ABOUT THE PATIENT

Physician's Spine and Rehab, LLC

Name ______________________ **Birth date** __________ **Age**______**SS#**______________
Address ______________________ **City** ______________ **State** _____ **Zip** ________
Home Phone ______________ **Cell Phone** ______________ **Work Phone** ______________**Gender** ❑ M ❑ F
Your Employer ______________________ **E-Mail Address** ______________________
Significant Other's Name ______________________ **Insured's SS#**_______-_____-_______

Insurance Company______________________ Insured's Birth date ______________________
Emergency Contact ______________________ ph # ______________________
Name of Medical Doctor(s)______________________

- I authorize Dr. Falls and/or his staff to render care as deemed appropriate for me and/or my child.
- I authorize Physician's Spine and Rehab, LLC to release/request records to/from providers as necessary.
- I understand I am responsible for all bills incurred in this office.
- I authorize assignment of my insurance benefits (if applicable) directly to the provider.
- I understand that an insurance deductible or copayment is due at the time of service

How did you hear about us?

❑ Family/Friend ______________
❑ Google
❑ Yelp
❑ Bing
❑ Yahoo

❑ Doctor ______________
❑ Attorney ______________
❑ Insurance Co. ______________

PRESENT COMPLAINTS

1. (Worst Complaint)______________________ **How long has this been an issue?** ______________
   How often? ❑ Constant (76-100% of day) ❑ Frequent (51-75% of day) ❑ Occasional (26-50% of day) ❑ Intermittent (1-25% of day)
   Is it: ❑ Sharp ❑ Dull ❑ Diffuse ❑ Achy ❑ Burning ❑ Shooting ❑ Stiff ❑ Numb ❑ Tingly ❑ Sharp w/ motion ❑ Radiates to ________
   How has this changed with time? ❑ Worse ❑ Same ❑ Better **Rate your pain from 1-10 (10 = worst)** 1 2 3 4 5 6 7 8 9 10
   How do you consider you pain: ❑ Minimum ❑Mild ❑ Moderate ❑ Severe ❑ Unbearable
   How did this problem begin?______________

2. **(Secondary Complaint):** ______________________ **How long has this been an issue?** ______________
   How often? ❑ Constant (76-100% of day) ❑ Frequent (51-75% of day) ❑ Occasional (26-50% of day) ❑ Intermittent (1-25% of day)
   Is it: ❑ Sharp ❑ Dull ❑ Diffuse ❑ Achy ❑ Burning ❑ Shooting ❑ Stiff ❑ Numb ❑ Tingly ❑ Sharp w/ motion ❑ Radiates to ________
   How has this changed with time? ❑ Worse ❑ Same ❑ Better **Rate your pain from 1-10 (10 = worst)** 1 2 3 4 5 6 7 8 9 10
   How do you consider you pain: ❑ Minimum ❑Mild ❑ Moderate ❑ Severe ❑ Unbearable
   How did this problem begin?______________

3. **What makes it better?**______________________
4. **What makes it worse?** ______________________
5. **Have had treatment for this before?** ❑ Yes ❑ No **By what type of provider?** ❑Chiropractor ❑ MD ❑DO ❑ Physical Therapist ❑ Massage
6. **What type of treatment was done?:**______________________
7. **Results:**______________________ **Rate your overall health** ❑ Excellent ❑ Very Good ❑ Good ❑ Fair ❑ Poor

GENERAL HEALTH HISTORY — Physician's Spine and Rehab, LLC

Patient Name______________________________ *Check all that apply.* Height____ft. _____in. Weight ______lbs

Past	Present		Past	Present	
❑	❑	Headaches	❑	❑	Dizziness
❑	❑	Neck Pain	❑	❑	High Blood Pressure
❑	❑	Upper/Mid back pain	❑	❑	Heart Attack
❑	❑	Low back pain	❑	❑	Chest pains
❑	❑	Shoulder/Arm pain	❑	❑	Stroke
❑	❑	Wrist/Hand pain	❑	❑	Angina
❑	❑	Hip/Upper leg pain	❑	❑	Kidney stones/disorders
❑	❑	Knee/Lower leg Pain	❑	❑	Bladder infection
❑	❑	Ankle/Foot Pain	❑	❑	Painful urination
❑	❑	Jaw Pain	❑	❑	Loss of bladder control
❑	❑	Joint swelling	❑	❑	Abnormal weight change
❑	❑	Arthritis	❑	❑	Loss of appetite
❑	❑	Rheumatoid arthritis	❑	❑	Abdominal pain
❑	❑	Muscular incoordination	❑	❑	Ulcer
❑	❑	Visual disturbances	❑	❑	Hepatitis
❑	❑	Asthma	❑	❑	Gall bladder problems
❑	❑	Chronic Sinusitis	❑	❑	Cancer
❑	❑	Diabetes	❑	❑	Tumors
❑	❑	Drug/Alcohol dependency	❑	❑	Heart Pacemaker
❑	❑	Allergies	❑	❑	Epilepsy
❑	❑	Depression	❑	❑	Dermatitis
❑	❑	SLE	❑	❑	HIV/AIDS

❑ ❑ Pregnancy (previous pregnancies ____________Under care of OBGYN? ________Last Exam?________)

❑ ❑ Hormone Replacement / Birth Control Use

❑ ❑ Other ____

1. Current Medications:____
2. Allergic to Medications: ______________________Reaction: ______________________
3. Smoking Status: ❑ Never ❑ Former ❑ Occasional ❑ Everyday
4. Drug/Alcohol Status: ❑ Never ❑ Former ❑ Occasional ❑ Everyday
5. Regular Exercise: ❑ Strenuous ❑ Moderate ❑ Light ❑ None

PAST HISTORY

4. List any past auto collisions:______________________________ Care received:______________
5. List any past work injuries: ______________________________ Care received: ______________
   -Are the symptoms you seek treatment for caused by the above mentioned injuries?__________________
6. List any past sport, recreational, or home injuries______________________________________
7. Describe any other past conditions and treatment received: ______________________________
8. List any hospitalizations and surgeries:____
   ____
9. List hobbies:____

FAMILY HISTORY

Father: □ Heart Disease □ Cancer □ Diabetes □ ALS □ Rheumatoid Arthritis □ Other________________

Mother: □ Heart Disease □ Cancer □ Diabetes □ ALS □ Rheumatoid Arthritis □ Other________________

Other family history: ____

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: ______________________ Date of Birth: ______________________

Previous Name: ______________________ Social Security #: ______________________

I request and authorize Physician's Spine and Rehab, LLC
to release healthcare information of the patient named above to the following doctors/medical facilities/other AND for them to release health records to Physician's Spine and Rehab, LLC: (include family members)

Name: ____

Address: ____

City: ____________________ State: ______________ Zip Code: __________

Name: ____

Address: ____

City: ____________________ State: ______________ Zip Code: __________

Name: ____

Address: ____

City: ____________________ State: ______________ Zip Code: __________

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: ______________________

____

☐ All healthcare information

☐ Other: ____

______________________________ ______________________________

Patient Signature Date Witness Date

IRREVOCABLE ASSIGNMENT, LIEN AND AUTHORIZATION

INSURANCE BENEFITS

To Whom It May Concern:

I hereby authorize and direct you, my insurance carrier to pay directly to Physician's Spine and Rehab, LLC such sums as may be due and owing this office for services rendered me, both by reason of accident or illness and by reason of any other bills that are due this office and withhold such sums from any disability benefits, medical payment benefits, no-fault benefits, health and accident, workers compensation benefits, or any other insurance benefits obligated to reimburse me from any settlement, judgment or verdict on my behalf as may be necessary to adequately protect Physician's Spine and Rehab, LLC. I hereby further give lien to said office against any and all insurance benefits named herein and any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of the injuries or illness for which I have been treated for by Physician's Spine and Rehab, LLC. This is to act as an assignment of my rights and benefits to the extent of the office's services provided.

I understand that I remain personally responsible for the total amounts due for services rendered. I further understand and agree that this Assignment, Lien and Authorization does not constitute any consideration for the office to await payments, and they may demand payments from me immediately upon rendering services at their option.

I authorize the office to release any information pertinent to my case to any insurance carrier or adjuster to facilitate collection under this Assignment, Lien and Authorization.

____

Patient Signature Date

HIPAA

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: ____ Date ____________________

Address:____

I have been given a copy of Physician's Spine and Rehab, LLC *Notice of Privacy Practices* (“*Notice*”), which describes how my health information is used and shared. I understand that Physician's Spine and Rehab, LLC has the right to change this *Notice* at any time. I may obtain a current copy by contacting the Facility Privacy Official, or by visiting the web site at www.physicianschiro.com.

My signature below acknowledges that I have been provided with a copy of the *Notice of Privacy Practices:*

____ _____________________________
Signature of Patient or Personal Representative Date

____
Print Name

____
Personal Representative’s Title (e.g., Guardian, Executor of Estate, Health Care Power of Attorney)

For Facility Use Only: Complete this section if you are unable to obtain a signature.

1. If the patient or personal representative is unable or unwilling to sign this *Acknowledgement*, or the *Acknowledgement* is not signed for any other reason, state the reason:

____

____

2. Describe the steps taken to obtain the resident’s (or personal representative’s) signature on the *Acknowledgement:*

____

____

Completed by:

____ ____________________________
Signature of Facility Representative Date

____
Print Name

Patient Name: _______________________ Date of Birth: __________________ Date: __________________

Patient Informed Consent

Congratulations on choosing chiropractic health care. This clinic believes it is the safest, most natural health care delivery system in the world today. Chiropractic adjustments (chiropractic manipulative therapy: CMT) and other care procedures are safe and cost effective.

All health care professionals (anesthesiologists, chiropractors, dentists, medical doctors, osteopaths, pharmacists, surgeons, etc.) are regulated by laws and boards. These health care professionals are required to give you, the patient, advanced notice of any care risks, because health care is not an exact science. It is not reasonable to expect any doctor to foresee all risks and/or complications. Informed consent information regarding any risks such as: paraplegia, quadriplegia, brain damage, stroke, disc injury, breaks, fractures, dislocations, drug reactions, death or loss of function of any organ or limb, or disfiguring scars associated with physical care, drugs, surgery and/or treatment is an undesirable result, but it does not necessarily indicate an error in clinical judgment. No guarantee of cure or results has been made to you, the patient in this clinic. Your care may involve the making of recommendations based upon facts known to the doctor at this time. Chiropractic care does not use drugs or surgery, and does not diagnose internal and/or medical conditions.

For your information, the following is furnished to all patients who request and/or accept chiropractic care in this clinic. Again, chiropractic care does not use drugs or surgery, and does not diagnose internal and/or medical conditions. This clinic is staffed with graduate chiropractors who are licensed and recognized by government agencies regulating all the aforementioned healing arts.

Chiropractic is the science that concerns itself with the relationship between the brain, central nervous system, spine and the function of the body. Any alteration of this relationship can cause the biomechanical and neurophysiological dynamics of the contiguous spinal and paraspinal structures to be disrupted. This can cause neuronal disturbances in the form of the vertebral subluxation complex (V.S.C.) with its physical and chemical components, which can then interrupt the body's inherent recuperative powers.

The practice of chiropractic can include exams and diagnostic testing. In some cases, this includes the utilization of specialized instrumentation, lab tests, radiological exams, nutritional and/or physical therapy, and rehabilitation procedures, etc. There is a special procedure unique to chiropractic: the chiropractic adjustment (chiropractic manipulative therapy – C.M.T.). Adjustments are made by chiropractors to correct and/or reduce and/or stabilize vertebral or extremity subluxation complexes. The goal of chiropractic health care is to reduce and/or stabilize vertebral or extremity subluxation complexes. The goal of chiropractic health care is to reduce and/or stabilize the nerve interference caused by the VSC and its component parts. There are over 200 different adjusting techniques, some using specialized equipment. Adjustments are usually performed by hand, but may be performed by hand-guided instruments. A C.M.T. is the application of a specific force, applied to a segmental contact point, usually on a vertebra, to reduce or stabilize the V.S.C. and its component parts.

You should understand the benefits of chiropractic health care, but you also need to be aware of some of the limited inherent risks. These occur seldom enough to contraindicate care, but should be considered in your informed decision to receive chiropractic care.

All health care procedures have some risks. With C.M.T.'s, these risks may include aggravating a pre-existing condition, musculoskeletal sprain/strain, disc injuries, dislocations, fractures, neurological deficits, Horner's Syndrome, Vertebral Artery Syndrome (V.A.S.), stroke, etc. The chances of this occurring have been estimated by experts to be approximately only 1 per 400,000 treatments, to 1 per 1,000,000 treatments.

Appropriate tests will be performed to identify if you may be susceptible to these risks, and you will be notified, in that case. If you have any questions about these issues, please do not hesitate to speak with your doctor of chiropractic.

I have read (or have had read to me) the above information. I wish to rely on the doctor's judgment during my course of care, based on the facts then known. I have also had opportunity to ask questions regarding the above information and possible consequences and risks. By signing below, I now agree to have the chiropractic care procedures recommended and performed. I have no questions, and I acknowledge no guarantee of cure has been made to me concerning results, care and treatment.

______________________________	X______________________________
Patient Name Printed	*Patient Signature* *Date*
______________________________	______________________________
Patient/Guardian Signature (if minor)	*Staff/Witness Signature* *Date*