

WELCOME!!

Thank you for selecting our office.

To help us meet all your healthcare needs, please fill out this form completely.

If you have any questions or need assistance, please ask us – we will be happy to help.

Patient Information (CONFIDENTIAL)

First Name _____ Middle _____ Last _____

Birthdate ___/___/___ Age ___ Social Security# _____

Address _____

City _____ State ___ Zip _____

Phone #(C / H) _____ *E-mail _____

Gender at birth: M ___ F ___ Pronouns ___/___ Marital Status: S M W D

Employer _____ Job Title _____

Emergency Contact _____ Phone _____

{ **Family Physician** _____ **Last Physical Exam?** _____
How did you hear about us? _____
What is your primary complaint? _____

IS THIS WORKERS COMPENSATION? _____ **IS THIS PERSONAL INJURY?** _____

Insurance Information

Name of Employer _____ Work Phone _____

Insurance Co. _____ Group # _____

Policy # _____

**Your Email usage includes, but is not limited to, general office communications, appointment reminders, and office newsletter. We will never communicate your PHI via email. Opt In Opt out*

****Returning Patients:** Is this a **NEW** Complaint? Y / N **

Primary Complaint?

Location: Head Neck Shoulder Arm Mid back
 Low back buttock Leg Other _____

History of Present Illness:

Date of onset? _____ Work related? Yes/No
What caused the onset? _____

Is your Condition: Constant Intermittent
 Frequent Occasional Changing

Have you had a similar episode before? Yes No

Over the past WEEKS/MONTHS has your condition:
 Improved Worsened Not changed

How would you rate your pain right now?

None 0 1 2 3 4 5 6 7 8 9 10 Most Severe

How do the following affect your condition?

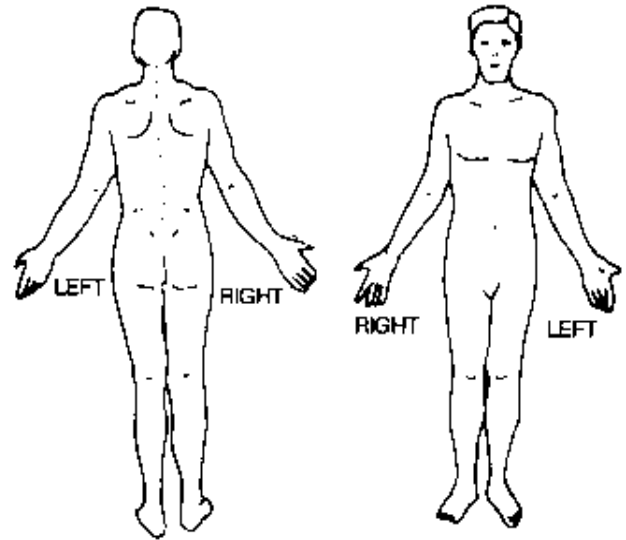
	Worse	Better	No Change
Cough/sneeze	_____	_____	_____
Sitting	_____	_____	_____
Standing (rising)	_____	_____	_____
Walking/Running	_____	_____	_____
Up/down Stairs	_____	_____	_____
Bending fwd/back	_____	_____	_____
Twisting	_____	_____	_____
Lifting	_____	_____	_____
Reaching/Grasping	_____	_____	_____
Lying on back	_____	_____	_____
Lying on stomach	_____	_____	_____
Lying on side (R/L)	_____	_____	_____
Rolling over in bed	_____	_____	_____
Looking up/down	_____	_____	_____
Turning head R/L	_____	_____	_____
AM/PM/Daytime	_____	_____	_____
Warmth/Cold	_____	_____	_____
Stretching	_____	_____	_____

How would you best describe your pain/symptom?

Sharp	Ache	Stabbing	Pins & Needles
Dull	Burn	Stinging	Numbness
Stiff	Tight	Radiating	

What are your goals regarding treatment:

Please mark your discomfort:



Prior treatment(s) for your complaint?

Medication _____
Steroid / Injection _____
Surgery _____
Physical Therapy _____
Chiropractic _____
Massage _____
MRI / X-Ray / CT Scan _____

Does your condition wake you from sleep? Y / N

What **activities** are impeded by your complaint?

1. _____
2. _____
3. _____
4. _____

What can **you** do to make your complaint better?

Does your complaint bother you at work? Y / N

___ Computer	___ Driving	___ Pushing
___ Sitting	___ Carrying	___ Pulling
___ Travel	___ Phone	___

Review of Systems: (Please check symptoms you are experiencing **related to your primary complaint**)

Constitutional: ___ Weight change ___ Fever ___ Chills ___ Night Sweats ___ Weakness/Fatigue
 Eyes: ___ Vision problem ___ Pain ___ Discharge
 Ears, Mouth, and Throat: ___ Hearing problem ___ Ringing ___ Pain ___ Discharge ___ Bleeding
 ___ Difficulty swallowing ___ Sore throat ___ Change in taste
 Skin: ___ Rash ___ Itching ___ Hair changes ___ Nail changes
 Neurologic: ___ Headaches ___ Dizziness ___ Fainting ___ Convulsions
 Gastrointestinal: ___ Appetite change ___ Stomach pain ___ Vomiting ___ Diarrhea ___ Constipation
 Genitourinary: ___ Frequent urination ___ Painful urination ___ Incontinence
 Cardiovascular: ___ Chest Pain ___ Palpitations ___ Difficulty breathing ___ Coughing
 ___ Wheezing ___ Blue extremities ___ Swollen extremities
 Psychosocial: ___ Anxiety issues ___ Depression ___ Moods ___ Memory
 Breasts (Female only): ___ Masses ___ Pain ___ Discharge
 Infection (recent): ___ Urinary tract ___ Respiratory ___ Skin ___ Other: _____

Family Medical History:

Has anyone in your family (Parents, Siblings) experienced any of the following?

___ Heart disease ___ Cancer ___ Stroke ___ Diabetes ___ Arthritis ___ High Blood Pressure
 ___ Muscle disease ___ Fibromyalgia ___ Auto-Immune ___ Alzheimer's/Dementia ___ Asthma
 Other _____

Past Medical History:

Please place a checkmark by the condition that applies to **you**:

___ Heart disease ___ Cancer ___ Arthritis ___ Alcoholism ___ Osteoporosis (penia)
 ___ High Cholesterol ___ Diabetes ___ Kidney disease ___ Seizures ___ Lung Disease ___ Concussion
 ___ High BP ___ Obesity ___ Thyroid disease ___ Ulcers ___ AIDS/HIV ___ Hepatitis
 ___ Stroke ___ IBS Issues ___ Depression ___ Anxiety ___ Joint Replacement

Other _____

Surgeries/Hospitalizations: Injuries/Fractures/Dislocations:

(Please list all that apply)

_____ Year: _____ _____ Year: _____
 _____ Year: _____ _____ Year: _____

Please list ALL of the medications/supplements you are currently taking:

Drug or Other Allergies: YES / NO if YES, please list: _____

Do you have a pacemaker? YES / NO	Are you pregnant? YES / NO / N/A (Due date: _____)
	Do you think you may become pregnant? YES / NO

Lifestyle Habits:

♦ Tobacco _____ (# of cigarettes/day) ♦ Frequency of exercise: Never Daily Weekly Monthly
 ♦ Alcohol _____ (# of drinks/week) ♦ How many times in D/W/M? _____
 ♦ Sleep _____ (#hours/day) ♦ What form of exercise do you prefer? _____
 ♦ Water _____ (#/day) ♦ **Has your condition prevented you from exercising? Y / N**

HIPAA Patient Consent Form

In this document, “I” and “my” refer to the patient, “chiropractor” refers to PSRC.

We are required by the Health Insurance Portability and Accountability act of 1996 (HIPPA) to maintain the privacy or your protected health information (PHI) and to provide you with a Notice of Privacy Practices. Our Notice of Privacy Practices provides information about how we may use and disclose your PHI. You have the right to review our Notice of Privacy Practices before signing this consent and you are encouraged to do so.

By signing this form, I consent to the use and disclosure to third parties of my PHI by chiropractor for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of chiropractor. I understand that analysis, diagnosis or treatment of me by chiropractor may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Chiropractor is not required to agree to the restrictions that I may request. However, if chiropractor agrees to a restriction that I request, the restriction is binding on chiropractor. I have the right to revoke this consent, in writing, at any time, except to the extent that chiropractor has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand that I have a right to review the Notice of Privacy Practices of chiropractor prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of chiropractor.

Chiropractor reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of chiropractor and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Signature of Patient or Responsible Party:

Date:

Printed Name

Informed Consent for Chiropractic Treatment

To the Patient: Please read this entire document prior to signing. It is important you understand the information enclosed. Please ask questions before you sign if there is anything unclear.

Chiropractic is a form of health care used to manage a wide variety of conditions including acute injury, chronic pain and disability – all related to spinal restrictions. As part of the analysis, examination and treatment, you are consenting to the following procedures: vital signs, orthopedic testing, range of motion, basic neurologic testing, muscle strength, postural analysis, functional movement evaluation, spinal manipulation, manual therapy, dry needling, therapeutic exercises, massage, and therapeutic modalities. The goal of such treatment is to accelerate recovery of ailment(s) and aid in achieving maximal functional capacity. All procedures will be thoroughly explained to you before you are asked to perform them.

The Doctor will make every reasonable effort during the examination to screen for contraindications to care; however if you have a condition that would otherwise not come to the Doctor’s attention it is your responsibility to inform the Doctor. It is your right to decline any part of your treatment at any time.

Response to chiropractic intervention varies from person to person; hence, it is not possible to accurately predict your response to treatment. As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: stiffness, soreness, fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination. Stroke and /or arterial dissection caused by chiropractic manipulation of the neck has been the subject of ongoing medical research and debate. The most current research on the topic is inconclusive as to a specific incident of this complication occurring. If there is a causal relationship at all it is extremely rare and remote. Unfortunately, there is no recognized screening procedure to identify patients with neck pain who are at risk of arterial stroke.

Other treatment options for your condition may include: • Self-administered, over-the-counter analgesics and rest • Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers • Hospitalization • Surgery. If you chose to use one of the above noted “other treatment” options you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician. Remaining untreated also has risks and benefits specific to the condition you are experiencing. Generally, leaving an injury untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

I have read, or have had read to me, the above explanation of chiropractic manipulation and related treatment(s). I understand I will have opportunities to discuss the information contained herein, with any questions I have being answered to my satisfaction, prior to beginning treatment. I understand I have the right to deny any part of treatment recommended to me at any time. By signing below I state that I have weighed the risks involved as explained herein, and have decided to undergo treatment. Having been informed of the risks, I hereby give my consent to treatment or treatment of my minor dependent.

Patient or Parent Signature:

Date:

Printed Name:

Financial Agreement

- **PAYMENT:** Due when services are rendered per applicable insurance plan details. **If you have a deductible, a payment of \$40 is required.**
- **CANCELLED APPOINTMENTS:** Please cancel appointment 24+ hours in advance. Failure to do so will result in a \$50.00 charge for missed appointments.
- **INSURANCE:** It is your responsibility to understand your insurance benefits. PSRC will NOT check insurance details and will NOT obtain authorizations for treatment. You acknowledge and agree to pay for all treatment charges resulting from no authorization, or any reason your insurance indicates claim is “not patient responsibility.”
- **COLLECTIONS:** Billing statements are sent periodically. An outstanding balance over 6 months is subject to collections. If placed into collections, you agree to pay all fees added by PSRC including, but are not limited to, a minimum \$50.00 late fee or 30-50% of the outstanding balance and attorney fees (if necessary).
- **Your insurance does NOT cover all chiropractic services.** Any denied or disputed claims will be treated as non-covered services, and you will be expected to pay such charges.

Usually covered services	Services which may NOT be covered	
<input type="checkbox"/> Initial Evaluation <input type="checkbox"/> Spinal Manipulation *Medicare does not cover exams. The cost is \$125 due at initial visit.	<input type="checkbox"/> Re-Evaluation <input type="checkbox"/> Therapeutic Exercise <input type="checkbox"/> Manual Therapy <input type="checkbox"/> Ultrasound <input type="checkbox"/> Orthotics Inserts	<input type="checkbox"/> Extremity Manipulation <input type="checkbox"/> Dry Needling <input type="checkbox"/> E-Stim <input type="checkbox"/> Infrared Light

You agree to assume full financial responsibility on all charges in excess, denied, are deemed “non-covered,” “not patient responsibility,” not medically necessary,” “investigational and/or experimental” by health or PI insurance, workers’ compensation or Medicare plan.

- **INSURANCE CHANGES:** you will notify PSRC of changes to billing details. Failure to do so, resulting in denial of billed claims, will result in you being responsible for the entirety of outstanding balance.
- If you are pursuing legal action for the injuries/conditions for which we are treating, this agreement provides a Letter of Protection ensuring that any proceeds recovered from the disposition of that legal action will be applied against any outstanding balance owed to Progressive Spine & Rehab Center.

Authorization is granted for payment directly to PSRC, of all group or individual insurance benefits payable as a result of treatment. Authorization is also granted to PSRC to release information pertaining to my treatment to the payor or its representatives via fax, phone, paper or electronically. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions

I acknowledge that I have read, understood, and fully agree to the terms outlined in the above financial policy regarding payment for professional fees. I understand that this agreement will remain in effect until I provide written notice of revocation.

X _____
Signature of Patient or Responsible Party

X _____
Date

Note: All services provided, whether covered or non-covered, will be thoroughly explained prior to application, taking care to address your questions and concerns (including cost).

OPTIONAL
DRY NEEDLING CONSENT AND INFORMATION FORM

To the patient: Please read this entire document prior to signing. It is important you understand the information enclosed. You have the right to withdraw consent for this procedure at any time.

Dry Needling involves inserting a tiny monofilament needle in a muscle or muscles in order to release shortened bands of muscles and decrease trigger point activity. This can help resolve pain and muscle tension, and will promote healing. This is not traditional Chinese Acupuncture, but is instead a medical treatment that relies on a medical diagnosis to be effective. Dry Needling is a valuable and effective treatment for musculoskeletal pain. Like any treatment, there are possible complications. While complications are rare in occurrence, they are real and must be considered prior to giving consent for treatment.

Risks: The most serious risk with Dry Needling is accidental puncture of a lung (pneumothorax). If this were to occur, it may likely require a chest x-ray and no further treatment. The symptoms of shortness of breath may last for several days to weeks. A more severe puncture can require hospitalization and re-inflation of the lung. This is a rare complication, and in skilled hands it should not be a major concern. Other risks include injury to a blood vessel causing a bruise, infection, and/or nerve injury. Bruising is a common occurrence and should not be a concern.

Patient's Consent: I understand that no guarantee or assurance has been made as to the results of this procedure and that it may not cure my condition. My therapist has also discussed with me the probability of success of this procedure, as well as the probability of serious side effects. Multiple treatment sessions may be required/needed, thus this consent will cover this treatment as well as consecutive treatments by this facility. I have read and fully understand this consent form and understand that I should not sign this form until all items, including my questions, have been explained or answered to my satisfaction. With my signature, I hereby consent to the performance of this procedure. I also consent to any measures necessary to correct complications which may result.

Please answer the following questions:

- | | | |
|---|------------------------------|-----------------------------|
| 1. Are you pregnant or think you may become pregnant? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Do you have a pacemaker or other electrical implants? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Are you currently taking anticoagulants (ex: Aspirin, blood thinners)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Are you currently taking antibiotics for an infection? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. Do you have a damaged heart valve or other risk of infection? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6. Do you suffer from metal allergies? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 7. Are you a diabetic or do you suffer from impaired wound healing? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 8. Have you undergone surgery or an implant within the past 4 months? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 9. Do you have Hepatitis B, C, HIV, or any other infectious disease? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

**** There is an additional \$35 charge for Dry Needling as this is a not covered by Insurance. ****

Signature

Date

Print Name

Relationship to patient (if other than patient)