PATIENT INITIAL PAPERWORK

GENERAL INFORMATION:

NAME: _____ AGE: _____ SEX: M / F

ADDRESS:_____

CITY: _____ STATE: _____ ZIP: _____

CELL PHONE: _____ BIRTHDATE: _____

EMAIL ADDRESS: _____

REFERRED BY: ▫ Friend ▫ Company ▫ Online Search ▫ Insurance Provider ▫ Other:_____

Please Select Payment Option: ▫ Keep Card on File ▫ Paypal Invoice ▫ At Time of Service

INSURANCE:

I clearly understand that all insurance coverage, whether accident, work related, or general coverage is an arrangement between my insurance carrier and myself. This office will provide any necessary reports or required information to aid in insurance reimbursement of services, but I understand that insurance carries may deny my claims and I am ultimately responsible for any unpaid balances.

Patient Signature:_____ Date:_____

Insurance Company:_____ Phone:_____

ID / Subscriber #:_____ Group #:_____

CONSENT FOR CARE:

I give the doctors, therapists and staff permission and authority to care for me in accordance with testing, diagnosis, analysis and treatment. I am responsible to inform you of any symptoms, conditions, or issues which would otherwise not come to their attention.

Patient Signature: _____ Date:_____

HIPPA NOTICE:

I acknowledge and agree to the following:

1. The privacy notice is available to me now and at any time in the future.
2. Appointment reminders may be used by the practice via email, phone or postcards.
3. I understand that if I revoke this consent at any time, the practice has the right to refuse treatment.
4. I authorize the release of my medical information to the following person(s): _____

Patient Signature: _____ Date:_____

WHAT BRINGS YOU IN TODAY?

Describe symptom/pain:_____

Is this related to auto accident / work injury: YES / NO

When did this begin?_____

What aggravates symptoms?_____

What helps/relieves symptoms?_____

Have you experienced these symptoms before? YES / NO

Who have you seen for this?_____

What did they do?_____

How did you respond?_____

What is your goal of your care? Pain Relief / Wellness / Both

LIFESTYLE:

Do you exercise? YES / NO How often/activities?_____

Do you smoke? YES / NO How much?_____

Do you drink alcohol? YES / NO How much/week?_____

Do you drink caffeine? YES / NO How much/day?_____

List vitamins/supplements:_____

List medications:_____

How many cups of water do you drink per day:_____

HEALTH CONDITIONS:

It is important for us to have a good understanding of your overall health. Please check any health conditions/symptoms that you may be experiencing currently and up to 6 months ago.

Cervical Region (Neck) -

▫ Neck Pain ▫ Headaches / Migraines ▫ Seizures ▫ Pain in shoulders/arms/hands

▫ Dizziness ▫ TMJ pain/clicking ▫ Weakness in grip ▫ Numb/Tingle in arms/hands

Thoracic Region (Upper & Mid Back) -

▫ Upper back pain ▫ Pain on deep breathing ▫ Mid back pain ▫ Pain in ribs/chest

Lumbar & Pelvis Region (Low Back & Hips) -

▫ Low Back Pain ▫ Pain in hips/legs/feet ▫ Weakness in legs/feet ▫ Numbness in legs/feet

List all Surgeries:_____

List any other Health Conditions not mentioned:_____