WELCOME PACKET

PATIENT INFORMATION

Name: ______________________________ Date Completed: ____________________
(Last, First MI) (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 **Height**________ **Weight**________

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

Occupation: ______________________________ Employer: ____________________

Employer Address: ______________________________ Phone: ____________________

Emergency Contact: Name: __________________ Phone: ______________ Relation: ____________

How Did You Find Us?

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? ______________________________

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: ____________________

IRREVOCABLE ASSIGNMENT OF BENEFITS AND RELEASE

I certify that I (or my dependent) have insurance coverage with____________________and I AUTHORIZE, REQUEST AND IRREVOCABLY 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

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, *and* improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated at approximately 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name:____________________________ Signature:__________________________ Date:

Parent or Guardian:________________________ Signature:__________________________ Date:

Witness Name:___________________________ 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 of last 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: __________

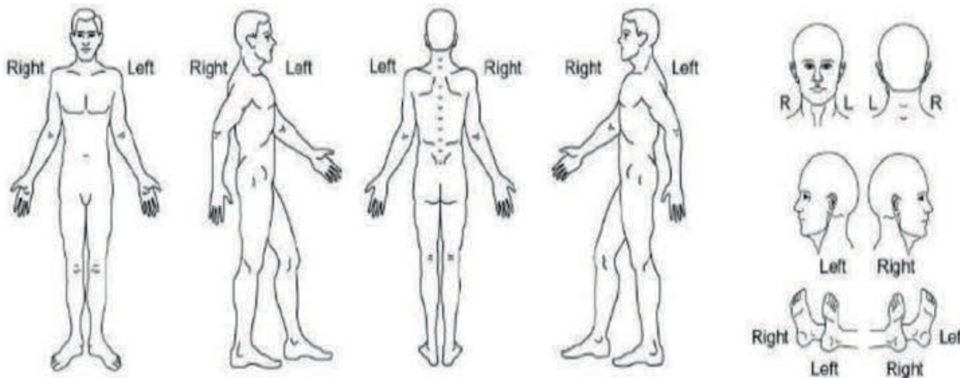
PAIN ASSESSMENT

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:_______

NAME: ________________________________

DOB: _____________DATE: ____________

SUPERIOR PHYSICAL MEDICINE

Cancellation & Missed Appointment Policy Update

Cancellation of an Appointment

Please be courteous and notify Superior Physical Medicine promptly if you are unable to show up for an appointment. This would allow us to fill your cancellation time with someone who is in need of treatment. If it is necessary to cancel your scheduled appointment, we ask that you call at least 24 hours in advance. Appointments in our office are in high demand, and your early cancellation will give another person the possibility to have access to timely medical care.

How to Cancel Your Appointment

To cancel appointments, please Email: frontoffice.spmed@gmail.com or call 714-692-7139. If you do not reach the receptionist, you may leave a detailed message on our voicemail. If you would like to reschedule your appointment, please leave your phone number and we will return your call and give you the next available appointment time.

Late Cancellations:

Any Patient who fails to cancel their appointment without a 24- hour notice will be charged a late fee of $25.00

1 hour massage appointments will be charged a $55 fee if cancelled without 24 hr notice.

No Show Policy:

A "no-show" is someone who misses an appointment without cancelling it in an adequate manner.

- First missed appointment: there will be no charge
- Second missed appointment: $25 fee will be billed to your account

THESE FEES ARE NOT COVERED BY YOUR INSURANCE

Patient Signature____ Date________________________

IE: ______________________________

: ____________DATE: ___________

Social Media Consent/Release Form
For News Media, Promotional Materials, Written Articles, Research and/or Photographs

I,__________________________ hereby authorize Superior Physical Medicine to use my photo and/or information related to my experiences with any services/treatment received at Superior Physical Medicine. I understand this information may be used in publications, including electronic publications, audiovisual presentations, promotional literature, advertising, and community presentations. Superior Physical Medicine will disclose to me or my legal representative , where appropriate, the specific information and/or photo to be used prior to release in the social media.

My consent is freely given as a public service to Superior Physical Medicine, without expecting payment.
I,________________________
Release Superior Physical Medicine and their respective employees, officers and agents from any and all liability which may arise from the use of such news media stories, promotional materials, written articles, videotape and/or photographs.

I prefer that:

- My complete name be used
- My first name only be used
- No name be used

I understand that I can revoke this release any time in writing and that the use of any photos or other information authorized by this release will immediately cease.

Please Print

Name: ____

Address:____

City, State, Zip:____

Phone: _________________________ Email:________________________

Please follow us on Facebook and Instagram **@superiorphysicalmed**