HEALTH QUEST chiropractic physical therapy

Welcome to Health Quest!

To maximize your time with the doctor, not to mention save you time in the waiting room, please fill out the following pages prior to your appointment. Once complete, please email back to us at one of the email addresses below:

- If you are treating in **Owings Mills, Towson/Lutherville, White Marsh or Catonsville**, please send your completed forms to ContactUs@HQChiro.com
- If you are treating in **Federal Hill or Remington/Charles Village**, please send your completed forms to TAizen@HQChiro.com

As a reminder, when you arrive for your appointment, you will need:

- A facemask worn over your nose and mouth
- Photo ID
- Insurance card (if applicable)

Note: If signature fields are not allowing you to sign any pages, we will have you sign manually during our check-in process

Thank you – we look forward to working with you!

HEALTH QUEST chiropractic physical therapy

Today's Date: _____

NEW PATIENT INFORMATION

****PLEASE PRINT LEGIBLY****

Name: _____ Social Security #: _____

Address: _____

City/State/Zip: _____ Email: _____

Home Ph.: _____ Work Ph.: _____ Cell Ph.: _____

Birth date: _____ Age: _____ Gender: M☐ F☐ Neutral☐ Marital Status: M☐ S☐ D☐ W☐

Occupation: _____ Height: _____ Weight: _____

Emergency Contact Name and Phone: _____

How did you hear about us *(we send a thank you, if possible)*? _____

Health Insurance Co: _____ Policy Subscriber: _____

Subscriber DOB: _____ ID #: _____ Group #: _____

Primary Care Dr.: _____

Are you here because of an auto related accident? Yes☐ No☐ If you answered "YES":

Name of Auto Insurance **for the car you were riding in**: _____

Attorney/Firm Name (if applicable): _____

PIP Claim #: _____

Are you here because of a work-related accident? Yes☐ No☐ If you answered "YES":

Name of Insurance Company/Adjuster: _____

Attorney/Firm Name (if applicable): _____

Claim #: _____

I hereby acknowledge that the information on this sheet is, to the best of my knowledge, true and accurate.

Patient/Guardian Signature: _____

HEALTH QUEST chiropractic physical therapy

Patient Name _____ DOB: _____ Today's Date: _____

Health History

General
- ☐ Loss of Sleep
- ☐ Fatigue
- ☐ Weight Loss
- ☐ Weight Gain
- ☐ HIV/AIDS
- ☐ Cancer
- ☐ Anemia

Ear, Eye, Nose, Throat
- ☐ Hearing difficulty
- ☐ Eye pain
- ☐ Ear pain
- ☐ TMJ/jaw pain
- ☐ Sinus Trouble
- ☐ Dental Problems

Gastrointestinal
- ☐ Loss of Appetite
- ☐ Abdominal pain
- ☐ Ulcer
- ☐ Liver Problems
- ☐ Gall Bladder Problems
- ☐ Hard masses

Cardiovascular
- ☐ Shortness of breath
- ☐ Difficulty breathing
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Heart disease
- ☐ Ankle Swelling
- ☐ Varicose Veins
- ☐ Stroke

Neurologic/Psych
- ☐ Weakness
- ☐ Headache
- ☐ Dizziness
- ☐ Seizures
- ☐ Stroke
- ☐ Numbness/Tingling
- ☐ Depression
- ☐ Anxiety

Endocrine
- ☐ Thyroid
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Diabetes

Respiratory
- ☐ Difficulty Breathing
- ☐ Chronic Cough
- ☐ Wheezing/Asthma
- ☐ Allergies

Genitourinary
- ☐ Frequent Urination
- ☐ Kidney Disease
- ☐ Urinary Infection
- ☐ Difficulty with Urination
- ☐ Breast Lump or Pain
- ☐ Hernia

Skin
- ☐ Change in Mole(s)
- ☐ Unusual masses
- ☐ Skin tenderness
- ☐ Skin changes
- ☐ Skin Cancer
- ☐ Scar Location(s)

_____

Musculoskeletal
- ☐ Neck Stiffness/Pain
- ☐ Pain Between Shoulders
- ☐ Low Back Pain
- ☐ Joint pain/swelling
- ☐ Muscle aches/soreness
- ☐ Spinal Curvature
- ☐ Arthritis

Men Only
- ☐ Prostate enlargement
- ☐ Prostate cancer
- ☐ Breast Lump or pain

Women Only
- ☐ Breast Lump or pain
- ☐ Are you pregnant Y, N, maybe?

Social Habits
- ☐ ☐M ☐ S ☐ W ☐ D
- ☐ Children ___
- ☐ Currently smoke
- ☐ Previously smoke
- ☐ Consume alcohol
- ☐ Regular exercise

Family History
(Parents & Siblings ONLY)
- ☐ Cancer
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Thyroid
- ☐ Heart Disease
- ☐ Other _____
- ☐ None of the above

☐ **None of the above**

List prior surgeries: _____
- ☐ Pacemaker
- ☐ Implants
- ☐ None

List all medications: _____
(If you have list of medications, please give to the Front Desk staff to make a copy)
- ☐ None

I hereby acknowledge that the information on this sheet is, to the best of my knowledge, true and accurate.

Patient/Guardian Signature: _____

HEALTH QUEST chiropractic physical therapy

Patient Name _____ DOB: _____ Today's Date: _____

AUTO-RELATED INJURY CONSULTATION

1. **Date of accident:** _____
2. **Were you:** Driver ☐ Front Passenger ☐ Rear Driver Side ☐ Rear Passenger Side ☐ Other: _____
3. **Were you wearing a seat belt?** Yes ☐ No ☐
4. **What type of vehicle were you in?** _____
5. **What was the *OTHER* vehicle?** _____ Not sure ☐
6. **Were multiple other vehicles involved?** Y ☐ N ☐
7. **Did your vehicle impact any other objects?** Y ☐ N ☐
8. **Was your vehicle:** ☐ Stopped ☐ Accelerating ☐ Slowing
9. **Were you working (on the job) when the accident occurred?** Y ☐ N ☐
10. **Were you taken by surprise?** Y ☐ N ☐
11. **Did air bags deploy?** Y ☐ N ☐
12. **Did you hit your head?** Y ☐ N ☐ Not Sure ☐

    If YES, your head hit: Headrest ☐ Windshield ☐ Car Door ☐ Steering Wheel ☐
13. **Did you lose consciousness (black out)?** Y ☐ N ☐ Not Sure ☐
14. **Did you strike any other body part?** Y ☐ N ☐

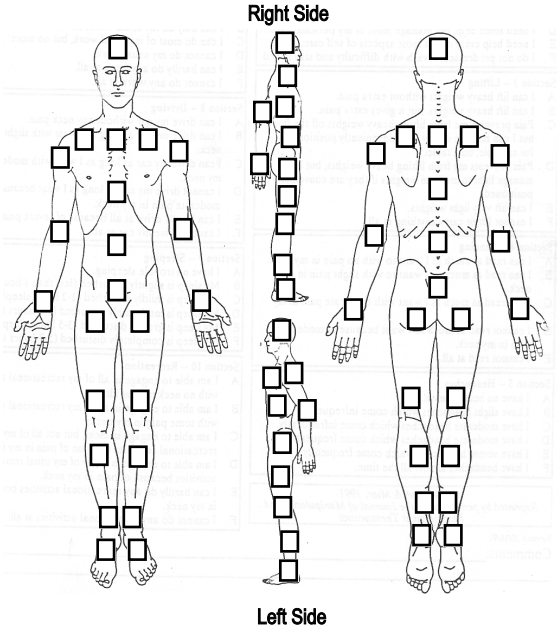
    If YES, you hit: Car Door ☐ Steering Wheel ☐ Dashboard ☐ Other ☐ Do not recall ☐
15. **Were you able to exit the vehicle by yourself?** Y ☐ N ☐
16. **Estimate of damage** ☐ Minimal ☐ Moderate ☐ Major
17. **Immediately after the accident, did you experience?** (Check all that apply)

    Anxiety ☐ Stress ☐ Dizziness ☐ Nausea ☐ Vomiting ☐ None ☐
18. **When did you first notice onset of pain after the accident?**

    Immediately ☐ Over the Next Few Hours ☐ The Next Morning ☐ Over the Next Few Days ☐
19. **Did you seek medical attention after the accident?** Y ☐ N ☐
    a. **If YES, what facility(s) did you go to?** _____
    b. **If YES, transported by ambulance?** Y ☐ N ☐
    c. **Were you prescribed medication?** Y ☐ N ☐
    d. **What tests/imaging did you receive?** X-rays ☐ CT scan ☐ MRI ☐ None ☐

Patient Name _____ DOB: _____ Today's Date: _____

20. **What kind of self-care have you tried for this condition?**
    Rest☐ Heat☐ Ice☐ Stretching☐ OTC Meds☐ Prescription Meds☐ Nothing☐ Other _____
21. **Prior motor vehicle accident?** Y☐ N☐ **If YES, when?** _____
22. **Prior work injury?** Y☐ N☐ **If YES, when?** _____
23. **What is your occupation?** _____
24. **Your occupation involves (check all that apply):** office/clerical☐ light duty☐ moderate duty☐ heavy labor☐
    prolonged driving☐ prolonged sitting☐ prolonged standing☐
25. **Have you missed time from work since the accident?** Y☐ N☐ **If YES, have you returned to work?** Y☐ N☐
26. **Where are your current symptoms?** Draw "**X**"s on the diagram below:



I hereby acknowledge that the information on this sheet is, to the best of my knowledge, true and accurate.

Patient/Guardian Signature: _____

HEALTH QUEST chiropractic physical therapy

Patient Name _____ DOB: _____ Today's Date: _____

INFORMED CONSENT FOR CHIROPRACTIC AND/OR PHYSICAL THERAPY TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic and/or physical therapy procedures on me (or the minor child named below, for whom I am legally responsible) by my treating Doctor or the staff of Health Quest Chiropractic & Physical Therapy, LLC. The practice of chiropractic includes many standard examinations and testing procedures. These include physical examination, orthopedic and neurological testing, palpation, specialized instrumentation, laboratory tests, radiology examinations, physical therapy and rehabilitative procedures. Additionally, there is a procedure unique to the chiropractic profession – the chiropractic spinal/limb adjustment.

My treatment options with possible adverse effects have been explained as follows:

1. **Chiropractic Treatment:** Chiropractic adjustments involve the use of the hands or the use of hand-guided instruments to manipulate the spinal or limb joints for the purpose of increasing joint movement. In the practice of chiropractic, as in the practice of medicine, there are some risks to treatment, including but not limited to fractures, disc injuries, dislocations, musculoskeletal sprains or strains, and vertebral artery syndrome (VAS). The risks or complications are seldom enough to contraindicate care, but should be considered in making the decision to receive chiropractic care. (Risk of stroke after manipulation is 1.46 per million manipulations. Rand Study 1996)
2. **Drug Therapy**: This includes over-the-counter or prescribed (for NSAIDS) such as Ibuprofen, Tylenol, Aleve, etc. Serious gastronomical events are 1,000 per million in all ages; 3,200 per million in those 65 years and older. (Rand Study)
3. **Surgical Treatment**: In-hospital surgeries involve risk as well. Death from neck surgery is 6,900 per million; neurological complications is 15,600 per million. (Rand Study 1996)
4. **No Treatment**: Remaining untreated allows for the formation of adhesions which reduce mobility and can set up further pain reaction and potential impairment or disability.

I do not expect my treating doctor or other licensed associates from Health Quest to be able to anticipate and explain all risks and complications, and I choose to rely the Doctors or other associates to exercise their best professional judgment during the course of the procedures which they think, at the time, based upon the facts then known, is in my best interest.

I HAVE READ (OR HAVE HAD READ TO ME) THE ABOVE CONSENT. I have also had the opportunity to ask questions about its content, and by signing below, I agree to the aforementioned procedures. I intend this **INFORMED CONSENT to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.**

_____ _____

Signature of patient (or guardian) Date

HEALTH QUEST chiropractic physical therapy

Patient Name _____ DOB: _____ Today's Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand and have been provided with a *Notice of Privacy Practices* (on our website) that provides a more complete description of information uses and disclosures,

AUTHORIZATION FOR RELEASE OF RECORDS

I hereby authorize Health Quest Chiropractic & Physical Therapy, LLC (Health Quest) to furnish my attorney and/or insurance carrier with any and all medical information, bills and/or records necessary for payment of services rendered to me or my dependent(s) at Health Quest. I also authorize any company that is in any way involved with any aspect of my claim to disclose any and all aspects of my claim to Health Quest so that appropriate status may be determined in the processing of my diagnosis, treatment and/or claim.

ASSIGNMENT OF BENEFITS/DOCTOR'S LIEN

I understand that health and accident policies are an arrangement between my attorney and/or insurance carrier and myself. Furthermore, I understand Health Quest will assist me in submitting claims to my attorney and/or insurance company. I hereby irrevocably assign to Health Quest Chiropractic & Physical Therapy, LLC and direct said attorneys to pay from the proceeds of any recovery in my case all reasonable fees for services provided by Health Quest, including fees for preparation and testimony, as a result of my injury or condition.

Payment is to be made directly to:
Health Quest Chiropractic & Physical Therapy, LLC; 7920 McDonogh Road, Suite 101; Owings Mills, MD 21117

FINANCIAL POLICY

I understand full payment of health insurance copays, estimated coinsurance, deductibles and/or services not covered by another party is due at the time of service. If my insurance plan requires a referral, I am responsible for bringing the referral prior to treatment. If I fail to provide a proper referral, I will be required to pay for my visit as if I was non-insured. I also understand it is my responsibility to notify Health Quest in writing of any changes in my personal information and/or changes of insurance information.

I agree that all unpaid invoices accrue interest at the rate of 6% per annum from the date of invoice, if any outstanding balance is not paid in full within thirty (30) days of the invoice date. I agree that should I not pay my balance in full, and Health Quest hires an attorney to pursue collection, that I am responsible for all litigation costs incurred by Health Quest, including reasonable attorney's fees in the amount of no less than 15% of the principal balance due and owing. I further agree that the Statute of Limitations applicable to any civil claim Health Quest may bring with respect to any claim for services mentioned above will not begin to run until I send a denial, in writing, of any outstanding balance. Said written denial must be mailed certified mail, return receipt requested, and said return receipt will be required to show proof of the notice of this denial. I understand that Health Quest does not waive its rights under this Paragraph if not immediately enforced.

I understand it is my responsibility to notify Health Quest 24 hours in advance if I am unable to make my scheduled appointment. There will be a $25 fee assessed to my account if I fail to do so. I understand all overpayments more than $10.00 will be automatically refunded to me once all outstanding claims have been processed by my insurance. Overpayments under $10 will remain credited to my account for future use unless I request a reimbursement.

Patient/Guardian Signature: _____ Date: _____