Superior Physical Medicine

WELCOME PACKET

PATIENT INFORMATION

Name: _____ (Last, First MI) Date Completed: _____ (m/d/yyy)

Email Address: _____ Appointment Date: _____ (m/d/yyy)

Mailing Address: Street: _____ City: _____ Zip: _____

Phone # (H) _____ (W) _____ (C) _____

Date of Birth: _____ (m/d/yyyy) Sex: ☐ M ☐ F ☐ T SS# _____

Age: _____ Marital Status: ☐Married ☐Not Married

Race/Ethnicity: ☐Caucasian ☐ African American ☐Asian ☐ Native American ☐ Hispanic ☐ Other

Occupation: _____ Employer: _____

Employer Address: _____ Phone:

Emergency Contact: Name: _____ Phone: _____ Relation: _____

ACCIDENT INFORMATION

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

Hast it been reported? ☐Yes ☐ No If yes, to whom? _____

INSURANCE INFORMATION

Do you have health insurance? ☐Yes ☐ No Name of Carrier: _____

Do you have secondary insurance? ☐Yes ☐ No Name of Carrier: _____

Policy Holder Name: _____ DOB: _____

Relationship to patient: _____ Phone: _____

ASSIGNMENT AND RELEASE

I certify that I (or my dependent) have insurance coverage with _____ and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PHYSICIAN/PRACTICE, INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the physician to release all information necessary, including diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

SIGNATURE (X) _____ DATE: _____

NAME: _____
DOB: _____**DATE:** _____

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.

_____ _____
Patient's Signature Date

Chiropractic care, like all forms of health care, while offering considerable benefit may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to stroke.

Prior to receiving chiropractic care this Chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, your spine health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies needed. In addition, they will help us determine if there is any reason to modify your care of provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care. I understand and accept that there are risks associated with chiropractic care and give consent to the examinations that the doctor deems necessary, and to the chiropractic care including spinal adjustments, as reported following my assessment.

This notice is effective as of the date it is signed and will expire seven years after the date on which you last received services from us.

_____
Patient Signature Date

NAME: _____
DOB: _____**DATE:** _____

X-ray Questionnaire: For women only

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

Name: _____

☐ **There is a possibility that I a may be pregnant at this time.**

☐ **Yes, I am definitely pregnant**

☐ **No, I am definitely not pregnant at this time**

☐ **I request that x-ray films not be taken because:** _____
_____
_____

Date oflast menstrual period: _____

NAME: _____
DOB: _____ **DATE:** _____

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name:_____ DOB: _____

I acknowledge that I have reviewed the Notice of Privacy Practices of Superior HealthCare. (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.

Please initial below:

_____ 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.

_____ I acknowledge that if I should have a problem or question in regard to my rights, I may speak with the Privacy Officer about my concerns.

_____ _____
Signature of Patient/Guardian Date

_____ _____
Witness (Office Staff) Date

NAME: _____

DOB: _____ **DATE:** _____

PAIN ASSESSMENT

Page 1

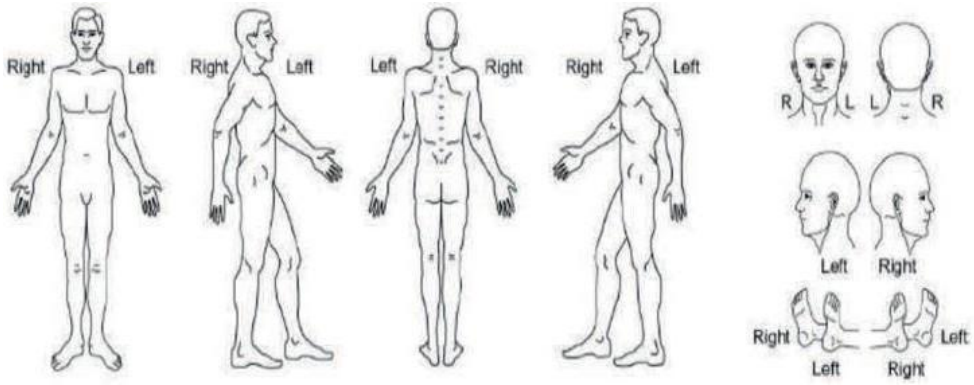
PAIN HISTORY

Chief Complaint (Reason for your visit today)? _____

Does this pain radiate? Yes No If so where? _____

Please list any additional areas of pain: _____

Use the diagram to the right to mark the areas you are having pain with an "X"



Onset of Symptoms

Approximately when did your pain start (mm/yy)? _____

What do you believe caused your current pain episode? _____

How did your current pain episode begin? ☐ Gradually ☐ Suddenly

Since your pain began, how has it changed? ☐ Improved ☐ Worsened ☐ Stayed the same

Associated Symptoms

	NO	YES	Comments (where, when, etc.)
Numbness/Tingling.....	☐	☐	_____
Weakness in the arm/leg.....	☐	☐	_____
Balance Problems.....	☐	☐	_____
Bladder Incontinence.....	☐	☐	_____
Bowel Incontinence.....	☐	☐	_____
Joint Swelling/Stiffness.....	☐	☐	_____
Fever/Chills.....	☐	☐	_____

Please mark all of the following treatments you have used for pain relief:

	NOT TRIED	NO CHANGE	HELPED	WORSENED
Physical Therapy				
Chiropractic Care				
Activity Modifications				
Bracing / Immobilizing				
Acupuncture				
Hot / Cold Packs				
Trigger Point Injections				
Massage Therapy				
TENS / E-Stim				

PAIN DESCRIPTION

Check all of the following that describe your pain:

☐Dull/aching	☐Hot/burning	☐Shooting	☐Stabbing/sharp
☐Cramping	☐Numbness	☐Spasming	☐Throbbing
☐Squeezing	☐Tingling/Pins & Needles		☐Tightness

When is your pain at its worst?

☐Mornings	☐Daytime	☐Evenings	☐Middle of the night
☐Always the same			

How often does it occur?

☐Constant	☐Intermittent	☐Changes in severity but always present

Mark the effect each of the following have on your pain level:

	Increases	Decreases	No Change
Bending Backward			
Bending Forward			
Changes in Weather			
Climbing Stairs			
Coughing/Sneezing			
Driving			
Lifting Objects			
Looking Upward			
Looking Downward			
Rising from Seated Position			
Prolonged Sitting			
Prolonged Standing			
Walking			

DIAGNOSTIC TESTING / SPECIALISTS

Mark all of the following tests that you have related to your current pain complaints:

☐MRI of the:_____ Date:_____Where? _____
☐X-ray of the:_____ Date:_____Where? _____
☐CT Scan of the:_____ Date:_____Where? _____
☐EMG/NCV study of the:_____ Date:_____Where? _____
☐Other:_____ Date:_____Where? _____

☐I have not had any diagnostic tests for my current pain complaint.

Mark the following physicians or specialists you have consulted for your current pain problem(s):

☐Acupuncturist	☐Neurosurgeon	☐Psychiatrist/Psychologist
☐Chiropractor	☐Orthopedic Surgeon	☐Rheumatologist
☐Internist/Family Practice	☐Physical Therapist	☐Neurologist

NAME: _____
DOB: _____**DATE:** _____

REVIEW OF SYSTEMS

Mark the following symptoms that you currently suffer from:

Constitutional:	☐Chills	☐Difficulty Sleeping	☐Easy Bruising
	☐Night Sweats	☐Fatigue	☐Fevers
	☐Insomnia	☐Low Sex Drive	☐Tremors
	☐Weight Gain	☐Weight Loss	☐Weakness
Eyes:	☐Recent Visual Changes		
Ears/Nose/Throat/Neck:	☐Dental Problems	☐Earaches	☐Hearing Problems
	☐Nosebleeds	☐Sinus Problems	☐ Allergies
Cardiovascular:	☐Chest Pain	☐Bleeding Disorder	☐Blood Clots
	☐Fainting	☐Palpitations	☐Swelling in Feet
Respiratory:	☐Cough	☐Wheezing	☐Shortness of Breath
Gastrointestinal:	☐Constipation	☐Acid Reflux	☐Abdominal Cramps
	☐Diarrhea	☐Nausea/Vomiting	☐Hernia
Musculoskeletal:	☐Back Pain	☐Joint Pains	☐Joint Stiffness
	☐Joint Swelling	☐Muscle Spasms	☐Neck Pain
Genitourinary:	☐Flank Pain	☐Blood in Urine	☐Painful Urination
	☐Decreased Urine Flow	☐Urinary Frequency	
Neurological:	☐Dizziness	☐Headaches	☐Tremors
	☐Numbness/Tingling	☐Seizures	☐Memory Loss
Psychiatric:	☐Depressed Mood	☐Feeling Anxious	☐Stress Problems
	☐Suicidal Thoughts	☐Suicidal Planning	☐Want to Hurt Others

☐**ALL OTHER SYSTEMS NEGATIVE**

Reviewer: _____

NAME: _____
DOB: _____**DATE:** _____

PAST MEDICAL HISTORY

Mark the following conditions/diseases that you have now or have been treated for in the past:

General Medical
☐Cancer – Type: _____
☐Diabetes – Type: _____

Cardiovascular/Hematologic
☐Anemia
☐Heart Attack
☐Coronary Artery Disease
☐High Blood Pressure
☐Peripheral Vascular Disease
☐Stroke/TIA
☐Heart Valve Disorders

Gastrointestinal
☐GERD (acid reflux)
☐Gastrointestinal Bleeding
☐Stomach Ulcers
☐Constipation

Urological
☐Chronic Kidney Disease
☐Kidney Stones
☐Urinary Incontinence
☐Dialysis

Neuropsychological
☐Multiple Sclerosis
☐Peripheral Neuropathy
☐Siezures
☐Depression
☐Anxiety
☐Schizophrenia
☐Bipolar Disorder

Other Diagnosed Conditions
☐ _____
☐ _____
☐ _____
☐ _____
☐ _____

Head/Ears/Eyes/Nose/Throat
☐Headaches
☐Migraines
☐Head Injury
☐Hyperthyroidism
☐Hypothyroidism
☐Glaucoma

Respiratory
☐Asthma
☐Bronchitis/Pneumonia
☐Emphysema/COPD

Musculoskeletal/Rheumatologic
☐Bursitis
☐Carpal Tunnel Syndrome
☐Fibromyalgia
☐Osteoarthritis
☐Osteoporosis
☐Rheumatoid Arthritis
☐Chronic Joint Pains

Date of last physical _____

Primary Care Physician_____

NAME: _____
DOB: _____ **DATE:** _____

PAST SURGICAL HISTORY

Please list any surgical procedures you have had done in the past including date:

1) _____ Date: _____
2) _____ Date: _____
3) _____ Date: _____
4) _____ Date: _____

☐ I have NEVER had any surgical procedures performed.

MEDICATION HISTORY

Are you currently taking any blood thinners or anti-coagulants? ☐YES ☐NO
If YES, which ones? ☐Aspirin ☐ Plavix ☐Coumadin ☐ Lovenox ☐Other _____

Please list all medications you are CURRENTLY taking including vitamins. Attach additional sheet if required:

	Medication Name	**Dose**	**Frequency**
1)			
2)			
3)			
4)			
5)			
6)			
7)			

Please list all PAST PAIN MEDICATIONS that you have been on at any point for your current complaints:

1)			
2)			
3)			
4)			

DRUG ALLERGIES

Do you have any drug/medication allergies? ☐ YES ☐ NO

If so, please list all medications you are allergic to:

	Medication Name	**Allergic Reaction**
1)		
2)		
3)		
4)		

NAME: _____
DOB: _____**DATE:** _____

FAMILY HISTORY

Mark all appropriate diagnoses as they pertain to your first degree relatives:

☐Arthritis ☐Cancer ☐Diabetes ☐Headaches/Migraine
☐Hypertension ☐Kidney Problems ☐Liver Disease ☐Osteoporosis
☐Rheumatoid Arthritis ☐Seizures ☐Stroke
☐ I have no significant family medical history

SOCIAL HISTORY

Occupation:_____**Last Date Worked:** _____
☐Temporary Disability ☐Permanent Disability ☐ Retired ☐Unemployed
Who is in your household? _____
Are there any stairs in your current home? ☐Yes ☐ No
Are you currently under worker's compensation? ☐Yes ☐ No
Is there an ongoing lawsuit related to your visit today? ☐Yes ☐ No
Alcohol Use:
☐ Social Use ☐History of alcoholism ☐Current alcoholism ☐Never
Tobacco Use:
☐Current User Packs per day?_____ How many years? _____
☐Former User Quit Date:_____ Never used tobacco
Illegal Drug Use:
☐Never used ☐Formerly used ☐Currently use
Have you ever abused prescription medications? ☐ Yes ☐ No

ALLERGY SCREENING

Do you experience any of the following symptoms?
☐Runny nose ☐Itchy or watery eyes ☐ Itchy nose ☐Stuffy nose ☐ Frequent sneezing
Overall what is the severity of those symptoms?
☐Mild ☐ Moderate ☐ Severe
Are your allergy symptoms present:
☐ Rarely ☐Seasonally ☐ Most of the year

Weight Loss Program

Are you interested in learning about our medically supervised weight loss program? Yes No

NAME: _____

DOB: _____ **DATE:** _____

Office Financial Policy

1. All patients are cash until our staff can verify all insurance coverage(s).
2. Your insurance will be verified promptly and will be reviewed with you if applicable.
3. After coverage and deductible are verified, this office may accept assignment on most policies provided the insured/patient signs an appropriate statement of benefits and/or a lien authorizing payment to be sent to the doctor.
4. Waiting for the insurance payment is a courtesy and it may be withdrawn under certain circumstances.
5. As a patient, it is your responsibility to take care of the co-payment (usually a percent or fixed amount) and any non-covered services in a monthly basis. This office may make payment arrangements on an individual basis. Any such plan or arrangements will be discussed during your report of findings.
6. This office does not warrant or guarantee that your insurance company will pay, nor does this office promise that an insurance company will or should pay the fees charged. Insurance policies are an arrangement between the insurance carrier and the patient/insured.
7. Any service not covered or coverage reductions by your insurance carrier will be the patient's responsibility.
8. This office will submit an insurance claim for you. We will not enter into any dispute with your insurance company. If coverage problems arise, you will be expected to assist directly with your insurance adjuster or agent. Any denied or disputed claims will be treated as uncovered.
9. If your account should go to collections for any reason, it will be the patient's responsibility for any court costs, attorney's fees, and or collection costs incurred in collecting the account balance.
10. I authorize the release of any medical or other records or information necessary to process any claims.
11. All insurance payments, regardless of which company issues a check first, are applied to your account as long as any balance is due. This means refunds are made only after your balance is completed and cleared with this office.
12. If you receive correspondence of checks from your insurance company, you agree to bring these into our office to determine if the checks are on assignment to this office.
13. If you change insurance companies or employers, you agree to provide this office with the current information immediately.
14. If this office gives you a professional accounting discount for treatment and you decide to drop out of care then our standard fees will apply.
15. The office accepts MasterCard, Visa, American Express, personal checks and cash.
16. If you have any questions concerning this or any other matter, please speak with the Front Desk Manager or our Billing Manager prior to seeing the doctor.
17. If you stop care and have a financial agreement signed with our office, you will be responsible for any/all charges that you have incurred at our office.

Patient Name:_____ Patient Signature:_____ Date:_____