

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_ Date: \_\_\_\_\_

Ht: \_\_\_\_\_ Wt: \_\_\_\_\_ Pulse: \_\_\_\_\_ BP: \_\_\_\_\_ RESP: \_\_\_\_\_ TEMP: \_\_\_\_\_

**Chief Complaint:**

*What is the main reason for seeking treatment?* \_\_\_\_\_

**How did this happen?** \_\_\_\_\_

**How long have you experienced your symptoms?** \_\_\_\_\_

**How bad are your symptoms at their worst?** 1 2 3 4 5 6 7 8 9 10 (circle) - 10 being the worst

**How bad are your symptoms at their best?** 1 2 3 4 5 6 7 8 9 10 (circle) - 10 being the worst

**What, if anything has made the problem worse?**

Driving  walking  working  bending  sports  sleeping  Other: \_\_\_\_\_

**What, if anything, has made the problem better?**

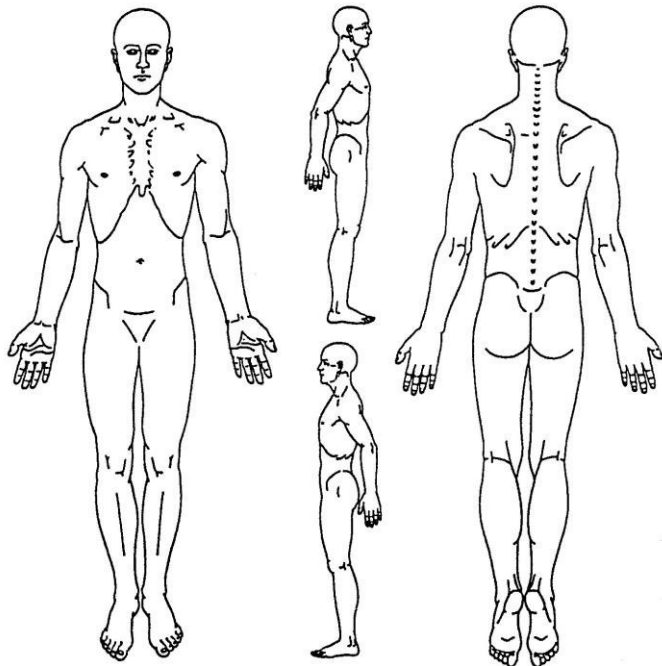
Rest  ice  heat  elevation  NSAIDS  pain meds  nothing

**What have you tried?**

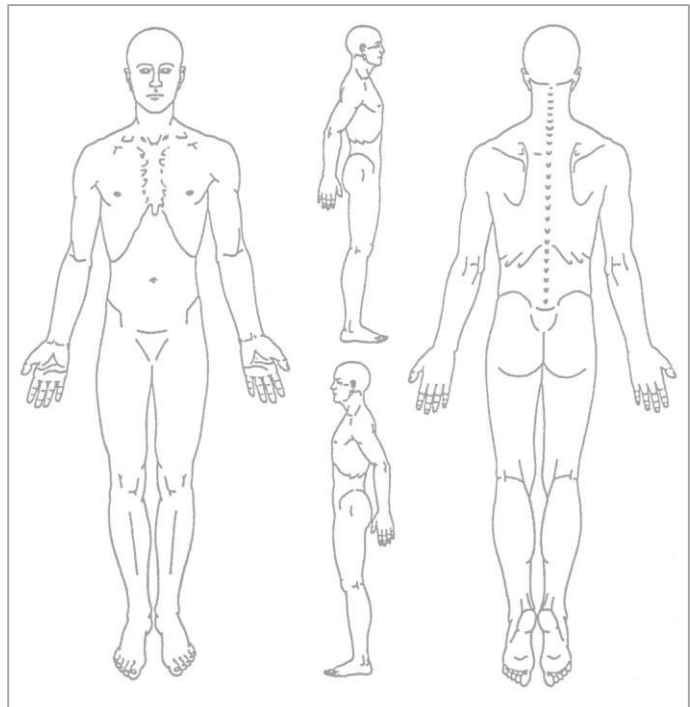
Chiropractic  Physical Therapy  Injections  Other: \_\_\_\_\_

**What was the outcome?** \_\_\_\_\_

Areas of complaint (please circle areas)



(provider use only)



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**History of Present Injury/Illness:**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Neck Pain/Stiffness | <input type="checkbox"/> Pins/Needles in Arms  | <input type="checkbox"/> Light Bothers Eyes    |
| <input type="checkbox"/> Sudden Weight Loss  | <input type="checkbox"/> Pins/Needles in Legs  | <input type="checkbox"/> Loss of Taste         |
| <input type="checkbox"/> Back Pain/Stiffness | <input type="checkbox"/> Depression            | <input type="checkbox"/> Nausea                |
| <input type="checkbox"/> Cold Feet           | <input type="checkbox"/> Arm/Hand Pain         | <input type="checkbox"/> Fatigue               |
| <input type="checkbox"/> Nervousness         | <input type="checkbox"/> Loss of Memory        | <input type="checkbox"/> Chest Pain            |
| <input type="checkbox"/> Leg/Knee Pain       | <input type="checkbox"/> Sleeping Difficulties | <input type="checkbox"/> Tension               |
| <input type="checkbox"/> Jaw Problems        | <input type="checkbox"/> Fever                 | <input type="checkbox"/> Headaches             |
| <input type="checkbox"/> Loss of Smell       | <input type="checkbox"/> Cold Sweats           | <input type="checkbox"/> Constipation          |
| <input type="checkbox"/> Fainting            | <input type="checkbox"/> Dizziness             | <input type="checkbox"/> Allergies             |
| <input type="checkbox"/> Stomach Problems    | <input type="checkbox"/> Shortness of Breath   | <input type="checkbox"/> Asthma                |
| <input type="checkbox"/> Blurred Vision      | <input type="checkbox"/> Night Pain            | <input type="checkbox"/> Bowel/Bladder Changes |

**History:**

- |  |   |                                    |   |   |
|--|---|------------------------------------|---|---|
| <input type="checkbox"/> Hypertension  | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Migraines | <input type="checkbox"/> Liver Disease      | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Herniated disc   | <input type="checkbox"/> Cancer    | <input type="checkbox"/> Kidney Disease     | <input type="checkbox"/> Fibromyalgia         |
| <input type="checkbox"/> Pinched nerve | <input type="checkbox"/> Pacemaker        | <input type="checkbox"/> Ulcers    | <input type="checkbox"/> Osteoporosis       | <input type="checkbox"/> Thyroid problems     |
| <input type="checkbox"/> Stroke        | <input type="checkbox"/> Arthritis        | <input type="checkbox"/> Diabetes  | <input type="checkbox"/> Bleeding Disorders |   |

Are you currently under drug and/or medical care?  Yes  No

Do you have any Allergies to Medications? \_\_\_\_\_

Who is your primary care Doctor? \_\_\_\_\_

List all medications: (Be sure to include dosage and frequency): \_\_\_\_\_

Supplements (vitamins/herbs/minerals): \_\_\_\_\_

Surgeries and/ hospitalizations (type & date): \_\_\_\_\_

**WOMEN ONLY:** Date of LMP: \_\_\_\_\_ **Any possibility of pregnancy: YES or NO**

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

- |  |   |                                       |
|--|---|---------------------------------------|
| <input type="checkbox"/> Heart Disease _____ | <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Cancer _____ |
| <input type="checkbox"/> Arthritis _____     | <input type="checkbox"/> Other _____    |                                       |

Intake of following: Cigarettes \_\_\_\_\_ packs/day Alcohol \_\_\_\_\_ drinks/week Caffeine \_\_\_\_\_ cups/day

Exercise frequency:  Never  Daily  Weekly

Type of exercise:  Walks  Runs  Swims  Other: \_\_\_\_\_

Occupation: \_\_\_\_\_

Does work mostly involve :  Sitting  Standing  Light Labor  Heavy Labor

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DOB: \_\_\_\_\_ Date: \_\_\_\_\_

## NEUROLOGICAL/ MRI/ VASCULAR PATIENT QUESTIONNAIRE

*For any YES answer, please include details.*

1. Do you suffer from neck pain with pain in your shoulder, arms or hands? NO YES  
Comment: \_\_\_\_\_
2. Do you have weakness, numbness or burning in your shoulder, arms or hands? NO YES  
Comment: \_\_\_\_\_
3. Do your hands or arms fall asleep regularly? NO YES  
Comment: \_\_\_\_\_
4. Do you have reduced feeling (sensation) or swelling in your hands or arms? NO YES  
Comment: \_\_\_\_\_
5. Do you suffer from a loss of handgrip strength? NO YES  
Comment: \_\_\_\_\_
6. Do you suffer from back pain with pain in your buttocks, legs or feet? NO YES  
Comment: \_\_\_\_\_
7. Do you have weakness, numbness or burning in your buttocks, legs or feet? NO YES  
Comment: \_\_\_\_\_
8. Do your legs or feet fall asleep regularly? NO YES  
Comment: \_\_\_\_\_
9. Do you have reduced feeling (sensation) or swelling in your legs, feet? NO YES  
Comment: \_\_\_\_\_
10. Do you suffer from cold hands or feet? NO YES  
Comment: \_\_\_\_\_
11. Do you suffer from seasonal or year round allergies? NO YES  
Comment: \_\_\_\_\_
12. Do you suffer from headaches? If yes, how often, how severe, what has been tried? NO YES  
Comment: \_\_\_\_\_
13. Do you/have you suffered from TMJ? What treatments have you tried?  
(bite guard, ice, massage, dental work, PT, Rx meds) NO YES  
Comment: \_\_\_\_\_
14. Any medicines previously tried for this complaint, dosage, duration and outcome. NO YES  
 Advil  Aleve  Tylenol  Steroids  Other: \_\_\_\_\_  
Prescriptions for a period of  0-3mos,  3-6mos,  6-12 mos  12+mos
15. Have you had an MRI or X-rays? NO YES  
If yes: When? Who ordered it? What was it ordered for? What facility? \_\_\_\_\_
16. Have you used any splint or braces or other prescribed treatment by your doctor? NO YES  
When? What kind? Who ordered it? \_\_\_\_\_

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ACTIVITIES OF DAILY LIVING	REQUIRES NO ASSISTANCE	SOME ASSISTANCE NEEDED	COMPLETE ASSISTANCE NEEDED	NOT APPLICABLE
BATHING/GROOMING				
DRESSING				
TOILETING				
TRANSFERRING				
WALKING				
CLIMBING STAIRS				
EATING				
SHOPPING				
COOKING				
MANAGING MEDICATIONS				
USES THE PHONE				
HOUSE WORK				
LAUNDRY				
DRIVING				

**PATIENT HEALTH INFORMATION ATTESTATION**

To the best of my knowledge, the information I have provided is accurate and complete. I understand that providing incorrect or incomplete information may affect my care. It is my responsibility to inform Restorative Spine and Joint of any changes in my medical condition or health status.

Patient Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Chiropractor Signature: \_\_\_\_\_ Date Reviewed: \_\_\_\_\_

Advanced Practice Provider Signature: \_\_\_\_\_ Date Reviewed: \_\_\_\_\_

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_ Date: \_\_\_\_\_

Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_  Male  Female

Patient's Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Cell phone \_\_\_\_\_ Alternate Phone \_\_\_\_\_

Email: \_\_\_\_\_

Employer Name: \_\_\_\_\_

Check appropriate Box:  Minor  Single  Married  Divorced  Widowed  Separated

Spouse or Patient's Guardian name \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Authorized Person to contact in case of an emergency: \_\_\_\_\_ Phone \_\_\_\_\_

### Responsible Party

Name of the person responsible for this account \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Driver's License # \_\_\_\_\_

Date of Birth: \_\_\_\_\_ is the person currently a patient at our office?  Yes  No

**Do you have Medical insurance?**  Yes  No if yes, complete the following:

Name of the insured \_\_\_\_\_

Relationship to patient \_\_\_\_\_ Birthdate \_\_\_\_\_ SS # \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_

Subscriber # \_\_\_\_\_ Union or local # \_\_\_\_\_

Ins. Co. Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

### CONSENT TO ELECTRONIC COMMUNICATIONS

I consent to receive communications from Restorative Spine and Joint via text message and/or email. I understand that these methods of communication may not be secure and may involve some risk to the privacy of my health information.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### RESTORATIVE SPINE & JOINT CONSENT TO CHIROPRACTIC CARE

I consent to examination and chiropractic care, including manipulation, manual therapy, and related therapeutic procedures, as clinically indicated by the providers at Restorative Spine and Joint. If the patient is a minor, I certify that I am the parent or legal guardian and have authority to consent to treatment. I understand that the nature and purpose of care will be explained to me, that I may ask questions and refuse or discontinue treatment at any time, and that results are not guaranteed. I understand that risks may include, but are not limited to: increased pain or discomfort, fractures, disc injuries, strokes, dislocations, and sprains. Therapeutic procedures and exercise may also involve risk, including rare cardiovascular events. I understand that not all risks can be anticipated. By signing below, I consent to care provided by Restorative Spine and Joint.

This consent remains valid for ongoing and future care unless revoked in writing.

Patient Name: \_\_\_\_\_

Signature of Patient or Parent/Guardian: \_\_\_\_\_

Relationship (if minor): \_\_\_\_\_ Date: \_\_\_\_\_

### ASSIGNMENT OF BENEFITS, LIMITED AUTHORIZATION, AND ERISA RIGHTS

I understand that I am financially responsible for all services rendered, regardless of insurance coverage. I assign and authorize payment of medical benefits directly to Restorative Spine and Joint. I authorize the use and disclosure of my health information for treatment, payment, healthcare operations, and insurance processing, in accordance with applicable law, including HIPAA and California law. If my plan is governed by ERISA, I assign the right to receive benefits, submit claims, appeal determinations, and

Patient Name:

\_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

obtain plan information related to services provided. This assignment is limited to payment matters and does not constitute a general power of attorney.

Signature of Patient or Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

#### **ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES**

I acknowledge that I have received or been offered the Notice of Privacy Practices and understand my rights. A copy is available upon request and on the practice website.

Patient Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If Personal Representative, relationship: \_\_\_\_\_

#### **FINANCIAL POLICY**

I understand that all charges are my responsibility regardless of insurance coverage, and that insurance is a contract between me and my insurer. As a courtesy, the practice may bill my insurance; however, verification of benefits is not a guarantee of payment. I am responsible for all co-payments, deductibles, co-insurance, and non-covered services.

**If my claim is unpaid or denied, I agree to pay the balance due.**

**Personal Injury / Auto:** I understand that third-party billing may be submitted, but I remain responsible for payment.

**Medicare:** I understand Medicare will be billed where applicable and I am responsible for non-covered services.

#### **WORK-RELATED INJURY DISCLOSURE**

I certify that my condition is not work-related. I understand this practice does not treat workers' compensation injuries and I may be referred if applicable.

#### **ADDITIONAL TERMS**

Time of Service: Discounts may apply only when payment is made at the time of service.

Missed Appointments: Less than 24-hour notice may result in a \$40 fee. Repeated missed appointments may result in scheduling limitations or discharge from care. Collections: Delinquent accounts may be subject to collection efforts, and I may be responsible for associated costs as permitted by law.

#### **AGREEMENT**

I have read and understand this Financial Policy and agree to be responsible for payment.

Patient Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

#### **OUT-OF-NETWORK FINANCIAL DISCLOSURE**

I understand that Restorative Spine & Joint may be out-of-network with my insurance. Reimbursement may be reduced or denied, and I am responsible for any difference between billed charges and insurance payment, including deductibles, co-insurance, and non-covered services.

Estimates are not guarantees of payment. I am responsible for all charges except where limited by law.

Patient Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_