Clearwater Spine & Rehabilitation

Chiropractic ♦ Physical Therapy ♦ Auto Accident Rehabilitation

Patient Information

Date _____

SS# _____

Name: First _____ MI ____ Last _____

Nickname _____

Address _____Apt.#_____

City _____ State _____ Zip _____

Birthdate _____ Age _____

Gender ☐ Male ☐ Female

Language ☐ English ☐ Other _____

Race _____ Ethnicity _____

☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Occupation _____

Employer/School _____

Spouse Name _____

Spouse Birthdate _____

Contact Information

Primary Phone # _____☐ Cell ☐ Home ☐ Work

Secondary Phone # _____☐ Cell ☐ Home ☐ Work

E-mail Address _____

The primary way I would like you to contact me for appointment reminders is: ☐ Text ☐ E-mail

Emergency Contact Name _____

Phone # _____ Relationship _____

_____

Accident Information

Is condition due to an accident? ☐ Yes ☐ No

Date of accident _____

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?

☐ Auto Insurance ☐ Employer ☐ Workers Comp. ☐ Other

Attorney Name (if applicable) _____

Patient Condition

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Please circle to rate the severity of your pain on a scale from 1 (least) to 10 (severe)

1 2 3 4 5 6 7 8 9 10

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting

☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

How often do you have this pain? _____

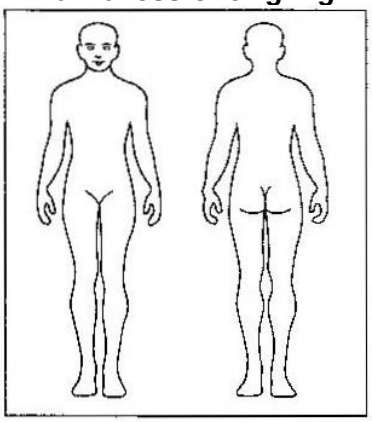
Is it constant or does it come and go? _____

Does it interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking

☐ Bending ☐ Lying Down ☐ Other _____

Mark an X on the picture where you have any pain, numbness or tingling



What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ None ☐ Other _____

Name and address of other doctor(s) who have treated you for your condition _____

_____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Spinal Exam _____

Chest X-Ray _____ MRI _____ CT-Scan _____ Bone Scan _____

Patient Name _____ **Date** _____

Health History

Place a mark on "Y" for Yes or "N" for No to indicate if you have had any of the following:

AIDS/HIV	☐ Y	☐ N	Diabetes	☐ Y	☐ N	Measles	☐ Y	☐ N	Rheumatoid Arthritis	☐ Y	☐ N
Alcoholism	☐ Y	☐ N	Emphysema	☐ Y	☐ N	Migraine Headaches	☐ Y	☐ N	Rheumatic Fever	☐ Y	☐ N
Allergy Shots	☐ Y	☐ N	Epilepsy	☐ Y	☐ N	Miscarriage	☐ Y	☐ N	Scarlet Fever	☐ Y	☐ N
Anemia	☐ Y	☐ N	Fractures	☐ Y	☐ N	Mononucleosis	☐ Y	☐ N	Stroke	☐ Y	☐ N
Anorexia	☐ Y	☐ N	Glaucoma	☐ Y	☐ N	Multiple Sclerosis	☐ Y	☐ N	Suicide Attempt	☐ Y	☐ N
Appendicitis	☐ Y	☐ N	Goiter	☐ Y	☐ N	Mumps	☐ Y	☐ N	Thyroid Problems	☐ Y	☐ N
Arthritis	☐ Y	☐ N	Gonorrhea	☐ Y	☐ N	Osteoporosis	☐ Y	☐ N	Tonsillitis	☐ Y	☐ N
Asthma	☐ Y	☐ N	Gout	☐ Y	☐ N	Pacemaker	☐ Y	☐ N	Tuberculosis	☐ Y	☐ N
Bleeding Disorders	☐ Y	☐ N	Heart Disease	☐ Y	☐ N	Parkinson's Disease	☐ Y	☐ N	Tumors, Growths	☐ Y	☐ N
Breast Lump	☐ Y	☐ N	Hepatitis	☐ Y	☐ N	Pinched Nerve	☐ Y	☐ N	Typhoid Fever	☐ Y	☐ N
Bronchitis	☐ Y	☐ N	Hernia	☐ Y	☐ N	Pneumonia	☐ Y	☐ N	Ulcers	☐ Y	☐ N
Bulimia	☐ Y	☐ N	Herniated Disk	☐ Y	☐ N	Polio	☐ Y	☐ N	Vaginal Infections	☐ Y	☐ N
Cancer	☐ Y	☐ N	Herpes	☐ Y	☐ N	Prostate Problem	☐ Y	☐ N	Venereal Disease	☐ Y	☐ N
Cataracts	☐ Y	☐ N	High Cholesterol	☐ Y	☐ N	Prosthesis	☐ Y	☐ N	Whooping Cough	☐ Y	☐ N
Chemical Dependency	☐ Y	☐ N	High Blood Pressure	☐ Y	☐ N	Psychiatric Care	☐ Y	☐ N	Other _____	☐ Y	☐ N
Chicken Pox	☐ Y	☐ N	Kidney Disease	☐ Y	☐ N						
			Liver Disease	☐ Y	☐ N						

Are you pregnant? ☐ No Date of last menstrual period _____ **☐ Yes Due Date** _____

Family History

Disease/Condition	Parents	Grandparents	Siblings
Heart Problems	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Cancer (Type) _____	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Stroke	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
High Blood Pressure	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Other Major Health Issues _____	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Exercise	Work Activity	Habits	
☐ None	☐ Mostly Sitting	☐ Smoking	Packs/Day _____
☐ Daily	☐ Light Labor	☐ Alcohol	Drinks/Week _____
☐ Moderate	☐ Mostly Standing	☐ Coffee/Caffeine Drinks	Cups/Day _____
☐ Heavy	☐ Heavy Labor		

Injuries/Surgeries you have had	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones/Dislocations	_____	_____
Surgeries	_____	_____

Medications	Allergies	Vitamins/Herbs/Minerals
_____	_____	_____
_____	_____	_____
_____	_____	_____

Patient Name _____ **Date** _____

Nutrition

□ Y □ N If you are taking supplements, do you feel they are effective?
□ Y □ N Have you ever had bloodwork done regarding your nutritional needs?
□ Y □ N Are you interested in nutritional counseling with one of our doctors?

Insurance

Insurance Co. _____

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with the above referenced insurance company and assign directly to Clearwater Spine & Rehabilitation all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Clearwater Spine & Rehabilitation may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

X_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of person signing above

_____ _____
Date Relationship to Patient

Office Financial Policy

By executing this agreement, you are agreeing to pay for all services that are received. You are considered a cash patient until you bring in your completed insurance forms and we qualify and accept your insurance coverage. Payments are expected at the time of service or by an authorized payment plan.

Contracted Insurance: If we are contracted with your insurance company, we must follow our contract and their requirements. If you have a co-pay or deductible, it must be paid at the time of service. It is the insurance co. that makes the final determination of your eligibility.

If your carrier has not paid a claim within sixty (60) days of submission, you agree to take an active part in the recovery of your claim. If your insurance carrier has not paid within ninety (90) days of submission, you accept responsibility for payment in full of any outstanding balance.

Finance Charge: A finance charge will be imposed on each item of your account which has not been paid within thirty (30) days of the time the item was added to the account. The **FINANCE CHARGE** will be computed at the rate of one percent (1%) per month or an **ANNUAL PERCENTAGE RATE** of twelve percent (12%).

There is a fee of $25 for any checks returned by the bank.

X _____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of person signing above

_____ _____
Date Relationship to Patient

Informed Consent for Examination and Treatment

I hereby consent to the performance of examination and treatment on me or on _____ by the licensed Doctor of Chiropractic, licensed massage therapists and/or chiropractic assistants who may be employed by or engaged in practice in this clinic.

I have had an opportunity to discuss with the doctor(s) or other clinic personnel the nature and purpose of the different physical therapy procedures and chiropractic treatment (manipulation/adjustment). I understand that neither chiropractic nor medical treatment is an exact science and that my care may involve judgments based upon facts and information known to the doctor. The doctor uses this judgment to attempt to anticipate or explain risks & complications & an undesirable result does not necessarily indicate an error in judgment. No guarantee for results can be made or expected, but rather I wish to rely on the doctor to choose & recommend the best course of treatment based upon facts known that is in my best interest.

I further understand that there are certain degrees of risk associated with chiropractic health care and physical therapy, which includes rarely, but not limited to: fractures, disc injuries and strain/sprains. I am therefore willing to accept and consent to the risk associated with the care that I am about to receive.

I have read, or the above information has been explained regarding consent. I have had an opportunity to ask questions about my examination and treatment. By signing below, I agree and intend this consent form to cover the procedures prescribed for my condition and for any future conditions for which I seek treatment.

X _____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of person signing above Relationship to Patient