



## 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](mailto:ContactUs@HQChiro.com)
- If you are treating in **Federal Hill or Remington/Charles Village**, please send your completed forms to [TAizen@HQChiro.com](mailto: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!

## 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: \_\_\_\_\_

Patient Name \_\_\_\_\_ DOB: \_\_\_\_\_ Today's Date: \_\_\_\_\_

### Health History

<p align="center"><b><u>General</u></b></p> <p><input type="checkbox"/> Loss of Sleep</p> <p><input type="checkbox"/> Fatigue</p> <p><input type="checkbox"/> Weight Loss</p> <p><input type="checkbox"/> Weight Gain</p> <p><input type="checkbox"/> HIV/AIDS</p> <p><input type="checkbox"/> Cancer</p> <p><input type="checkbox"/> Anemia</p> <p align="center"><b><u>Ear, Eye, Nose, Throat</u></b></p> <p><input type="checkbox"/> Hearing difficulty</p> <p><input type="checkbox"/> Eye pain</p> <p><input type="checkbox"/> Ear pain</p> <p><input type="checkbox"/> TMJ/jaw pain</p> <p><input type="checkbox"/> Sinus Trouble</p> <p><input type="checkbox"/> Dental Problems</p> <p align="center"><b><u>Gastrointestinal</u></b></p> <p><input type="checkbox"/> Loss of Appetite</p> <p><input type="checkbox"/> Abdominal pain</p> <p><input type="checkbox"/> Ulcer</p> <p><input type="checkbox"/> Liver Problems</p> <p><input type="checkbox"/> Gall Bladder Problems</p> <p><input type="checkbox"/> Hard masses</p>	<p align="center"><b><u>Cardiovascular</u></b></p> <p><input type="checkbox"/> Shortness of breath</p> <p><input type="checkbox"/> Difficulty breathing</p> <p><input type="checkbox"/> High Blood Pressure</p> <p><input type="checkbox"/> High Cholesterol</p> <p><input type="checkbox"/> Heart disease</p> <p><input type="checkbox"/> Ankle Swelling</p> <p><input type="checkbox"/> Varicose Veins</p> <p><input type="checkbox"/> Stroke</p> <p align="center"><b><u>Neurologic/Psych</u></b></p> <p><input type="checkbox"/> Weakness</p> <p><input type="checkbox"/> Headache</p> <p><input type="checkbox"/> Dizziness</p> <p><input type="checkbox"/> Seizures</p> <p><input type="checkbox"/> Stroke</p> <p><input type="checkbox"/> Numbness/Tingling</p> <p><input type="checkbox"/> Depression</p> <p><input type="checkbox"/> Anxiety</p> <p align="center"><b><u>Endocrine</u></b></p> <p><input type="checkbox"/> Thyroid</p> <p><input type="checkbox"/> Osteopenia</p> <p><input type="checkbox"/> Osteoporosis</p> <p><input type="checkbox"/> Diabetes</p> <p align="center"><b><u>Respiratory</u></b></p> <p><input type="checkbox"/> Difficulty Breathing</p> <p><input type="checkbox"/> Chronic Cough</p> <p><input type="checkbox"/> Wheezing/Asthma</p> <p><input type="checkbox"/> Allergies</p>	<p align="center"><b><u>Genitourinary</u></b></p> <p><input type="checkbox"/> Frequent Urination</p> <p><input type="checkbox"/> Kidney Disease</p> <p><input type="checkbox"/> Urinary Infection</p> <p><input type="checkbox"/> Difficulty with Urination</p> <p><input type="checkbox"/> Breast Lump or Pain</p> <p><input type="checkbox"/> Hernia</p> <p align="center"><b><u>Skin</u></b></p> <p><input type="checkbox"/> Change in Mole(s)</p> <p><input type="checkbox"/> Unusual masses</p> <p><input type="checkbox"/> Skin tenderness</p> <p><input type="checkbox"/> Skin changes</p> <p><input type="checkbox"/> Skin Cancer</p> <p><input type="checkbox"/> Scar Location(s) _____</p> <p align="center"><b><u>Musculoskeletal</u></b></p> <p><input type="checkbox"/> Neck Stiffness/Pain</p> <p><input type="checkbox"/> Pain Between Shoulders</p> <p><input type="checkbox"/> Low Back Pain</p> <p><input type="checkbox"/> Joint pain/swelling</p> <p><input type="checkbox"/> Muscle aches/soreness</p> <p><input type="checkbox"/> Spinal Curvature</p> <p><input type="checkbox"/> Arthritis</p>	<p align="center"><b><u>Men Only</u></b></p> <p><input type="checkbox"/> Prostate enlargement</p> <p><input type="checkbox"/> Prostate cancer</p> <p><input type="checkbox"/> Breast Lump or pain</p> <p align="center"><b><u>Women Only</u></b></p> <p><input type="checkbox"/> Breast Lump or pain</p> <p><input type="checkbox"/> Are you pregnant Y, N, maybe?</p> <p align="center"><b><u>Social Habits</u></b></p> <p><input type="checkbox"/> __ M __ S __ W __ D</p> <p><input type="checkbox"/> Children ____</p> <p><input type="checkbox"/> Currently smoke</p> <p><input type="checkbox"/> Previously smoke</p> <p><input type="checkbox"/> Consume alcohol</p> <p><input type="checkbox"/> Regular exercise</p> <p align="center"><b><u>Family History</u></b> <b>(Parents &amp; Siblings ONLY)</b></p> <p><input type="checkbox"/> Cancer</p> <p><input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> High Blood Pressure</p> <p><input type="checkbox"/> Thyroid</p> <p><input type="checkbox"/> Heart Disease</p> <p><input type="checkbox"/> Other _____</p> <p><input type="checkbox"/> None of the above</p>
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☐ 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: \_\_\_\_\_

Patient Name \_\_\_\_\_ DOB: \_\_\_\_\_ Today's Date: \_\_\_\_\_

## WORK-RELATED INJURY CONSULTATION

1. Date of accident: \_\_\_\_\_
2. What is your occupation? \_\_\_\_\_
3. Where are your current symptoms? Draw "X"s on the diagram to the right:
4. Did you seek medical attention after accident? Y ☐ N ☐

a. If YES, what facility(s) did you go to?

b. Were you prescribed medication? Y ☐ N ☐ If YES, please list:

c. What tests/imaging did you receive?

X-rays ☐ CT scan ☐ MRI ☐ Don't Recall ☐ None ☐

5. Were you prescribed any other medical care? Y ☐ N ☐
6. Were you given a note to be excused from work? Y ☐ N ☐

If YES, for what dates: \_\_\_\_\_

7. Have you returned to work? Y ☐ N ☐

If YES, when did you return: \_\_\_\_\_

Work Status: Full Time Hours ☐ Modified Hours ☐ Full duty ☐ Modified duty ☐

8. Are you working in pain? Y ☐ N ☐

9. Prior motor vehicle accident? Y ☐ N ☐

10. If YES, when? \_\_\_\_\_ Resolved ☐ Unresolved ☐

11. Prior work-related injury? Y ☐ N ☐

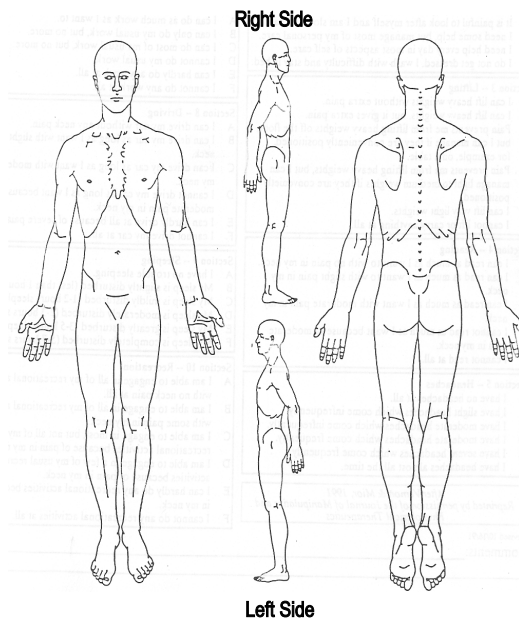
12. If YES, when? \_\_\_\_\_ Resolved ☐ Unresolved ☐

13. Your occupation involves (check all that apply):

office/clerical ☐ light duty ☐ moderate duty ☐ Heavy Labor ☐ prolonged driving ☐ prolonged sitting ☐

14. What kind of self-care have you tried for this condition?

Rest ☐ Heat ☐ Ice ☐ Stretching ☐ OTC Meds ☐ Prescription Meds ☐ Nothing ☐ Other \_\_\_\_\_



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

Patient/Guardian Signature: \_\_\_\_\_

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

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: \_\_\_\_\_