ **Light** ☐ **Moderate** ☐ **Strenuous**

INTERESTS/HOBBIES: What interests, hobbies, or activities do you enjoy? _____

HABITS: Do you drink alcohol? ☐ **Never** ☐ **Once a week** ☐ **Several times a week** ☐ **Once daily** ☐ **Several times per day**

Tobacco Use:

Cigarettes: ☐ **Never** ☐ **Used in the past** ☐ **Less than ½ pack/day** ☐ **½ pack/day** ☐ **1 pack/day** ☐ **2 packs/day** ☐ **More than 2 packs/day**

Chewing tobacco: ☐ **Never** ☐ **Used in the past** ☐ **Occasionally** ☐ **Often**

Cigars: ☐ **Never** ☐ **Used in the past** ☐ **Occasionally** ☐ **Often**

For how many years have you used tobacco products? _____

If you have quit smoking, when did you quit? _____ months ago / years ago **(please circle one)**

DIET/NUTRITION: Are you dieting currently? ☐ **Yes** ☐ **No** Is this a physician prescribed medical diet? ☐ **Yes** ☐ **No**

How many meals do you eat on average every day? _____

Do you drink water daily? ☐ **0-2 glasses** ☐ **2-4 glasses** ☐ **4-6 glasses** ☐ **6-8 glasses** ☐ **8-10 glasses**

Do you drink beverages containing caffeine? ☐ **Never** ☐ **Once a week** ☐ **Several times/week** ☐ **Once daily** ☐ **Several times per day**

Do you eat refined sugar? ☐ **Never** ☐ **Once a week** ☐ **Several times per week** ☐ **Once daily** ☐ **Several times per day**

Do you consume dairy products? ☐ **Never** ☐ **Once a week** ☐ **Several times per week** ☐ **Once daily** ☐ **Several times per day**

Do you eat wheat products? ☐ **Never** ☐ **Once a week** ☐ **Several times per week** ☐ **Once daily** ☐ **Several times per day**

SLEEP PATTERNS:

Does your complaint disrupt your sleep? ☐ **Yes** ☐ **No**

How do you rate your quality of sleep?: Perfect 1 2 3 4 5 6 7 8 9 10 Terrible

What position do you sleep in? _____

Do you sleep with a pillow? ☐ **Yes** ☐ **No** **If Yes, how many?** _____

STRESS FACTORS: Please rate your stress management strategies: Perfect 1 2 3 4 5 6 7 8 9 10 Terrible

Please rate your daily stress level : None 1 2 3 4 5 6 7 8 9 10 Terrible

PREGANANCY/CHILDREN: # of Pregnancies_____ # Birth Children _____

DOCTOR SIGNATURE: _____ PATIENT SIGNATURE: _____

Please check the boxes below to indicate how this condition has affected the following aspects of your life:

	Severely	Moderately	Mildly	Not at all
Quality of work				
Ability to do household chores				
Social life				
Family life				
Recreational activities				
Quality of sleep				

Has this condition affected your life in any other way? ☐ Yes ☐ No **If Yes, how:** _____

FAMILY HEALTH HISTORY

Please help us to identify your potential health risks by **placing a check in any column that applies to you or your blood relatives.**

Condition / Body System	Self	Grandparent	Parent	Sibling	Child	None
Aids / HIV						
Arthritis						
Bleeding disorders						
Cancer						
Endocrine / glandular (diabetes, thyroid)						
Hepatitis						
Immune						
Stroke / TIA						
Circulatory Problems (blood vessels, heart)						
Ear, Nose, Throat						
Heart Problems						
High blood pressure						
Neurological (brain, nerves)						
Gastrointestinal (stomach, intestines)						
Muscle / Joint / Bone						
Genitourinary (urinary, kidney, prostate)						
Psychological						
Respiratory (lung, breathing)						
Skin						

WORK STATUS

Has this condition caused you to miss work? ☐ Yes ☐ No **(IF "NO" PLEASE SKIP THIS SECTION)**

Date you were first off work ___/___/____ **Returned to work?** ☐ Yes ☐ Limited hours only ☐ No **Date of return:**

___/___/____

(*Ex: MD, chiropractor, neurologist)*

Returned to work with recommendation from _____. ☐ **Returned without recommendation**

Can you perform your usual work duties? ☐ Yes ☐ No **Is alternative work available to you?** ☐ Yes ☐ No

Has a physician placed you on work restriction/disability? (If NO, PLEASE SKIP THIS SECTION)

☐ Yes, **TOTAL** restriction/disability ☐ Yes, **PARTIAL** restriction

By whom? (List doctor's name and specialty) _____

Please list your work restrictions _____

Return to regular work duties: Exact Date: ____/____/_____ Approx. Date : ____/____/_____

☐ **Date for return to regular work is unknown.**

DOCTOR SIGNATURE: _____ PATIENT SIGNATURE: _____