Twins Physical Medicine Intake Examination

Patient Information

Date_____

Full name_____

Street Address_____

City_____ State____ Zip_____

E-mail_____

Sex: ☐ M ☐ F Age___ Birth date_____

Social Security Number_____

☐ Married ☐ Single ☐ Divorced ☐ Widowed

Best number to reach you at: (_____)_____

During emergency contact (name): _____

Relationship_____ Phone: (_____)_____

Occupation_____

Patient Employer/School_____

Employer/School City_____

Employer/School 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 tell us what type of health insurance you have should you decide to continue care in our clinic. ☐ PPO ☐ HMO ☐ Kaiser ☐ None

Insurance Company_____

*Please give insurance card and driver's license to front desk staff to scan, we will do a complimentary benefit check.

Who is responsible for the insurance account?
☐ Self ☐ Spouse ☐ Family member

Name if not self_____

Present Condition Information

Reason for Visit_____

_____

Is this pain due to an accident? ☐ Yes ☐ No

If yes: ☐ work ☐ auto accident ☐other_____

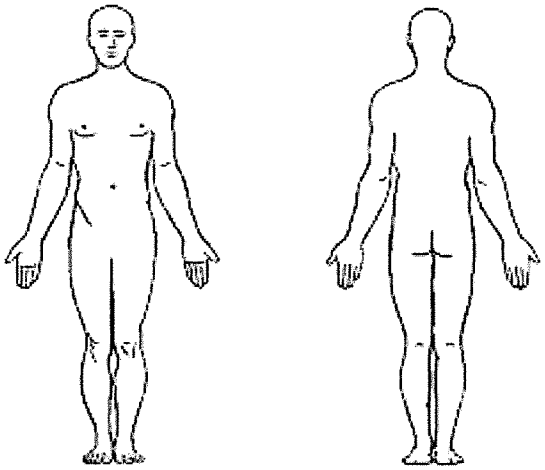
When did the symptoms appear? _____

(i.e. days, weeks, months, years?)

Is this condition getting progressively worse?

☐ Yes ☐ No ☐ Unknown

Please mark an X on the diagram below where you are feeling pain, stiffness, numbness, or tingling.



___

Rate your pain severity on a scale of 1-10

Area:_____pain rating_____/10

Area:_____pain rating_____/10

Type of pain: ☐ Stiff ☐ Sharp ☐ Shooting

☐ Dull ☐ Achy ☐ Burning

☐ Numb/Tingling? If yes, where_____

How often do you have this pain (daily, weekly, monthly, etc)_____

Is the pain **constant** or **come and go**? (circle)

Does the pain interfere with your: (check box)

☐ Work ☐ Sleep ☐ Daily Routine ☐ Exercise

Activities or movements which hurt: ☐ Laying down

☐ Sitting ☐ Standing ☐ Walking ☐ Bending

Health History

Height_____ Weight_____lbs Date_____

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

Name and city of Primary care doctor_____

Name and city of other doctor(s)/providers who have treated you for your condition_____

Date of last: Physical exam_____ Spinal Exam_____ Spinal X-ray_____
MRI/CT scan _____ Blood Test_____

What, if anything has helped with the pain? ☐ Rest ☐ Ice ☐ Heat ☐ Pain medication ☐ Stretching

What, if anything has made the pain worse? ☐ Driving ☐ Walking ☐ Working ☐ Bending ☐ Exercise

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_____
☐ Suicide Attempt	☐Hepatitis/TB	☐ Lung Disease	☐ Venereal Disease/HIV

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

Past Medical History:

Please check boxes indicating current or past illnesses

☐ High blood pressure	☐ Heart Disease	☐ Migraines	☐ Liver Disease	☐ Rheumatoid arthritis
☐ 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 ☐Other

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

Please mark in each column which boxes best describes your activities:

EXERCISE: ☐ None ☐ Moderate ☐ Daily ☐ Heavy

WORK ACTIVITY: ☐ Sitting ☐ Standing ☐ Light labor ☐ Heavy labor

HABITS: ☐ Smoking-Packs/day_____ ☐ Alcohol-Drinks/week_____

☐ Coffee/Caffeine-cups/day_____ ☐High stress level – cause? _____

Medications with dosage and frequency_____

_____

Pain medications tried and outcome? ☐ Advil ☐ Aleve ☐ Tylenol ☐ Steroids (check)

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

Did the medications? ☐ Heal the injury/pain OR ☐ Mask the pain (check one)

Supplements (vitamins, minerals, herbs)_____

Please list all allergies and reaction_____

☐ Runny nose ☐ Itchy watery eyes ☐ Itchy nose ☐ Stuffy Nose ☐ Sneezing

☐ Allergies are seasonal ☐ Allergies are Most of the Year ☐ Allergies are Rarely

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 for fam. hx.

Weight Loss Program

Are you interested in learning about our medically supervised Weight loss program: ☐YES ☐NO

The above information on pages 1-3 were filled out to the best of my knowledge.

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.

Informed Consent for Care

I as a patient coming to the doctor give him/her permission and consent to care for myself in accordance with appropriate testing, diagnosis, and treatment. The clinical procedures in this office are typically beneficial and rarely cause problems. However, although rare, medical treatment, chiropractic, 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 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 and any new prescriptions should be issued by your primary care provider.

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 have read to me, the above consent. By signing below I agree to the above, and allow the doctor or intern, affiliated with Twins 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 Guardian's Signature

Acknowledgement of Receipt of Twins Physical Medicine Notice of Privacy Policy

By signing this document, I acknowledge that I have received/read a copy of Twins Wellness Center's Notice of Privacy Practices. I also acknowledge that I can request a copy of Privacy Policy at any time as well as read the one which is posted in the office.

_____ _____

Patient name (Print) Date

_____

Patient or Guardian's Signature

Twins Chiropractic

600 S. Placentia Ave. Suite 600, Placentia, CA 92870

Date: _____

Patient: _____
Employer: _____
Claim Group: _____
SS#/ID#: _____

I hereby instruct and direct _____Insurance Company to pay by check made out and mailed to:

Twins Chiropractic
13341 Garden Grove Blvd Suite D,
Garden Grove, CA 92843

If my current policy prohibits direct payment to doctor, I hereby also instruct and direct you to make out the check to me and mail it as follows:

Twins Chiropractic
600 S. Placentia Ave. Suite 600
Placentia, CA 92870

For the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

Dated at _____ this_____ day of_____, 20_____

_____ _____
Signature of Policyholder/Claimant **Witness**

Twins Chiropractic INC

Dr. David J Clements and Dr Daniel A. Clements
600 S. Placentia Ave, Placentia, CA, 92870
714-985-9554
714-985-9353 (fax)
www.twinschiropractic.com

Name:_____ DOB_____

Patient Consent to X-Ray

I authorize the performance of diagnostic x-ray examination of myself by Twins Chiropractic.

Signed _____ Date _____

If Patient is a Minor

I am the parent or legal representative of _____ who is a minor, _____ years of age. I authorize the performance of diagnostic x-ray of this minor to be done by Twins Chiropractic.

Signed _____ Date _____

Females: Regarding Possibility of Pregnancy

This is to certify that, to the best of my knowledge, I am not pregnant, and Twins Chiropractic has my permission to perform diagnostic x-ray examination. I have been advised that certain x-ray examinations, particularly those involving the pelvis, can be hazardous to an unborn child.

Signed _____ Date _____

FINANCIAL AGREEMENT

WE RECOGNIZE THE VALUE OF CLEAR COMMUNICATION BETWEEN YOU AND YOUR MEDICAL PROVIDER AND WE WILL DO OUR BEST TO PROVIDE YOU WITH YOUR CURRENT BENEFIT INFORMATION. **PLEASE READ AND INITIAL BELOW.**

_____ Payment is expected at the time of service unless other arrangements have been made with the receptionist prior to treatment.

_____ Massage appointments require a 24-hour cancellation notice. If 24-hour notice is not given a $20.00 fee will be charged to cover the therapist fee.

_____ To receive your full massage, it is recommended you arrive promptly. If you arrive late to your appointment the full fee will be charged. If you arrive 30 minutes late or more, your appointment will be canceled and a 20.00 cancellation fee will apply.

_____ Your insurance policy is a contract between you and your insurance company. As a courtesy, we will verify your benefits and coverage and will try to have this information ready for you prior to your first visit with our office. Should your insurance company be closed at the time you arrive in our office, our insurance specialist will be happy to give you a call on the next business day. **Please be aware this verification is an estimate of benefits and not a guarantee of payment.**

_____ As a service to you, we will bill your health insurance for services rendered. **Some insurance companies may mail the checks directly to you.** Any checks issued to you must be forwarded to Twins Chiropractic, endorsed on the back, and written on the check "pay to the order of Twins Chiropractic". If you chose to write a personal check in the amount of the insurance payment, please include a copy of the explanation of benefits so we may apply your payment to the proper date of service. This payment is due within 15 days of receipt along with any and all EOB's.

_____ Please inform our office of any changes in your insurance policy, change of address or phone number. This is important to insure proper billing of your claims.

_____ Our office welcomes walk-ins. We will do our best to get you in for treatment as soon as possible. There may or may not be a small wait depending on the time of day you arrive for treatment. If for any reason you are rushed for time, make the receptionist aware and they will do their best to get you seen promptly.

_____ ACCEPTED METHODS OF PAYMENT: **Checks** - Any check returned to our office as nonsufficient funds will be subject to a $35.00 fee. Postdated checks are not accepted. We do accept **cash, all major credit cards and care credit.**

CONSENT TO CHIROPRACTIC CARE

Congratulations for having chosen the safest and most natural health care program ever conceived: Chiropractic.

This painless, logical, and effective approach to health has been serving everyday people for over 100 years. It is licensed in every state, and in many countries as well. Chiropractic has the least chance of side effects of any other type of health care. Mild headaches and muscles soreness may sometimes occur.

Let's look at a few statistics about possible serious side effects:

The #1 cause of death in the US is from correctly and incorrectly prescribed pharmaceutical drugs. (CDC, FDA, NIH sites, also Gary Null: Death By Medicine)

Stroke is one of the most common causes of death in the US. With people going to doctors all the time it is probable that many will have had a recent doctor visit. But causation is another matter entirely.

There is no absolutely known material risk of chiropractic care being greater than risks from medical treatment. In fact, when all the factors are taken together, deaths and injuries from a combination of medical mistakes and intentional drugs dwarf any injuries from chiropractic.

Risk of stroke from chiropractic? Virtually zero chance of stroke from chiropractic. The largest study ever done – the 2008 study in Canada – www.belleviewchiro.com/index.php?p=213660 – looking at 12 million people over 9 years, showed that 53% of strokes had visited their MD within 30 days prior, while only 4% had visited their DC. No evidence of excess risk of stroke associated with chiropractic care.

In 2001 the Canadian Medical Association Journal found there is only a one-in-5.85-million risk that a cervical manipulation from an MD, PT, or DC would be followed by a stroke. Author David Cassidy, a professor of epidemiology at the University of Toronto said patients had already damaged the artery before seeking help from either a medical doctor or a chiropractor, and then the stroke occurred after the visit.

Speaking of risks associated with chiropractic, we should look also at the risk associated with NOT GETTING adjusted. This risk was one of the 4 components of risk in the Association of Chiropractic Colleges guidelines on informed consent in 2008. Disc degeneration, loss of mobility, loss of overall tone, decreased quality of life – these are real risks of the untreated spine as time goes by.

I fully understand these risks, the doctor has explained them to me and I consent to chiropractic care.

_____ _____ _____

Sign print date