# Application for Patient Care

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**Patient Information**

Name: ______________________________________________
Last First MI

Email address: ______________________________________________

Mailing Address: ______________________________________________

Phone Number: Home____________________Work ____________________Other ____________________

Your preferred method of contact for appointment reminders? Email / Text by Cell Phone/ Phone Call

Date of Birth: ______________ Sex: ☐ Male ☐ Female SS# ____________________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Minor

Race: ☐ Caucasian ☐ African American ☐ Asian ☐ Native American ☐ Latin American ☐ Other____________

Ethnicity: ☐ Hispanic ☐ Latino ☐ Non-Hispanic/Non- Latino

Occupation: ______________________________ Employer: ______________________________

Employer Address:______________________________ Phone Number: ____________________

How did you hear about our office? ______________________________________________

Emergency Contact: Name ____________________ Relation: ______________Phone # ____________________

**Accident Information**

Is this visit due to an accident? ☐ Yes ☐ No If yes, what type? ☐ Auto ☐ Work ☐ Other____________

Has it been reported? ☐ Yes ☐ No If yes, to whom?______________________________

Attorney Information: ______________________________ Phone Number:____________________

**Insurance Information**

Name of Health Insurance Carrier: ______________________ Secondary Insurance?____________________

Policy Holder Name: ______________________________ DOB ______________________________

Relationship to Patient (if other than self):____________________ Phone # ____________________

**PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR ID & INSURANCE CARD(S)**

**SIGNATURE (X)** ______________________________ **DATE** ____________________

## Patient Health History

**Check off any of the following symptoms you have experienced in the past 6 months:**

- ☐ Low Back Pain
- ☐ Pain between Shoulder
- ☐ Neck Pain
- ☐ Tension/Headaches
- ☐ Fibromyalgia
- ☐ Tension Across Top of Shoulders
- ☐ Numbness/Tingling in Arms/Hands
- ☐ Numbness/Tingling in Legs/Feet
- ☐ Pain in the legs
- ☐ Pain in the feet
- ☐ Tired/Fatigued
- ☐ Difficulty Sleeping
- ☐ Allergies
- ☐ Digestive
- ☐ Carpal Tunnel

Other (explain) ______________________________

Which of the above is the worst? ______________________________

How long have you had it? ______________________________

How often does it occur? ______________________________

What does it feel like?(describe) ______________________________

What have you done that has helped this problem? ______________________________

What activities would you like to do if this was not a problem? ______________________________

**Does this cause you to be:**
- ☐ Moody
- ☐ Irritable
- ☐ Interrupt sleep
- ☐ Restricted in your daily

**Does this affect your work:**
- ☐ Decision making
- ☐ Poor attitude
- ☐ Decreased productivity
- ☐ Exhausted at the end of the day
- ☐ Unable to work long hours

**Does this affect your life:**
- ☐ Lose patience with spouse/children
- ☐ Restricted household duties
- ☐ Hinders ability to exercise or
- ☐ Interferes with ability to do hobbies or other activities

**What have you tried to help relieve/get rid of this problem and how much did it help? (circle appropriately)**
- ■ Medications...Helped: Little Some Much
- ■ Physical Therapy...Helped: Little Some Muc
- ■ Chiropractic...Helped: Little Some Much
- ■ Exercise...Helped: Little Some Much
- ■ Nutrition...Helped: Little Some Much
- ■ Stretching...Helped: Little Some Much

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

Who is your primary care doctor? ______________________________

Please all medications: (**Be sure to include dosage and frequency**) ______________________________

______________________________

Supplements (vitamins/herbs/minerals): ______________________________

Allergies: ______________________________

Approximate Date of last Flu vaccine:______ ***WOMEN ONLY:*** Date of LMP:________ ***Any possibility of pregnancy: YES or NO***

**Surgical History:**
Surgeries and/or hospitalizations (**type & date**): ______________________________

______________________________

**Family History:** Is there a family history of any of the following conditions? (Indicate parents, grandparents, children, & siblings)

☐ Heart Disease ______________ ☐ Diabetes ______________
☐ Cancer ______________ ☐ Arthritis ______________ ☐ Other ______________

**Social History:**

Intake of the following: **Cigarettes** ____ packs/day **Alcohol** ___ drinks/week **Caffeine** ___ cups/day

Exercise frequency: ☐ Never ☐ Daily ☐ Weekly ☐ Walks ☐ Runs ☐ Swims

## Past Medical History and Review of Systems

| Y | N | Neurological |
|---|---|---|
| ___ | ___ | Migraines |
| ___ | ___ | Headaches: how often? Slurring of |
| ___ | ___ | speech |

| Y | N | Ear/Nose/Throat |
|---|---|---|
| ___ | ___ | Altered |
| ___ | ___ | taste/smell Night |
| ___ | ___ | Blindness Sore |
| ___ | ___ | Throat Gingivitis |
| ___ | ___ | Nose bleeds |

| Y | N | Endocrine |
|---|---|---|
| ___ | ___ | Diabetes |
| ___ | ___ | Thyroid problems |

| Y | N | Cardiovascular |
|---|---|---|
| ___ | ___ | High blood pressure |
| ___ | ___ | High cholesterol |
| ___ | ___ | Chest pain |
| ___ | ___ | Palpitations-racing heart |
| ___ | ___ | beat Swelling in hands/feet |
| ___ | ___ | Anemia |

| Y | N | Respiratory |
|---|---|---|
| ___ | ___ | Recurrent Respiratory Infections |
| ___ | ___ | Asthma |
| ___ | ___ | Chest Congestion |
| ___ | ___ | Wheezing |

| Y | N | GI |
|---|---|---|
| ___ | ___ | Stomach Pains or Cramping |
| ___ | ___ | Constipation |
| ___ | ___ | Reflux or Heartburn |
| ___ | ___ | Bloating/Gas |
| ___ | ___ | Nausea or Vomiting |

| Y | N | Musculoskeletal |
|---|---|---|
| ___ | ___ | Joint Pain |
| ___ | ___ | Arthritis |
| ___ | ___ | Chronic pain |
| ___ | ___ | Muscle Aches |

| Y | N | Skin |
|---|---|---|
| ___ | ___ | Eczema |
| ___ | ___ | Dermatitis |
| ___ | ___ | Excessive Sweating |
| ___ | ___ | Rashes |
| ___ | ___ | Brittle Nails |
| ___ | ___ | Hair Loss |
| ___ | ___ | Easy Bruising |
| ___ | ___ | Increased Bleeding |
| ___ | ___ | Numbness/tingling |

| Y | N | Genitourinary |
|---|---|---|
| ___ | ___ | Uterine fibroids |
| ___ | ___ | Ovarian cysts |
| ___ | ___ | Cancer (breast, ovarian, prostate, uterine) |
| ___ | ___ | Prostate problems |

| Y | N | Emotional/Mental |
|---|---|---|
| ___ | ___ | Depression |
| ___ | ___ | Anxiety |
| ___ | ___ | Mood Swings |
| ___ | ___ | Irritability |
| ___ | ___ | Memory Loss |
| ___ | ___ | Confusion |

| Y | N | Energy |
|---|---|---|
| ___ | ___ | Fatigue |
| ___ | ___ | Hyperactivity |
| ___ | ___ | Restlessness |
| ___ | ___ | Insomnia |
| ___ | ___ | Decreased Libido |
| ___ | ___ | Stress |

| Y | N | Weight |
|---|---|---|
| ___ | ___ | Decreased Appetite |
| ___ | ___ | Weight Gain |
| ___ | ___ | Inability to Lose Weight |
| ___ | ___ | Food Cravings |
| ___ | ___ | Binge Eating |
| ___ | ___ | Water Retention |

Medicines previously tried, dosage, duration and outcome.

☐ Advil ☐ Aleve ☐ Tylenol ☐ Steroids ☐ Prescriptions for a period of ☐ 0-3mos, ☐ 3-6mos, ☐ 6-12 mos ☐ 12+mos

Please check ALL options you have previously tried to assist in above symptoms:

- ____Over the counter medications
- ____Prescriptions
- ____Dietary Changes
- ____Exercise
- ____Consult with specialist
- ____Supplements
- ____Alternative medication/treatment therapies

# Funtional Rating Index

In order to properly assess your condition, we must understand how much your **neck, back, and/or extremity pain** has affected your ability to manage everyday activities. For each item below, **please circle the number which most closely describes your condition right now.**

### 1. Pain Intensity

| 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| No Pain | Mild Pain | Moderate Pain | Severe Pain | Worst Pain Possible |

### 2. Sleeping

| 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| Perfect Sleep | Mildly Disturbed Sleep | Moderately Disturbed Sleep | Greatly Disturbed Sleep | Totally Disturbed Sleep |

### 3. Personal Care (washing, dressing, etc.)

| 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| No Pain | Mild Pain | Need To Go Slow | Need Assistance | Need 100% Assistance |

### 4. Travelling (driving, etc.)

| 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| No Pain On Long Trips | Mild Pain On Long Trips | Moderate Pain On Long Trips | Moderate Pain On Short Trips | Severe Pain On Short Trips |

### 5. Work

| 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| Can Do 100% Of Work | Can Do 75% Of Work | Can Do 50% Of Work | Can Do 25% Of Work | Cannot Work |

### 6. Recreation

| 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| Can Do All Activities | Can Do Most Activities | Can Do Some Activities | Can Do A Few Activities | Cannot Do Any Activities |

### 7. Frequency of Pain

| 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| No Pain | 25% of day | 50% of day | 75% of day | 100% of day |

### 8. Lifting

| 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| No Pain | Pain With Heavy Weight | Pain With Moderate Weight | Pain With Light Weight | Pain With Any Weight |

### 9. Walking

| 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| No Pain | Pain After 1 Mile | Pain After ½ Mile | Pain After ¼ Mile | Pain With All Walking |

### 10. Standing

| 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| No Pain | Increased Pain After Several Hours | Increased Pain After 1 Hour | Increased Pain After ½ Hour | Increased PainWith Any Walking |

Patient Signature:______________________________ Date:____/____/____ Total Score ____/40

**ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS AS WELL AS AN APPOINTMENT AND/OR DESIGNATION AS AN ERISA/PPACA REPRESENTATIVE AND A BENEFICIARY**

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay ________________________ as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided.

I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, and/or medications that *have been* or *will be* rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under.

I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same.

I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA plan, PPACA plan, or insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our representative, ERISA representative, or PPACA representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals to obtain benefits and/or payments that are due to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan or insurer. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment and/or designation will remain in effect unless revoked in writing. A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

Signed this _______ day of __________________ 20 _____.

X______________________________

(patient signature)

______________________________

(please print patient name)

X______________________________

(signature of Guardian if applicable)

**Informed Consent to Care**

A patient coming to the doctor gives him/her permission and authority to care for them in accordance with appropriate test, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare case, underlying physical defects, deformities or pathologies may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the physician. This office does not perform breast, pelvic, prostate, rectal, or full skin evaluations. These examinations should be performed by your family physician, GYN, and dermatologist to exclude cancers, abnormal skin lesions that should undergo biopsy/removal or other treatments. This clinic does not provide care for any condition (such as high blood pressure, diabetes, high cholesterol) other than those addressed in your physical medicine care plan. We also do not prescribe or refill ANY controlled substances. All prescriptions should be refilled by your original prescriber and any new prescriptions should be issued by your primary care provider.

The patient assumes all responsibility/liability if the patient does not report on health forms any past medical history, illnesses, medicines, or allergies.

I agree to settle any claim or dispute I may against or with any of these persons or entities, whether related to the prescribed care or otherwise, will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

**Sign here:** X__________________________________I have read and understand the above consent form.

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I acknowledge that I have reviewed the Notice of Privacy Practices of ________________________.
(Please initial one of the following options and sign below.)

__________ I wish to receive a paper copy of Privacy Notice.

__________ I do not request a copy of the Privacy Notice at this time. I acknowledge that I can request a copy at any time and the Privacy Notice is posted in the office. If I should have a problem or question in regard to my rights, I may speak with the Privacy Officer about my concerns.

This serves a notice that as part of our efforts to deliver the most consistent healthcare we can to every patient, we use an electronic healthcare system that enables us to retrieve up to 13 months of prescription history through your insurance carrier.

I acknowledge that it is the policy of this office to leave reminder messages on my answering machine or with another person in my home. I may make a request of an alternative means of communication (within reason) in writing.

X__________________________________ ____________________
**Signature of Patient/Guardian** Date

X__________________________________ ____________________
Witness (Office Staff) Date