Elite SPORTS AND SPINE

☐ *Chiropractic* ☐ *Physical Therapy*

Email Completed Form

Revised 2/23/14

Patient Registration and History

1 Patient's Personal Information

Patient Name: _____ (First / Middle / Last) Today's Date: _____

Date of Birth: _____ Social Security #: _____ Spouse/Parent: _____ (First / Last)

Address: _____ (Street / City / State / Zip)

Home Phone #: _____ Cell Phone #: _____ Work Phone #: _____

Sex: ☐ Male ☐ Female Age: _____ Email Address: _____

Driver's License #: _____ Which best describes you?: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Occupation: _____ Employer: _____

Employer Address: _____ (Street / City / State / Zip)

Employer Phone #: _____ ☐ Full-time ☐ Part-time # Hours/week worked: _____

In the event of an emergency:

Contact: _____ Phone#: _____ Relationship: _____

Is this condition due to an accident? ☐ Yes ☐ No *If yes, please indicate:* ☐ Auto ☐ Work ☐ Home/Other (see box 5)

Whom may we thank for you being referred to us? _____

Would you like us to send you appointment reminders via text? ☐ Yes ☐ No *If yes, Phone #:* _____

2 Health Insurance Information

Primary Health Insurance

Insurance Company: _____

Phone # of Insurance Company: _____

Relationship to Policy Holder: _____

Policy Holder Date of Birth: _____

Policy #: _____ Group #: _____

Secondary Health Insurance *(if applicable)*

Insurance Company: _____

Phone # of Insurance Company: _____

Relationship to Policy Holder: _____

Policy Holder Date of Birth: _____

Policy #: _____ Group #: _____

3 Auto Insurance Information

(Complete this section if your injury is related to an auto accident)

Motor Vehicle Insurance

Owner of Vehicle: _____

Insurance Company: _____

Phone # of Insurance Company: _____

Policy #: _____ Claim #: _____

Have you retained an attorney? ☐ Yes ☐ No

Name (Attorney): _____ Phone: _____

Third Party Information *(other party involved in accident)*

Name: _____

Phone #: _____

Auto Insurance Company: _____

Policy #: _____ Claim #: _____

Phone # of Insurance Company: _____

Patient Name: _____ Date of Birth: _____

4 Auto Accident Information

(Complete this section only if your injury is related to an auto accident)

Date of Accident: _____ Time of Accident: _____ ☐AM ☐PM

State in which accident occurred: _____

Please answer the following questions:

Were you the ☐ Driver ☐ Passenger

Were you wearing a seatbelt? ☐ Yes ☐ No

Were you stopped during impact ☐ Yes ☐ No

Were the police notified? ☐ Yes ☐ No

Where were you sitting? ☐ Front Seat ☐ Back Seat

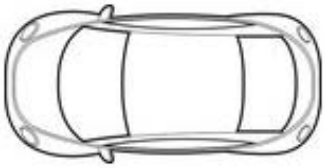
Did you brace for impact? ☐ Yes ☐ No

Did you know you were going to be hit? ☐ Yes ☐ No

Did the police file a report? ☐ Yes* ☐ No

*If yes, you must provide a copy of the report to our office within 5 business days

Please mark impact location on the diagram with an "X"



Approximate speed you were traveling: _____mph

Approximate speed of other vehicle: _____mph

Make and Model of your vehicle: _____

Make and Model of other vehicle: _____

How badly was the vehicle damaged? ☐ Totaled ☐ Extensive ☐ Moderate ☐ Minimal

Amount of damage: $_____

Was your vehicle towed from the scene? ☐ Yes ☐ No

5 Work/Other Injury Information

(Complete this section if your injury is related to work or 'other')

Date of Accident: _____ Time of Accident: _____ ☐AM ☐PM

State in which Accident Occurred: _____

Please describe how the injury occurred, in detail: _____

6 Your Doctor(s)

Please list all current and previous doctors involved in your health care

Type/Specialty	*Name*	*Phone #*
Primary Care Physician		

Patient Name: _____ Date of Birth: _____

7 Current Complaints

Please describe your chief complaint(s): _____

_____

Date when complaint first presented: _____

Symptoms interfere with: ☐ Daily Routine ☐ Sleep ☐ Work ☐ Recreation

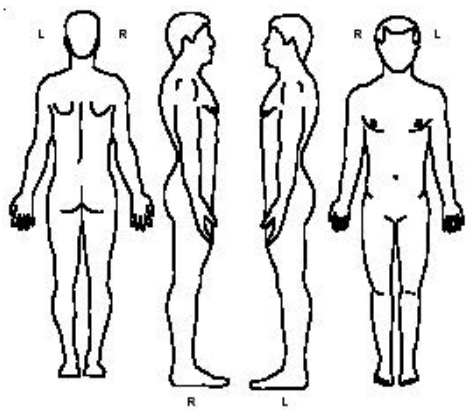
Does this complaint(s) cause you to work less? ☐ Yes* ☐ No
*Please explain: _____

Activities that are painful or difficult to perform due to complaint(s):
☐ Sitting ☐ Walking ☐ Bending ☐ Standing ☐ Laying ☐ _____

Since the first onset, are your symptoms:
☐ Worsening ☐ Unchanged ☐ Improving

How would you rate your symptoms?
☐ Mild ☐ Moderate ☐ Severe

Please mark location of symptom(s) with an "X" on the diagram below



How would you rate your current symptoms/pain?
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
No symptoms → *Worst possible*

8 Previous Examination/Hospitalization History

Answer the following questions based on ***Current Complaints*** *ONLY*

Have you seen any other doctors for this complaint? ☐ Yes ☐ No Name of Doctor(s): _____

Doctor's Address: _____ Doctor's Phone #: _____

Date(s) seen: _____ Diagnosis: _____

Treatment(s) received by other Doctor(s): _____

Have you been hospital for this condition? ☐ Yes ☐ No If 'Yes', what hospital? _____

Date of hospital visit: _____ How did you get there? ☐ Ambulance ☐ Self ☐ Family/Friend

Treatment received at hospital: _____

Please list any medications prescribed by doctor(s) for this condition: _____

Diagnostic Imaging/Examination History *(place an 'X' in boxes that apply)*

☐ Examination(s): _____ (Region/Body Part(s)) _____ (Date)

☐ MRI: _____ (Region/Body Part(s)) _____ (Date)

☐ X-Ray: _____ (Region/Body Part(s)) _____ (Date)

☐ CT: _____ (Region/Body Part(s)) _____ (Date)

☐ NCV/EMG: _____ (Region/Body Part(s)) _____ (Date)

☐ _____ (Test): _____ (Region/Body Part(s)) _____ (Date)

☐ _____ (Test): _____ (Region/Body Part(s)) _____ (Date)

☐ _____ (Test): _____ (Region/Body Part(s)) _____ (Date)

Female Patients Only

Are you currently pregnant? ☐ Yes ☐ No Date of onset of most recent menstrual cycle: _____

Patient Name: _____ Date of Birth: _____

9 Health History – Supplemental Medical Data

Please check boxes relevant to your previous or current health history.

Have you ever been told you have or have had:

☐ Cancer? ☐ Diabetes? ☐ Heart disease?
☐ Angina/chest pain? ☐ High blood pressure? ☐ Stroke?
☐ Osteoporosis? ☐ Rheumatoid arthritis? ☐ High cholesterol?

Have any of your immediate family members been told they have or have had:

☐ Cancer? ☐ Diabetes? ☐ Heart disease?
☐ Angina/chest pain? ☐ High blood pressure? ☐ Stroke?
☐ Osteoporosis? ☐ Rheumatoid arthritis? ☐ High cholesterol?

In the past 3 months, have you had or do you experience:

☐ A change in your health? ☐ Nausea/vomiting? ☐ Unexplained weight change?
☐ Fever/chills/sweats? ☐ Numbness or tingling? ☐ Changes in bowel or bladder?
☐ Changes in appetite? ☐ Difficulty swallowing? ☐ Upper respiratory infection?
☐ Shortness of breath? ☐ Dizziness? ☐ Urinary tract infection?
☐ Change in balance? ☐ Excessive loss of hair? ☐ Extreme mood swings?

Do you have a history of:

☐ Allergies/Asthma? ☐ Headaches? ☐ Bronchitis?
☐ Kidney disease? ☐ Rheumatic Fever? ☐ Sexually transmitted diseases?
☐ Seizures? ☐ Ulcers? ☐ Multiple Sclerosis?
☐ Fibromyalgia? ☐ Psychiatric disorder(s)? ☐ Tuberculosis?

Are you currently:

☐ Depressed? ☐ Under stress?

Do you have a problem with:

☐ Hearing? ☐ Speech? ☐ Vision?
☐ Communication? ☐ Controlling movement?

My symptoms are worse in the:

☐ Morning ☐ Afternoon ☐ Evening ☐ Night

My symptoms are best in the:

☐ Morning ☐ Afternoon ☐ Evening ☐ Night

Do you currently use or have you previously used tobacco products?:

☐ Yes ☐ No If yes, _____ packs/tins for _____ years Last tobacco use: _____

Do you currently drink alcoholic beverages?:

☐ Yes ☐ No If yes, how many drinks do you have per week? _____ drinks per weeks

Date of last physical examination: _____

List of current medications: _____

_____

_____

_____

Patient Name: _____ Date of Birth: _____

10 Previous Injuries & Surgeries

Please describe any injuries you may have experienced in the past:

Fractured Bones: _____ Date(s): _____

Work Injuries: _____ Date(s): _____

Auto Accident(s): _____ Date(s): _____

Other: _____ Date(s): _____

Previous Surgeries

Spinal Related: ☐ Discectomy ☐ Laminectomy ☐ Fusion ☐ Other: _____ Date(s): _____

Other Surgeries: _____ Date(s): _____

Non-Surgical Treatments

☐ Chiropractic; when? _____ ☐ Physical Therapy; when? _____ ☐ Acupuncture; when? _____

☐ Injection(s); when? _____ ☐ Massage(s); when? _____ ☐ Other_____; when? _____

☐ Other_____; when? _____ ☐ Other_____; when? _____ ☐ Other_____; when? _____

☐ Other_____; when? _____ ☐ Other_____; when? _____ ☐ Other_____; when? _____

Patient Name: _____ Date of Birth: _____

11 Patient's Rights

We respect our patients' and families' personal health information. We will ensure all information is safeguarded and that our staff members exercise proper ethics at all times. The following rights will be exercised on our patients' behalf:

1. The patient has the right to considerate and respectful care.
2. The patient has the right to and is encouraged to obtain from the doctor(s) relevant, current, and understandable information concerning diagnosis, treatment, and prognosis.
3. The patient has the right to know the identity of the doctor, staff, and all involved in patient care.
4. The patient has the right to make decisions about the plan of care prior to and during the course of treatment, and to refuse recommended treatment or plan of care to the extent permitted by law, and to be informed of the consequences of this action.
5. The patient has the right to every consideration of privacy.
6. The patient has the right to expect that all communications and records pertaining to his/her care will be treated as confidential, except in cases where reporting is permitted or required by law.
7. The patient has the right to expect reasonable continuity of care when appropriate and to be informed by the doctor of available and realistic patient care options.

Patient's Initials ☐

12 Use of Personal Health Information, Payment and Insurance Policies

I hereby authorize release of any medical information necessary to process health care claims and request payment of insurance benefits either to myself or to the party who accepts assignment.

I authorize payment of any medical benefit from third-parties for benefits submitted for my claim to be paid directly to Elite Sports and Spine Chiropractic or Elite Sports and Spine Physical Therapy. I authorize the direct payment to this office of any sum I now or hereafter owe this office by my attorney, out of proceeds of any settlement of my case and by any insurance company contractually obligated to make payment to me or you based upon the charges submitted for products and services rendered.

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Elite Sports and Spine Chiropractic or Elite Sports and Spine Physical Therapy will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for products or professional services rendered will be immediately due and payable. I understand that any past-due balance 90 days or greater may be sent to collections.

Patient's Initials ☐

13 Female Patients Only

I certify, to the best of my knowledge, that I ☐ **AM** ☐ **AM NOT** pregnant, and I may receive all treatment methods, if clinically indicated, listed in the informed consent document (e.g. X-ray, EMS therapy, etc.).

Patient's Initials ☐

14 No-Show and Cancellation Policy

Upon cancellation and not showing for a scheduled appointment, Elite Sports and Spine Chiropractic and/or Elite Sports and Spine Physical Therapy have the right to assess a $50.00 fee to your account. Please cancel your appointment at least 12 hours prior to your scheduled appointment time. If a patient presents 15 minutes (or more) later than the scheduled appointment time, it may be necessary to reschedule the office visit.

Patient's Initials ☐

I certify that I have filled out this form accurately, to the best of my ability. Should any information change, I agree to disclose required information as soon as possible.

_____ *Patient/Legal Representative Signature*

Email Completed Form

_____ *Date*

Thank you for trusting our providers at

Elite SPORTS AND SPINE

CHIROPRACTIC PHYSICAL THERAPY

Welcome to the family!

Find us on

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@ ESportsSpine

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