PATIENT INITIAL PAPERWORK

NAME: _____ PREFERRED PRONOUNS: _____

AGE: _____ BIRTHDATE: _____ SEX: ☐ M / F ☐

ADDRESS:_____

CITY: _____ STATE: _____ ZIP: _____

EMAIL: _____ CELL PHONE: _____

REFERRED BY:
□ Family / Friend □ Company □ Online Search □ Insurance Provider □ Other:_____

PREFERRED PAYMENT METHOD: □ Time of Service □ Credit Card on File □ PayPal

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 carriers may deny my claims and I am ultimately responsible for any unpaid balances. We are in-network with BCBS, Cigna, Aetna, MVP, and CBA Blue. If your insurance is not listed, please reach out prior to your appointment should you have any questions about billing and/or our non-insurance rates.

Insurance Company: _____

ID / Subscriber #:_____ Group #:_____

Patient Signature:_____ Date: _____

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 an auto accident / work injury: ☐ YES ☐ NO

When did this begin? _____

What aggravates symptoms? _____

What helps and/or relieves symptoms? _____

Have you experienced these symptoms before? ☐ YES ☐ NO

Who have you seen for this? _____

What did they do/response? _____

What is your goal of care (select all that apply)?

□ Pain Relief □ Improved Athletic Performance □ Maintenance

LIFESTYLE:

EXERCISE: Activities and frequency? _____

WATER INTAKE: How many ounces per day? _____

TOBACCO USE: How much? _____

LIST MEDICATIONS: _____

LIST VITAMINS / SUPPLEMENTS: _____

OVERALL: 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 □ Pain in shoulders/arms/hands □ Dizziness
□ TMJ Pain/clicking □ Numb/Tingle in arms/hands

Thoracic Region (Upper & Mid Back):

□ Upper back pain □ Mid back pain □ Pain in ribs/chest

Lumber & Pelvis Region (Lower Back & Hips):

□ Low back pain □ Pain in hips/legs/feet □ Sciatica into legs/feet

List all surgeries: _____

List any other health conditions: _____

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