Grossman Chiropractic and Physical Therapy Patient Information

Today's Date:_____

Patient Contact Information

First Name:_____ Last Name:_____

What would you prefer to be called? _____

How did you hear about our practice? _____

Date of Birth: _____ Gender: (circle one) Male Female Not Specified

Marrital Status: (circle one) Single Married Divorced Widowed Separated

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Referring Physician

Referring Physician (full name & office location): _____

_____

Primary Care Physician

Primary Care Physician (full name & office location): _____

_____

Emergency Contact Information

Name: _____

Relation: _____ Phone: _____

Describe Your Current Condition

Diagnosis/Reason for your appointment: _____

Date of Onset: (if chronic, date of most recent exacerbation) _____

Cause: _____

Have you had previous episodes of this condition? (circle one) Yes No

Date of previous episode: _____

Have you received previous treatment for this condition? (circle one) Yes No

Do you have numbness? (circle one) Yes No

Grossman Chiropractic and Physical Therapy Patient Information

Do you have tingling? (circle one) Yes No

Do you have any weakness? (circle one) Yes No

What worsens your condition? _____

What improves your condition? _____

Are you getting: (circle one) Better Worse Staying the same

How close to full normal functioning are you? (circle one) 25% 50% 75% 100%

Indicate any tests (and associated dates) you may have had to diagnose this condition (i.e XR, MRI, US, CT, etc.) _____

Physical Therapy Goals

What are your goals for physical therapy? _____

_____

Social History/Lifestyle Information

What type of residence do you live in? (i.e house, apartment, condo) _____

Who do you live with? (i.e. parents, spouse, children, pets) _____

What are your usual home responsibilities? (circle all that apply)

heavy cooking light meal prep heavy cleaning light cleaning laundry

gardening yard work self-care care for another snow removal

other: _____

Occupation: _____ Are you currently working? Yes No

Do you exercise? Yes No How many times per week? _____

Types of exercise: _____

Hobbies or other recreational activities: _____

How many hours each night do you sleep? _____ Times per night you get up: _____

General Medical Information

Please indicate any of the following conditions you currently have or have had in the past by circling "Y." If you do not or have not had the condition please circle the letter "N."

Y N Asthma

Y N AIDS

Y N Alcohol/Drug Abuse

Y N Artificial Joints

Y N Artificial Valves

Y N Bladder/Bowel Disorder

Y N Blood Clotting Disorder

Grossman Chiropractic and Physical Therapy Patient Information

Y N Cancer
Y N Cardiac Condition
Y N Chemotherapy
Y N Chronic Infection
Y N Congenital Heart Defect
Y N Diabetes
Y N Difficulty Breathing
Y N Fainting Spells
Y N Heart Attack
Y N ulcers/colitis
Y N Heart Murmur
Y N Hepatitis
Y N High Blood Pressure
Y N Hypoglycemia
Y N Immunocompromised
Y N Metal or other surgical implants
Y N Migraine Headaches
Y N Polio
Y N Pregnancy
Y N Radiation Therapy
Y N Respiratory Condition
Y N Rheumatic Fever
Y N Seizure disorder
Y N Sinus problems
Y N sleep disorder
Y N smoker
Y N stroke
Y N thyroid condition
Y N tuberculosis

Please list any assistive devices or orthotics you may use: _____

_____

Please list any allergies: _____

Please list any other medical conditions not listed above: _____

Please list past surgeries and procedure dates: _____

Medications

Please List all current Medications Below including over the counter medications and supplements.

_____

_____

_____

_____

_____

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Patient or Guardian Signature: _____ Date: _____

Consent to Treat/Release of Information

Please initial each line and then sign and date below.

_____ CONSENT TO EVALUATE AND TREAT: I do hereby consent to the evaluation and treatment by Grossman Chiropractic and Physical Therapy. I understand that it is my right to accept or refuse any treatment offered me. I acknowledge and understand that no guarantee has been made to me as to the results that may be obtained from such treatment.

_____ RELEASE OF INFORMATION: I authorize Grossman Chiropractic and Physical Therapy to release information from my medical record, whether it be written, video, photographic, audio or verbal, to my physician and/or any third party payor (such as insurance company or governmental agency) for its use in processing claims for payment. I understand the nature of the authorization and have been informed that I have the right to revoke consent at any time by written communication with custodians of records. I consent to the release of medical information to my physicians for communication and care coordination on by behalf.

_____ PRIVACY PRACTICES: I acknowledge receipt of the Grossman Chiropractic and Physical Therapy Privacy Practice, which I have received at the time of this initial visit or previously.

_____ ASSIGNMENT OF BENEFITS: I request that payment of Medicare and/or other insurance benefits be made on my behalf to Grossman Chiropractic and Physical Therapy for any services furnished to by Grossman Chiropractic and Physical Therapy.

_____ FINANCIAL AGREEMENT: The undersigned agrees, whether signing as agent or patient, that s/he individually obligates her/himself to pay for services rendered in accordance with the regular rates and terms of Grossman Chiropractic and Physical Therapy. As a courtesy, Grossman Chiropractic and Physical Therapy will attempt to verify insurance benefits on behalf of the patient. However, it is the patients sole responsibility to know their insurance benefits. Verification is no guarantee of payment. The agent/patient is responsible for any co-payment, deductible, coinsurance and all amounts identified by the insurer as the patient's responsibility.

_____ INSURANCE COVERAGE: I understand that if I fail to disclose any effective insurance coverage at the time of this signing or after the first service date when said insurance became effective, I can be held responsible for any balances not covered by said insurance, including balances due to lack of authorization.

The undersigned certifies that I have read, understood and accept the terms of this form, received a copy, and is the patient or is duly authorized by the patient as the patient's general agent to execute this form.

_____ _____

Signature Date

_____

Printed Name

Grossman Chiropractic and Physical Therapy General Office Policies

Please read our office policies below, initial each line and sign at the bottom.

_____ CANCELLATION AND NO-SHOW POLICY: We consider it an honor and privilege to be of service to you. In order to maximize the benefit of your treatment, our physical therapy staff provides one-on-one care during treatment sessions reserved especially for you. We do not double book in order to ensure quality care. Missing appointments will impede your progress. Make every effort to attend every scheduled visit according to the treatment plan recommended by your therapist and doctor.
You are responsible for your schedule. Make a habit of double-checking your next visit. Note changes to your schedule right away. Not showing up for your appointment or appointments cancelled less than 24 hours in advance affect us all. Available appointments are in high demand and your early cancellation will give another person the possibility to have the treatment they need.
Although we do understand that there may be extenuating circumstances, cancellations less than 24 hours will result in a $25 cancellation fee. Not showing up for your appointment without prior cancellation, for any reason, will result in a $40.00 fee. These charges are not covered by your insurance and will have to be paid by your personally. Three violations of this policy within a three month period will result in discharge from treatment, physician notification, and a referral to an alternate facility will be provided.

_____ LATE FOR APPOINTMENT POLICY: We encourage all patients to arrive 10 minutes early to each appointment to give adequate time to check in, schedule or alter additional appointments, complete any required insurance paperwork, etc prior to your treatment. We make every effort to run on time. As such, it is our policy to reschedule your appointment if you arrive more than 15 minutes late without notifying the clinic. We want clients to have sufficient time to work with their service providers and we may not be able to accommodate late arrivals. If you are concerned you may be running late for your appointment, please call the office as soon as possible so we may do out best to accommodate you and our other patients. If you arrive more than 15 minutes late without notifying the clinic, we will work with you to reschedule your appointment when you arrive.

_____ FINANCIAL POLICY: Our policy requires payments in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days if the date if service and no financial arrangements have been made, you will responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account.with our clinic.

The undersigned certifies that I have read, understood and accept the terms of this form, received a copy, and is the patient or is duly authorized by the patient as the patient's general agent to execute this form.

_____ _____

Signature Date

_____

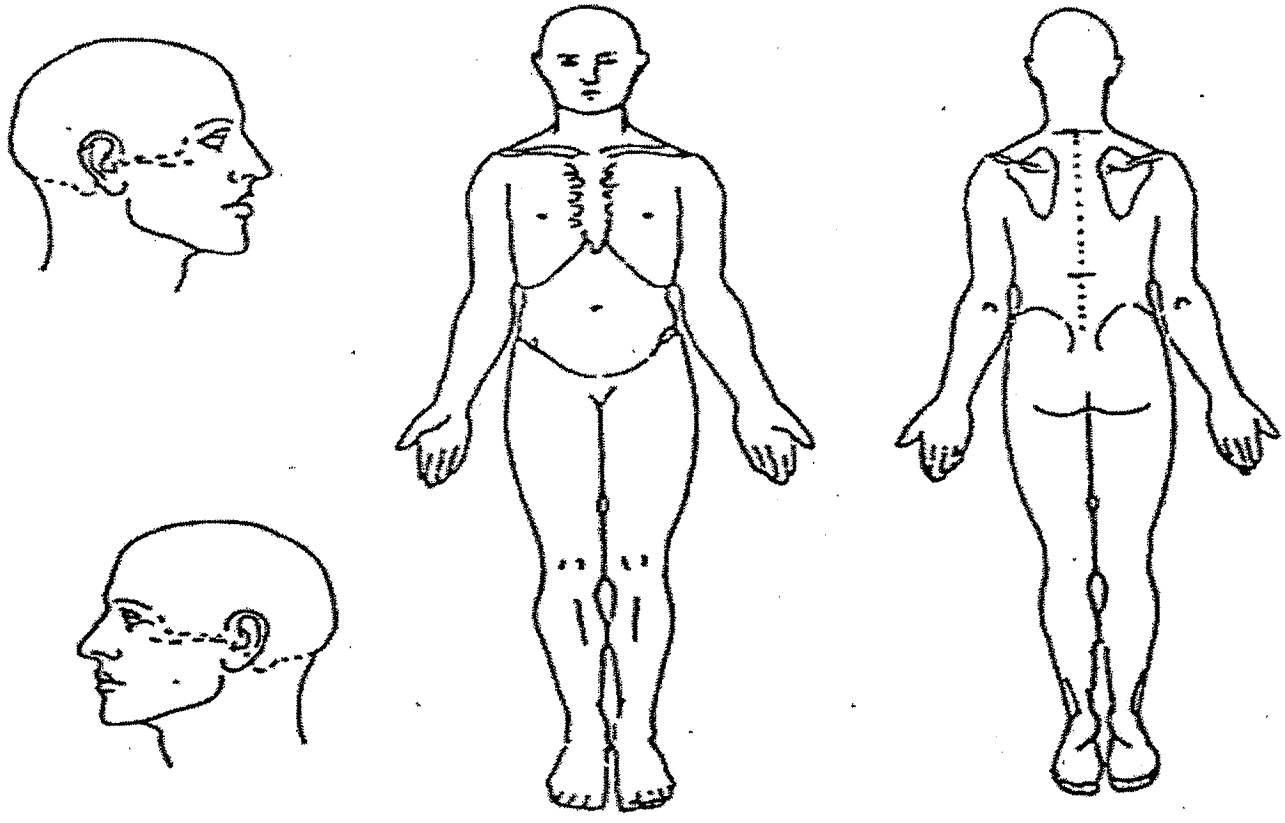
Printed Name

Numeric Pain Rating Scale and Body Diagram

Name:_____ Date:_____

Please mark the figure below by using the following symbols to indicate where your pain is and what kind of pain you are having.

Burning: xxxxx Stabbing: >>>>> Aching/Throbbing: ooooo Numbness/Tingling: ///////



Please let us know how severe your pain is with "0" being no pain at all while "10" is the worst pain imaginable. Circle the one number that most closely indicates your pain level.

Rate your **pain at this moment** (circle only one number):

no pain										worst pain
0	1	2	3	4	5	6	7	8	9	10

Rate the **least amount of pain** you have had **in the past 24 hours** (circle only one number)

no pain										worst pain
0	1	2	3	4	5	6	7	8	9	10

Rate the **most amount of pain** you have had **in the past 24 hours** (circle one number)

no pain										worst pain
0	1	2	3	4	5	6	7	8	9	10