APEX CHIROPRACTIC + PHYSICAL MEDICINE Intake

Patient Information

Date ____/____/_____

Full name _____ Street Address_____

City_____State ___ Zip_____ E-mail _____

Sex □M □F Age___Birth date____/____/_____ Social Security Number_____

Check appropriate box: □Married □Single □Divorced □Widowed

Best number to reach you at: (____)_____

Emergency contact: (name): _____ Relationship_____Phone: (_____) _____

Patient Occupation_____ Patient Employer_____

Employer City_____

Employer Phone_____ Spouse's name_____

Spouse's employer_____

How did you hear about us? □Online, which website?_____

□Friend or family, their name?_____

□Event, which one?_____

Insurance Information

Please give insurance card and driver's license to front desk staff to scan

Please tell us what type of health insurance you have should you decide to continue care in our clinic.

□PPO □HMO □Kaiser □None

Insurance Company_____

Who is responsible for the insurance account

□Self □Spouse □Family member

Name if not self_____

ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS
AS WELL AS AN APPOINTMENT AND/OR DESIGNATION AS MY PERSONAL REPRESENTATIVE
AND AN ERISA/PPACA REPRESENTATIVE AND BENEFICIARY

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay Apex Chiropractic and Apex Physical Medicine as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided. I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that have been or will be rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under. I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same. I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment, appointment, and designation will remain in effect unless revoked by me in writing. It is my intent that the effective date of this document shall relate back to include all services, supplies, test, treatments, or medications that have been previously provided by Healthcare Provider. A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

Patient Signature:_____ Date:_____

Health History Patient Name: _____ DOB:_____ Date____/____/___

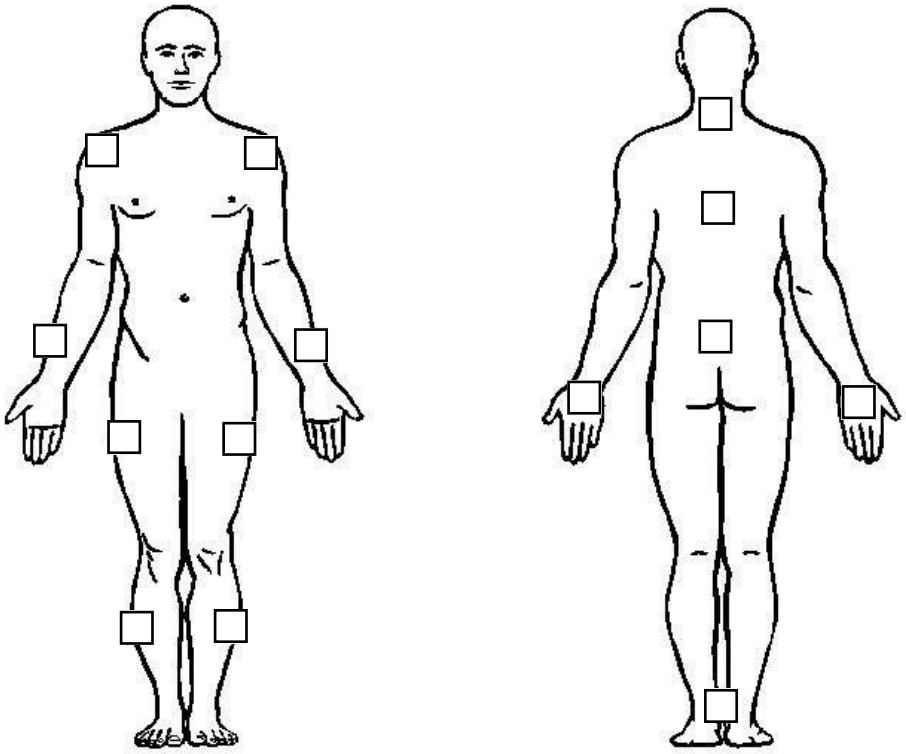
Chief Complaint(s)_____

How long have you had this Pain/Problem?_____

What caused the Pain/Problem?_____

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

Please draw/mark on the diagram below where you are feeling pain/problem(s)



Rate your pain/problem severity on a scale of 1-10, with 10 being the worst

Area:_____Pain rating_____/10

Area:_____Pain rating_____/10

Area:_____Pain rating_____/10

What does the pain/problem feel like?:_____

□ Achy □ Dull □ Stiff □ Sharp □ Numb/Tingling? If yes, where _____

Is the pain □ constant or does it □ come and go?

What does the pain/problem interfere with in your activities of daily living?:_____

□ Work □ Sleep □Daily Routine □Exercise

What makes the pain/problem feel worse?

□Sitting □Standing □Walking □Bending □ Exercise

What makes the pain/problem feel better? :_____

□ Ice □ Heat □Other:_____

What treatments have you already received for your condition?

□ Medications □ Surgery □ Physical Therapy □ Chiropractic □ Other_____

Health History

Patient Name: _____ DOB:____/____/__ Date____/____/___

Height_____' ____" Weight _____lbs

History of Present Injury/Illness: Please check boxes indicating current or past symptoms

☐ Neck pain/stiffness	☐ Numbness/tingling in arms	☐ Sudden weight loss	☐ Nausea
☐ Back pain/stiffness	☐ Numbness/tingling in legs	☐ Depression	☐ Loss of taste
☐ Arm/hand pain	☐ Fatigue	☐ Cold feet	☐ Nervousness
☐ Leg/knee pain	☐ Loss of memory	☐ Chest pain	☐ Sleeping difficulties
☐ Tension	☐ Jaw Problems	☐ Fever	☐ Loss of smell
☐ Headaches	☐ Cold/night sweats	☐ Constipation	☐ Fainting
☐ Stomach problems	☐ Shortness of breath	☐ Blurred Vision	☐ Night pain
☐ Dizziness	☐ Asthma	☐ Light sensitivity	☐ Bowel/bladder changes
☐ Sinus issues	☐ Allergies	☐ Food sensitivity	☐ Arthritis- where_____
☐ Varicose veins			

List others/comments:_____ *blank boxes are considered negative.

Past Medical History: Please check boxes indicating current or past illnesses

☐ **High blood**	☐ **Heart Disease**	☐ Migraines	☐ Liver Disease	☐ Rheumatoid arthritis
☐ **pressure Diabetes**	☐ Pinched nerve	☐ Ulcers	☐ Fibromyalgia	☐ Cancer- if yes where_____
☐ **Kidney Disease**	☐ High cholesterol	☐ Stroke	☐ Arthritis	☐ Herniated disc
☐ Bleeding disorders	☐ Osteoporosis	☐ Pacemaker	☐ TMJ Issues	☐ Thyroid problems

List others/comments:_____

Injuries/surgeries you have had	**Description**	**Date**
Falls	_____	____/____/_____
Head injury	_____	____/____/_____
Broken bones	_____	____/____/_____
Dislocations	_____	____/____/_____
Surgeries	_____	____/____/_____

Family History- Aside from your personal history, please tell us any conditions that run in your family, along with the family member.

☐ Heart disease_____ ☐ Diabetes_____ ☐ Cancer_____

☐ Arthritis_____ ☐ Stroke_____ ☐ High blood pressure_____

☐ Other_____*All blanks will be considered negative.

Clinician Signature:_____ Date____/____/___

Patient Name: _____ DOB:_____ Date____/____/___

Patient social History:

EXERCISE: ☐ None ☐ Moderate ☐ Daily ☐ Heavy

WORK ☐ Sitting ☐ Standing ☐ Light labor ☐ Heavy labor

ACTIVITY: ☐ Smoking-Packs/day_____ Alcohol-drinks/week_____

HABITS: ☐ Coffee/Caffeine-cups/day_____ High stress level—cause?_____

Medication Information

Current medications with dosage and frequency:_____

_____

Are you currently taking any Beta Blockers? ☐Yes ☐ No

Pain medications tried and outcome? ☐Advil ☐Aleve ☐Tylenol ☐Steroids

Duration of use? ☐0-3 months ☐3-6 months ☐ 6+ months

Pain medication outcome? ☐ Mask the pain ☐Temporary Relief ☐ Resolved the problem

Allergy Information

Please list all allergies and reaction: _____

Do you have a history of Anaphylaxis?☐Yes ☐ No , If yes to what?_____

Are you allergic to Sulfa or Shellfish ☐Yes ☐ No

If filling out digitally the below section may be filled out in office

Indicate which of the below you have experienced in the last 1-2 months
1 = Never; 2 = Rarely; 3 = Occasionally; 4 = Frequently; 5 = Constantly

Eyes/Ears/Nose/Throat/Respiratory

Asthma	1 2 3 4 5
Stuffy nose	1 2 3 4 5
Sore throat	1 2 3 4 5
Chronic cough	1 2 3 4 5
Chest congestion	1 2 3 4 5
Frequent sneezing	1 2 3 4 5
Itchy/watery eyes	1 2 3 4 5
Earache or ear infection	1 2 3 4 5
Itching	1 2 3 4 5
Hoarseness	1 2 3 4 5
Shortness of breath	1 2 3 4 5
Wheezing	1 2 3 4 5

Muscular/Skeletal

Muscle aches	1 2 3 4 5
Fibromyalgia	1 2 3 4 5
Arthritis	1 2 3 4 5
Joint pain	1 2 3 4 5
Low back pain	1 2 3 4 5
Neck pain	1 2 3 4 5
Wrist/Hand pain	1 2 3 4 5
Elbow pain	1 2 3 4 5
Hip pain	1 2 3 4 5
Knee pain	1 2 3 4 5
Ankle/Foot pain	1 2 3 4 5
Shoulder pain	1 2 3 4 5

General

Fatigue	1 2 3 4 5
Malaise (not feeling well)	1 2 3 4 5
Diarrhea	1 2 3 4 5
Constipation	1 2 3 4 5

Neurological

Headaches	1 2 3 4 5
Migraines	1 2 3 4 5
Numbness	1 2 3 4 5
Tingling	1 2 3 4 5

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

Patient Name: _____

Patient Signature_____ Date____/____/_____

Thank you for your patience filling out our intake paperwork and questionnaire so we can be well- informed and offer the best care possible for you and your family.

Clinician Signature:_____ Date____/____/___

Informed Consent for Care

I, as a patient coming to the Apex Chiropractic and Apex Physical Medicine, give him/her permission and consent to care for myself in accordance with the appropriate testing, diagnosis, and treatment. The clinical procedures in this office are typically beneficial and rarely cause problems. However, although rare, medical treatment, chiropractic, acupuncture, and physical therapy all carry a small risk with treatment, including but not limited to: fractures, disc injuries, stroke, and sprains.

I do not expect the doctor, nurse practitioner, acupuncturist to be able to anticipate and explain all risk and complications. I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, are in my best interest. We use all precautions (exams, X-rays) and gentle treatment procedures to mitigate any risk.

This office does not perform breast, pelvic, prostate, rectal or full skin evaluations. These examinations should be performed by your family physician, GYN, or dermatologist to exclude cancers, abnormal skin lesion, or other conditions discovered by routine screenings. 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 do not prescribe or refill ANY controlled substances. All prescriptions should be refilled by your original prescriber ans any new prescriptions should be issued by your primary care provider.

I, the patient assumes all responsibility/liability if the patient does not report on health forms any past medical history illnesses, medications, or allergies.

I have read or had read to me, the above consent. By signing below I agree to the above, and allow the doctor, nurse practitioner, acupuncturist or intern, affiliated with Apex Chiropractic and Apex Physical Medicine to perform treatment procedures and protocols. I intend for this consent to cover the entire course of treatment for my present condition and for any further condition(s) for which I seek treatment.

_____ _____/_____/_____

Patient name (Print) Date

_____ _____/_____/_____

Patient or Signature Date