Patient Intake

Today's Date:___/_____/_____

Name_____Sex_____ Age_____Date of Birth_____

Address_____City_____State____Zip_____

Marital Status_____Spouse Name _____Home Phone_____Cell Phone_____

Email Address:_____Occupation_____

Emergency Contact_____Phone_____Relationship _____

How did you hear about our office?

☐ Drive By ☐ Walk-In ☐ Internet ☐ Referral (Please tell us who) _____ ☐ Other: _____

Health Insurance Information

Primary Insurance_____Policy Holder's Name_____DOB_____

Policy Holder's Relationship to Patient_____

Accident Information (SKIP this section if you were not involved in an accident)

Is your condition due to an: ☐ ***Auto Injury*** ☐ ***Work Injury*** ☐ ***Slip and Fall*** ☐ ***Other Accident (describe below)***

Date of Accident_____Place (City/State)_____

Auto/Work Insurance Company_____Insured's Name and DOB

If Auto Injury, have you reported the accident to your insurance company? ☐ No ☐ Yes Claim #_____

If Work Injury, have you reported the accident to your supervisor/boss? ☐ No ☐ Yes Claim #_____

If Slip and Fall or Other Type of Injury, please describe:_____

*Do you have an **Attorney** for your Auto or Work Comp. injury* ☐ Yes ☐ No

Please provide Attorney Name, address and phone # _____

Current complaint

I. Please list your **worst** complaint:_____How long have you had it:_____

How did it start?_____ ***A) Is it:*** ☐*Improving* ☐*Worsening* ☐*Staying the Same* ***B) Is it:*** ☐*Mild* ☐*Moderate*

☐*Severe* ***C) What worsens it:*** ☐*General activity* ☐*Moving Wrong* ☐*Bending* ☐*Lifting* ☐*Walking* ☐*Sports* ☐*Getting up from a chair*

☐*Using a computer/desk work* ☐*Other:*_____ ***D) What makes it better:*** ☐*Rest* ☐ *General Activity* ☐ *Ice Packs*

☐*Heating Pad* ☐*OTC Meds* ☐*Rx Meds* ☐*Massage* ☐*Chiropractic* ☐*Other:*_____ ***E) Is it worse in the:*** ☐*AM* ☐*PM*

☐*After day wears on* ☐*Steady* ☐*Off and on* ***F) Is the symptom:*** ☐*Dull and Achy* ☐*Tight and Stiff* ☐*Sharp and Stabbing*

☐*Numb and Tingly* ☐*Shooting* ☐*Burning* ☐ *Cramping*

II. Please list your **2nd worst** complaint:_____How long have you had it: _____

How did it start? _____ ***A) Is it:*** ☐*Improving* ☐*Worsening* ☐*Staying the Same* ***B) Is it:*** ☐*Mild* ☐*Moderate*

☐*Severe* ***C) What worsens it:*** ☐*General activity* ☐*Moving Wrong* ☐*Bending* ☐*Lifting* ☐*Walking* ☐*Sports* ☐*Getting up from a chair*

☐*Using a computer/desk work* ☐*Other:*_____ ***D) What makes it better:*** ☐ *Rest* ☐ *General Activity* ☐ *Ice Packs*

☐*Heating Pad* ☐*OTC Meds* ☐*Rx Meds* ☐*Massage* ☐*Chiropractic* ☐*Other:*_____ ***E) Is it worse in the:*** ☐*AM* ☐*PM*

☐*After day wears on* ☐*Steady* ☐*Off and on* ***F) Is the symptom:*** ☐*Dull and Achy* ☐*Tight and Stiff* ☐*Sharp and Stabbing*

☐*Numb and Tingly* ☐*Shooting* ☐*Burning* ☐ *Cramping*

Current Health

• Name and phone number of family doctor: _____

• List all CURRENT illnesses or diseases you have been diagnosed with (cancers, tumors, infections, diabetes, aneurysms, etc.):

_____

• If you are currently taking any prescription or nonprescription medications, please list them below with dosages:

Medication:_____Dose:_____Medication:_____Dose: _____

Medication:_____Dose:_____Medication:_____Dose: _____

• Please list any medications you are allergic to: _____

• Please indicate your height and weight_____

Health History

• List any operations, surgeries or medical procedures:

Date:_____Procedure:_____Date:_____Procedure: _____

Date:_____Procedure:_____Date:_____Procedure: _____

• If you have ever had in the past or currently have any serious illnesses or injuries, please list:

Date:_____Condition:_____Date:_____Condition: _____

Date:_____Condition:_____Date:_____Condition: _____

Any current loss of bowel or bladder control: ☐Yes ☐No Any current seizures, paralysis, speech, vision problems: ☐Yes ☐No

Any unexplained recent weight loss: ☐Yes ☐No Current fever: ☐Yes ☐No Current nutritional problems: ☐Yes ☐No

• Please list any significant family illnesses_____

• Have you had spinal X-Rays within the past 5 years? If yes, when and where _____

• **Do you have a pacemaker? ☐Yes ☐No If yes, please ALERT our doctor and/or chiropractic assistant**

• Do you have any blood/lymph disorders? ☐Yes ☐No If yes, please list _____

• Do you have osteoporosis or rheumatoid arthritis? ☐Yes ☐No

• Please list any other electrical device that you currently wear_____

• Please select one: ☐ I have never smoked ☐ Former smoker ☐ Current smoker, if so how much:_____pk./day_____pk./wk.

• Please select one: ☐ I don't drink alcohol ☐ Rarely drink ☐ Social drinker ☐ Heavy drinker (_____oz. per day/week)

• Have you ever had chiropractic care ☐Yes ☐No If yes, last date of treatment_____ By whom: _____

Similar or difference condition:_____Results: _____

What are your overall expectations from your treatment with our doctor: _____

I, the undersigned, hereby give my consent for the doctor to examine and treat my condition as he/she deems appropriate through the use of Chiropractic care. I also give my consent to the doctor to order x-rays (if needed) or to perform other diagnostic aids as he/she deems appropriate in my case.

• ***WOMEN ONLY*** *I hereby declare that to the best of my knowledge* ☐ ***I am*** ☐ ***I am not pregnant****. If there is a chance that I may be pregnant, I will inform the doctor prior to my examination.*

Patient Signature_____

(Parent/Guardian signature if under 18 years of age)

GENERAL/FINANCIAL POLICY

Welcome to Performance Medicine & Sports Therapy. We strive to provide you with excellent Sports Rehabilitation care in a clean, friendly, professional setting and our goal is to make your visits as convenient as possible.

By signing below, you confirm that you have read this policy and understand that:

- It is your responsibility to inform our office of any address or telephone number changes.
- Your account is to be kept current. All self-pay or insurance copayments, co-insurances and deductibles will be collected at the time of service payable by cash, check, Visa, MasterCard, Discover or American Express.
- If you do not have your payment (s), your appointment may be rescheduled.
- If you are unable to keep a scheduled appointment, please notify us no later than 12 hours before your scheduled time so that we may offer that time to another patient. Failure to give proper notice of cancellations will result in the following charges. **There is a $40 charge for missing a Physical Therapy appointment. There is a $25.00 charge for missing a Chiropractic or Acupuncture appointment. There is a $25 charge for missing a half hour massage appointment and a $40.00 charge for missing a full hour massage appointment.**
- A returned check will result in a $25.00 service charge and all future payments being required in the form of cash or credit card.

IF YOU HAVE HEALTH INSURANCE COVERAGE: As a courtesy to you, our office will attempt to pre-verify your primary insurance coverage for your Chiropractic care and Physical Therapy care. Coverage information is obtained from your insurance company using information provided by you prior to your initial visit. **We must emphasize that as medical providers, our relationship is with you, not your insurance company.** Please be advised that the information provided by your insurance company is not a guarantee of payment, only an estimate of what might be covered under your policy at the time of inquiry.

By signing below you confirm you understand that:

- It is your responsibility to inform us of any changes to your insurance policy so that your coverage can be re-verified.
- Not all services are a covered benefit with all insurance plans.
- It is your responsibility to be aware of what service (s) is being provided to you and if it is a covered benefit under your insurance.
- You are responsible for any non-covered charges not payable by your insurance policy.
- We will send all required claim forms and documentation to ensure your claims are processed in a timely manner.
- Final determination of benefits available is determined when the claim is sent to your insurance company and we receive an explanation of benefits from them.
- After all co-pays, contracted plan reductions and insurance payment credits are applied to your account, any remaining portion will be your responsibility.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we urge you to contact us promptly for assistance in the management of your account. If you have any questions about the above information, *please* do not hesitate to ask us. **WE ARE HERE TO HELP YOU.**

By signing below, you have read and understand the above Financial Policy and agree to meet all financial obligations.

Printed Name	Signature of Patient/Legal Guardian	Date

CONSENT TO TREAT: I hereby authorize and give consent for the Chiropractic Physicians, Physical Therapists and Medical Doctors at Performance Medicine & Sports Therapy to examine, and provide me treatment.

Printed Name	Signature of Patient/Parent/Legal guardian	Date

CONSENT TO RELEASE INFORMATION: In the event that you ever wish to have a family member or friend come to our office and get a copy of your medical records for whatever reason, we ask that you sign below allowing them to do so. By signing below I hereby give my consent for Performance Medicine & Sports Therapy to release my medical records to:

Name of Family Member/Friend	Signature of Patient/Legal Guardian	Date

Authorization to Discuss Medical Information

Performance Medicine and Sports Therapy is committed to quality patient care and we are advocates of maintaining patient confidentially. Our policy is to speak only to patients and/or guardians personally in regards to their confidential medical information. Also, we will not leave any confidential medical information on a voice mail system without permission to do so. By filling out this form and signing below, you are giving the physicians and staff at PMST permission to communicate more detailed information to other individuals and/or your voicemail. Examples included but are not limited to; your lab and test results, information about your condition, prescription refills or changes, appointment scheduling or insurance details. ***Performance Medicine and Sports Therapy will keep this consent form in your chart. This form will be effective until otherwise notified by the patient with a written request.***

Patient Name: _____ Date of Birth: _____

Patient Signature:_____Date:_____

I _____ (INI) authorize the physician and staff at Performance Medicine and Sports Therapy to leave a detailed voice message regarding my medical care at the following phone number(s). You may write specific instructions below.

Patient Phone #1 _____

Instructions: _____

Patient Phone #2 _____

Instructions:_____

I _____ (INI) authorize the physician and staff at Performance Medicine and Sports Therapy to speak with the following individual(s) about my medical care. You may write instructions below.

Name: _____ Relationship: _____ Date: _____

Instructions:_____

Name: _____ Relationship: _____ Date: _____

Instructions:_____