# Advanced Spine Rehab and Athletics – Patient Intake

## GENERAL INFORMATION

Name: _____ Age: _____ Gender: M F
Home Address: _____ Home Phone: _____
City, State, Zip: _____ Cell Phone: _____
Email Address: _____ Work Phone: _____
Birth Date: _____ Social Security #: _____ Marital Status: S M D W
Occupation: _____ Employer: _____
Spouse's Name: _____ Cell Phone: _____
Spouse's Employer: _____ Occupation: _____
Names of Children: _____ Ages: _____

As a convenience to our patients, we offer appointment reminders through emails and text messages. Would you like to be set up on automatic reminders? □ Email Reminders □ Text Reminders – Cell Phone Provider: _____

## ACCIDENT INFORMATION

Is this visit due to an accident? □ Yes □ No Type? □ Auto □ Work □ Other Date of Accident: _____
Has the accident been reported? □ Yes □ No To Whom? _____

## HEALTH INSURANCE INFORMATION

Primary Health Insurance Co.: _____
Member ID #: _____ Group #: _____
Policyholder Name: _____ Relationship to Insured: _____
Policyholder SS#: _____ Policyholder DOB: _____ Employer: _____

Secondary Health Insurance Co.: _____
Member ID #: _____ Group #: _____
Policyholder Name: _____ Relationship to Insured: _____
Policyholder SS#: _____ Policyholder DOB: _____ Employer: _____

## EMERGENCY CONTACT

Name: _____ Relationship: _____
Home Phone: _____ Cell Phone: _____

I clearly understand that all insurance coverage whether accident, work or general coverage is an arrangement between my insurance carrier and myself. If this office chooses to bill any service to my insurance carrier that they are performing, these services are strictly as a convenience to me. The office will provide any necessary reports or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny my claims and that I am ultimately responsible for any unpaid balances. Any monies received will be credited to my account.

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

**Guardian's Signature Authorizing Care:** _____ **Date:** _____
I hereby authorize Advanced Spine Rehab and Athletics to administer care as deemed necessary to my child, a minor under the age of 18 years old.

# HEALTH HISTORY AND LIFESTYLE

Reason for your visit: _____

Have you seen a Medical Doctor, Chiropractor or Physical Therapist for this condition? □ Yes □ No

If yes, whom and when? _____ How did you respond to care? _____

Did your previous Doctor take before and after x-rays? □ Yes □ No

Who is your primary care physician? _____

**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 | □ Eczema |
| □ Asthma | □ Blurred Vision | □ Night Pain | □ Bowel/Bladder Changes | |

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

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

□ Other _____

Are you currently Pregnant? □ Yes □ No

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

Please list any medications you are currently taking (include dosage and frequency): _____

_____

Please list any surgeries or hospitalizations (include type and dates): _____

_____

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

Are you currently on any blood thinners? (aspirin regimen included) □ Yes □ No List type: _____

**Contraindications:** A few procedures in the office should be avoided if patient's have certain conditions. Please answer the following:

Do you have a pacemaker? □ Yes □ No Do you suffer from blood clots? □ Yes □ No Do you have a knee/hip replacement? □ Yes □ No

Do you have a local or systemic infection? □ Yes □ No Do you have a corticosteroid or Local Anesthetic Allergy? □ Yes □ No

Do you have an egg allergy? □ Yes □ No Please list any additional allergies _____

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

□ Heart Disease _____ □ Diabetes _____ □ Other _____

□ Cancer _____ □ Arthritis _____ □ Other _____

Do you exercise? □ Yes □ No How Often? _____ Per week What activities? _____

Do you work activities mostly involve: □ Sitting □ Standing □ Light Labor □ Heavy Labor

What is your daily/weekly intake of the following:

Caffeine _____ cups/day Alcohol _____ drinks/week Energy Drinks _____cups/day Cigarettes _____packs/day

**I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.**

**Patient/Guardian's Signature:** _____ **Date:** _____

# AUTHORIZATION OF CARE

I understand that Advanced Spine Rehab and Athletics will attempt to diagnose any ailments I may have and attempt to correct them through chiropractic care, active/passive rehabilitation, massage therapy and/or physical medicine. If there appears to be a condition/disease present that is out of our scope of practice, I will be referred to an appropriate physician. I am also aware that any treatment provided is meant to be beneficial and help improve my condition, however in certain cases, underlying physical defects, pathologies or deformities may increase the risk for injury. I am responsible to bring any of these conditions (illnesses, deformities, etc.) to the attention of the Doctor(s).

I also clearly understand that if I do not follow the Doctor's and/or Physician's specific recommendations that I will not receive the full benefit from the treatment/programs, and if I terminate my care prematurely that all fees incurred will be due and payable at that time. I authorize the assignment of all insurance benefits be directed to the Doctor and/or Physician for all services rendered.

I understand that I am financially responsible for all fees incurred for the services provided, regardless of any health insurance coverage that may provide payment, and I agree to ensure full payment. By signing below, I hereby authorize the clinic to release any medical information necessary to process any insurance claims. Upon receipt of written request, I authorize any fiduciary or plan administrator, my attorney or insurer to release any and all insurance policy, settlement information or plan documents to such Doctor and clinic for the purpose of medical benefits and reimbursement. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

**Name of Guarantor** (person responsible for guaranteeing payment of all services) _____

I certify that I have read and fully understand this assignment and authorize this assignment to remain in effect until revoked by me in writing. A copy of this assignment is as valid as the original.

| _____ | _____ | _____ | _____ |
|---|---|---|---|
| Patient's Name Printed | Date | Patient's Signature | Date |

| _____ | _____ | _____ |
|---|---|---|
| Minor's Name | Guardian/Spouse's Signature of Authorizing Care for Minor | Date |

# RADIOGRAPH CONSENT FORM

I understand that my consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze my condition.

By signing below, I do hereby give my consent to allow Advanced Spine Rehab and Athletics and its representatives, as deemed by the examining physician to take radiographs of my spine and/or extremities.

Female Only: I also hereby declare that to my knowledge, I am not pregnant _____ (Initial)

**Signature of Patient/Guardian of said Minor:** _____ **Date:** _____

# HIPAA / HEALTH CARE AUTHORIZATION FORM

The following authorizes **Advanced Spine Rehab and Athletics** to use and/or disclose protected health care information in accordance with the following specific authorizations:

I give my permission to Advanced Spine Rehab and Athletics to use my information, including but not limited to: name, address, phone numbers and clinical records to contact me with text or e-mail appointment reminders, birthday/holiday related cards, health related e-mail messages and information about treatment alternatives or other health related information as well as any advertisements, newsletters or patient of the week/month postings.

I also understand that my Protected Health Information may be used or disclosed to others for the purposes of treatment, obtaining payment or supporting the day-to-day health care operations of this office.

I give permission to Advanced Spine Rehab and Athletics to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protective health information during the course of my treatment. Should I need to speak with one of the Doctors or Physical Therapist in private, the Doctor or Therapist will provide a private room for these conversations. By signing the following you are giving Advanced Spine Rehab and Athletics permission to use and disclose your protected health information in accordance with the directives listed above.

**Patient/Guardian's Signature:** _____ **Date:** _____

## ACKNOWLEDGEMENT OF RECEIPT & NOTICE OF PRIVACY PRACTICES

I _____ on this date _____ understand and have been provided with a notice of privacy practices that provides me a more detailed description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent
- The right to object to the use of my health care information for directory purpose
- The right to request restrictions as to how my health care information may be used or disclosed in this office to carry out treatment, payment or health care operations.

**By signing below, I give my permission to use and disclose my health information as described above and in the privacy practices.**

**Signature of Patient/Guardian of said Minor:** _____ **Date:** _____