Physicians HealthSource

CONFIDENTIAL PATIENT HISTORY

Date _____

Full Name _____

❑ Male ❑ Female Marital Status ❑ Married ❑ Single ❑ Widowed ❑ Divorced ❑ Other

Address _____ Number of Children _____

City _____ State_____ Zip _____

Social Security Number_____ Age_____ Birth Date _____

Email Address_____

Home Phone _____ Cell Phone _____

Occupation _____ Employer_____

Address _____

City _____ State_____ Zip _____

Work Phone _____

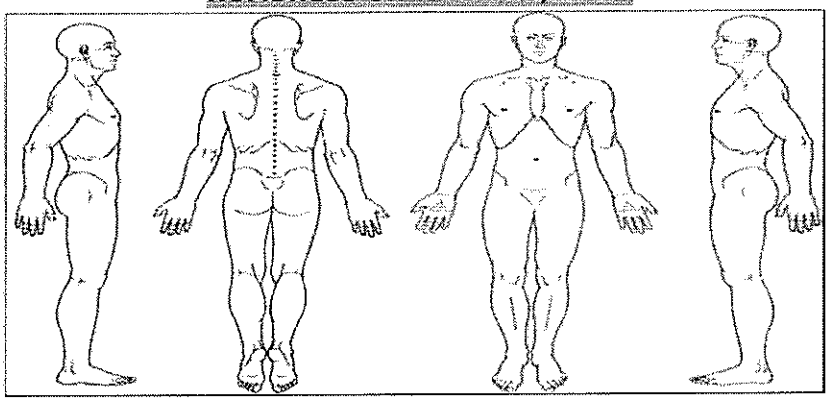
Name of Insurance Company _____

Name of Emergency Contact _____ Phone _____

(Nearest relative or friend, not spouse)

Present Complaint _____

MARK ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS. INCLUDE SYMPTOMS OF PAIN, NUMBNESS OR TINGLING, ETC.



Patient Name _____ **Date** _____

When did your problem begin? Specific date if possible _____

How did your problem begin? _____

_____

In the past have you had anything similar to this? ❑ YES ❑ NO Please explain

_____

Please describe the character of your current pain. You may check one or more answers.

❑ Sharp ❑ Stabbing ❑ Burning ❑ Shooting ❑ Aches ❑ Soreness
❑ Weakness ❑ Throbbing ❑ Numbness ❑ Dull ❑ Constricting ❑ Stiff

❑ Other _____

On a scale from 0-10, with 10 being the worst pain you have ever experienced and 0 being no pain.

What is your current scale of pain?	0	1	2	3	4	5	6	7	8	9	10
What is your pain at its best?	0	1	2	3	4	5	6	7	8	9	10
What is your pain at its worst?	0	1	2	3	4	5	6	7	8	9	10

How often are the complaints present?
❑ Constant 100% of the time ❑ Frequent 75% ❑ Intermittent 50% ❑ Occasional 25%

Comments _____

Is the pain: ❑ Increasing ❑ Decreasing ❑ Not Changing ❑ Varies

Pain is aggravated by: ❑ Walking ❑ Sitting ❑ Standing ❑ Riding in a car ❑ Lifting
❑ Bending ❑ Stretching ❑ Twisting ❑ Running ❑ Transitioning from seated to standing

❑ Other _____

Pain is reduced by:
❑ Medicine ❑ Exercise ❑ Rest ❑ Physical Therapy ❑ Supplements

❑ Other _____

What would you like to do, but can't, because of pain? _____

Are your complaints, in any way, affecting your ability to work or be active?
❑ No effect ❑ Some physical restrictions ❑ Unable to perform regular duties

Is there any dizziness associated with symptoms? ❑ Yes ❑ No

Any fever or chills? ❑ Yes ❑ No

Are your complaints affecting your ability to sleep? ❑ Yes ❑ No Explain _____

On average, how many hours of sleep do you get per night? _____
Do you sleep through the night uninterrupted? ❑ Yes ❑ No

Patient Name _____ **Date** _____

Bournemouth Questionnaire

Instructions: The following scale shave been designed to find out about your pain and how it is affecting you. Please answer **ALL** the scales, and mark the **ONE** number on **EACH** scale that best describes how you feel.

1. Over the past week, on average, how would you rate your pain?

No pain ... Worst pain possible

0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much as your pain interfered with your daily activities (housework, washing, dressing, walking, climbing stairs, getting in/out of bed/chair)?

No interference ... Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your pain interfered with your ability to take part in recreational, social, and family activities?

No interference ... Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

Not at all anxious ... Extremely anxious

0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed ... Extremely depressed

0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your pain?

Have made it no worse ... Have made it much worse

0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce/help) your pain on your own?

Completely control it ... No control whatsoever

0 1 2 3 4 5 6 7 8 9 10

_____ _____

Physician's Signature Score

Patient Name _____ **Date** _____

FAMILY DOCTOR/PRIMARY CARE PHYSICIAN _____

REVIEW OF SYSTEMS

Check any symptoms that you have experienced in the past month ❑ **NONE**

GENERAL
- ❑ Poor appetite
- ❑ Weight Loss
- ❑ Weight gain
- ❑ Poor sleep
- ❑ Fatigue
- ❑ Tremors

SKIN/BREAST
- ❑ Ulcer
- ❑ Rashes/Hives
- ❑ Color change/cyanosis
- ❑ Breast lump/discharge

HEAD/EYES
- ❑ Headache/migraine
- ❑ Vision change
- ❑ Ear ache
- ❑ Sinus problems
- ❑ Nose bleed
- ❑ Grinding teeth/TMJ
- ❑ Facial pain
- ❑ Sore throat

CARDIOVASCULAR
- ❑ High blood pressure
- ❑ Chest pains
- ❑ Irregular heartbeat
- ❑ Dizzy with standing
- ❑ Heart murmur
- ❑ Swelling hands/feet

RESPIRATORY
- ❑ Cough
- ❑ Shortness of breath
- ❑ Pain with deep breath
- ❑ Coughing blood
- ❑ Wheezing

GASTROINTESTINAL
- ❑ Difficulty swallowing
- ❑ Heartburn
- ❑ Nausea
- ❑ Vomiting
- ❑ Abdominal cramps/pain
- ❑ Diarrhea
- ❑ Constipation
- ❑ Stool incontinence
- ❑ Blood in stools
- ❑ Rectal Pain

GENITOURINARY
- ❑ Pain with urination
- ❑ Frequent urination
- ❑ Urgency to urinate
- ❑ Urine incontinence
- ❑ Blood in urine
- ❑ Loss of libido (desire)
- ❑ Pain with intercourse

IMMUNOLOGY
- ❑ Frequent illness
- ❑ Fevers
- ❑ Chills
- ❑ Night sweats
- ❑ Allergies

MUSCULOSKELETAL
- ❑ Muscle pain
- ❑ Joint pain
- ❑ Joint swelling
- ❑ Joint stiffness
- ❑ Cramps
- ❑ Fracture
- ❑ Muscle weakness
- ❑ Osteoporosis
- ❑ Scoliosis
- ❑ Feet pain

NEUROLOGIC
- ❑ Seizures
- ❑ Dizziness
- ❑ Loss of balance
- ❑ Lack of coordination
- ❑ Poor memory
- ❑ Speech difficulty
- ❑ Hearing difficulty
- ❑ Numbness
- ❑ Weakness/paralysis

PSYCHOLOGICAL
- ❑ Depression
- ❑ Anxiety
- ❑ Obsessive ideas
- ❑ Emotional D/O
- ❑ Considered suicide

ENDOCRINE
- ❑ Increased thirst
- ❑ Appetite change
- ❑ Heat/cold intolerance
- ❑ Cold feet/hands

HEMATOLOGY/LYMPHATICS
- ❑ Easy bruising
- ❑ Excessive bleeding
- ❑ Nodules/swollen glands

MEDICAL HISTORY

❑ **NONE**

- ❑ Anemia
- ❑ Arthritis
- ❑ Cancer: _____
- ❑ Cardiovascular Problems
- ❑ Hepatitis/HIV
- ❑ Currently Pregnant
- ❑ Heart attack
- ❑ Blood clots
- ❑ Ulcerative colitis
- ❑ Parkinson's
- ❑ Neuropathy
- ❑ Stomach Ulcers
- ❑ Bleeding disorder
- ❑ Other
- ❑ Depression
- ❑ Dizziness/Fainting
- ❑ Fractures
- ❑ Headaches
- ❑ Thyroid Problems
- ❑ Low Blood Pressure
- ❑ Angina
- ❑ Ankylosing spondylitis
- ❑ Brain Injury
- ❑ Essential Tremor
- ❑ Liver Disease
- ❑ Esophageal reflux
- ❑ Gall bladder D/O
- ❑ Respiratory Problems
- ❑ Asthma
- ❑ COPD
- ❑ Seizures
- ❑ Pacemaker
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ Spine Disc Degenerate
- ❑ Multiple Sclerosis
- ❑ Sleep Disorder
- ❑ Pancreatitis
- ❑ Kidney Problems
- ❑ Alcohol/drug abuse
- ❑ Bipolar D/O
- ❑ PTSD
- ❑ ADHD
- ❑ Gout
- ❑ Lupus
- ❑ Glaucoma
- ❑ Schizophrenia
- ❑ Anxiety D/O
- ❑ Myopathy
- ❑ Psoriasis
- ❑ Osteoporosis
- ❑ Stroke
- ❑ Fibromyalgia

List **any** past surgeries you have had:

Surgery	Performed by / Date

Patient Name _____ **Date** _____

Height: _____ Weight: _____

FAMILY HISTORY

Mother ❑ Living ❑ Deceased Age now or at death: _____ Cause of death: _____

Father ❑ Living ❑ Deceased Age now or at death: _____ Cause of death: _____

Has any blood relative had any of the following:

❑ Anesthesia problems	❑ Bleeding disorder	❑ Arthritis	❑ Asthma	❑ Kidney disease
❑ High blood pressure	❑ Cancer: _____	❑ Diabetes	❑ Heart disease	❑ Tuberculosis
❑ Neurological disorder	❑ Seizures	❑ Stroke	❑ Other: _____	

Do you have any allergies? ❑ **NONE**

Are you currently taking any medications? (Please include any regularly used over-the-counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg per day, etc.)

Consume alcohol? ❑ Yes ❑ No _____ drinks per ❑ day ❑ month

Smoking Status ❑ Every Day Smoker ____ packs per day ❑ Occasional Smoker ❑ Former Smoker ❑ Never Smoked

Have you ever been in an accident? ❑ Yes ❑ No Explain _____

_____

Please list **any other doctors** you have seen for your current problems and the **tests you have had done**:

Specialist Name	Date

Test Name	Where / Date

INFORMED CONSENT FOR CHIROPRACTIC CARE

CHIROPRACTIC EXAMINATION AND TREATMENT

On occasion, some patients experience increased discomfort following chiropractic care and examination. Chiropractic physical examination and treatment may involve bending and physically challenging joints and soft tissues (e.g. muscles and ligaments) of the spine and extremities, and it can possibly lead to temporary feelings of soreness and pain. During treatment, the Doctor of Chiropractic may use their hands or mechanical devices to move, adjust, or manipulate joints and mobilize soft tissues. With certain soft tissue therapies, light to moderate bruising may also occur. This is nearly always a temporary issue that occurs while the area under care is undergoing therapeutic change. Patients reserve the right to consent to, or refuse, certain aspects of care once therapeutic options have been presented.

RISKS OF CHIROPRACTIC CARE AND TREATMENT

I understand and have been informed that there are risks and side effects and complications anytime a healthcare provider is asked to intervene in an encounter with a patient. I have been informed of the following: that although the risk of serious complications for chiropractic treatment are rare and unlikely, events ranging form soreness, sprains and strains, to fracture or dislocation, to injuries of the spinal discs, nerves and cord have occurred. Cerebrovascular accidents, such as stroke, have also been reported and that these have been estimated to occur in 1 in 2 million to 1 in 3.8-5.8 million cervical manipulations, about the same probability of stroke occurring from turning your head or having your hair washed in a salon ("beauty parlor stroke"). It cannot be said with any certainty that the specific treatment caused the stroke or aggravated an underlying, pre-existing condition, or the treatment given was totally unrelated to the resulting stroke. You are being informed of this reported associate because a stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with cervical adjustment or manipulation is extremely remote.

I understand and I do not expect the Doctor of Chiropractic to be able to anticipate all the potential risks or complications. There may be problems or complications that might arise from treatment and recommendations other than those noted. These other events or complications occur so rarely that it is not possible to anticipate and/or explain them all in advance of treatment.

I wish to rely on the Doctor of chiropractic to exercise their best professional judgment during the course of the chiropractic examination and treatment, which the doctor feels is in my best interest, based upon the facts known at the time.

I will immediately notify a member of the office staff of any unanticipated side effects or adverse rations associate with treatment. I also understand that if I become concerned about any post-treatment discomfort, or if I should develop any new or unrelated symptoms, I should call the practice for immediate attention. I also understand that if, for some reason, I am unable to reach or contact the practice, that I should telephone my personal primary care doctor or present myself to the nearest hospital emergency room.

ALTERNATIVE TREATMENTS AVAILABLE

I understand that there are reasonable alternatives to treatment including, but not limited to: rest, home application of therapy, prescription or over-the-counter medication, exercise, non-treatment, treatment and evaluation by another provider and surgery. Each is associated with their own benefits and risks. I have the right to request a referral to another provider for further evaluation, assessment, and management of my presenting conditions(s) at any time.

CONSENT By affixing my signature below, I acknowledge that I have read and understood the above consent and have had the opportunity to ask questions about its content and meaning, if so desired, which have been answered to my satisfaction,
PRIOR TO MY SIGNING OF THIS CONSENT FORM.

I, the undersigned, hereby request, consent to, and authorize Physicians HealthSource to conduct physical examinations, perform testing procedures as are required, and administer treatment as deemed necessary or advisable for my presenting complaint(s) that are within the scope of the practice of chiropractic care. I attest that the information provided in regards to my, or my dependents, current and past health history has been completed to the fullest extent and to the best of my knowledge and ability, and does not contain false or misleading information, nor omission. I also certify that no guarantee or assurance has been made to me as to the results that my be obtained from any treatment rendered.

I intended this consent form to cover the entire course for treatment for my present condition and for any future conditions for which I seek examination and treatment for myself or my dependent.

_____

Signature (Patient, Parent, or Legal Guardian)

_____

Print Name (Patient, Parent, or Legal Guardian)

PRIVACY PROTECTION AND AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: plan, coordinate, and direct my treatment and follow-up among the healthcare providers who may be directly and indirectly involved in providing my treatment, obtain payment from third party payers, and conduct normal healthcare operations such as quality assessments and accreditation. This includes release of information and notification of care to my primary health care and/or referring provider.

I hereby authorize Physicians HealthSource to release a complete report of services rendered including diagnosis, findings, and details of treatment, and progress for the purpose of receiving payment for the services rendered to it's authorized billing agents, my insurance carriers, employer's workers compensation insurance company, or other category of their party payers, the Social Security Administration under Title XVIII of the Social Security Act, any Professional Review Organization, attorney, or their intermediaries responsible for payment of my charges and hereby release Physicians HealthSource from any consequences thereof. I understand that I may revoke this consent at any time by giving written notice.

Please list below the names of and your relationship to individuals whom you authorize Physicians HealthSource to release your protected health information.

Name and Relationship

_____

_____

_____

ACKNOWLEDGEMENT OF RECEIPT OF THE NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided a copy of the Notice of Privacy Practices and that I have read or declined the opportunity to read and understand the Notice of Privacy Practices. I understand that these privacy practices will be followed by Physicians HealthSource to ensure the privacy of my protected health information. I understand that this acknowledgment will be placed in my electronic file and maintained for six years. A copy of this notice is available at any time upon request.

AUTHORIZATION TO AQUIRE HEALTHCARE INFORMATION

I hereby authorize Physicians HealthSource to obtain details regarding my current and/or prior health care status from my primary care provider, referring provider, and/or other providers to facilitate appropriate care. All health records, diagnostic imaging results, diagnostic testing results, surgical information, and any data that is held regarding my medical and health management are applicable for release. I understand that I may revoke this consent at any time, except for the extent that action already been taken, with written notice.

ASSIGNMENT OF INSURANCE BENEFITS AND FINANCIAL POLICY

In consideration of all services provided, I hereby assign and transfer to Physicians HealthSource all of my rights, title, and interest to healthcare reimbursement in accordance with the terms and benefits otherwise payable to me for those services rendered, including Medicare Part B. I certify that the health insurance information that I have provided is accurate and that I am responsible for keeping it updated.

I understand that I will be fully responsible for payment for any and all charges not paid by health insurance. I understand that the balance of my account is due in full within 90 days of notice, unless a payment plan arrangement has been made in advance. In the event that a bill is disputed, notification must be made with in 90 days. If I do not notify Physicians HealthSource within that time, the bill will be resumed valid and due. All balances remaining unpaid after 90 days will be reported to a collection agency, and I will be responsible for all collection expenses including reasonable attorney's fees and court costs.

I hereby authorize Physicians HealthSource to submit claims, on my or my dependent's behalf, to the benefit plan (or its administrator) listed on the current insurance card I have provided, in good faith. I also hereby instruct my benefit plan (or its administrator) to pay Physicians HealthSource directly for services rendered to me or my dependent.

I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services from Physicians HealthSource are paid in full. I also understand that I am responsible for all amounts not paid by my health insurance, including co-payments, co-insurances, and deductibles.

Physicians HealthSource accepts cash, personal check, Visa, Discover, and MasterCard. I understand that I will have to pay a $30.00 fee for each check that is returned to Physicians HealthSource for non-sufficient funds.

Prior balances considered delinquent must be paid prior to being seen for any further scheduled visits. Charges added to your account will be due in full as stated on the invoice.

NOTICE OF OFFICE PROCEDURES AND COMMUNICATIONS

Many areas of our office are an open concept. While we do our best to discuss information regarding your treatment and/or accounts privately, at times other patients may be able to overhear. We ask that if you would like to discuss something more privately that you let us know.

Communications from our office include, but are not limited to, patient bills, letters, thank you cards, and claims sent to insurance companies are all sent out in envelopes with our office name on them.

It is the policy of Physicians HealthSource to not leave messages via voice-mail, e-mail, or with another party regarding your care, testing results, specific follow up instructions, or other situations involving your personal health or care provided in this office or elsewhere. When needed, communications will be limited in scope and nature with as little identifying or specific information as possible, often requesting a return phone call to discuss pertinent information. However, with your consent, detailed information can be left via the following methods:

❑ I hereby authorize that Physicians HealthSource can leave messages regarding my healthcare.
Please check all that apply.

❑ Cell ❑ Home ❑ Work ❑ Email

❑ I hereby authorize that Physicians HealthSource can leave detailed messages regarding my healthcare via another person:

To whom can we leave messages with?
Please list the person (or persons) name, relationship to you and their phone number:

_____

_____

_____

_____

I, the undersigned, hereby certify that I have read, fully understand, and agree to be bound by these policies, assignment, and authorization pertaining to myself or my dependent. I have asked or have declined the opportunity to ask any pertinent questions regarding this information before applying my signature. A photocopy of this document shall be considered as effective as the original. I intend this certification to cover the entire course of treatment for my present condition and for any future conditions for which I seek examination and treatment for myself or my dependent.

_____
Signature (Patient or Responsible Party)

_____
Print Name (Patient or Responsible Party)

_____
Date

CONSENT TO TREAT A MINOR WITHOUT PARENT OR GUARDIAN PRESENT

I do hereby authorize and give my consent to Physicians HealthSource to provide evaluation and treatment as needed and necessary to my minor child in my absence following initial consultation.

❑ Yes ❑ No

My child will be accompanied by (check all that apply):

❑ Himself or Herself

❑ Other: _____

❑ Other: _____

_____
Signature (Parent or Responsible Party)

EXTENDED FINANCIAL POLICY

Please read our financial policy in its entirety. If you have any questions or concerns please feel free to ask any questions that you may have. Your clear understanding of our Patient Financial Policy is important to our professional relationship.

INSURANCE It is the patient's responsibility to provide our office with current insurance information. We will ask for your insurance card at your first visit and will copy it for our records. We will request a copy annual in office visit, or if you have not been seen in the past six months. If your insurance information changes at any time during your treatment, it is your responsibility to provide us with the new information as soon as it becomes active. If current information is not obtained at the time of service it will be the patient's responsibility to pay the entire balance until current information is provided to our office. It is the patients responsibility to know their benefits and coverage.

Your insurance policy is a contract between you and the insurance company. As a courtesy and pursuant to contractual obligations we will file all your claims for you. However, we will not become involved in any disputes between you and your insurance carrier. This includes, but is not limited to, deductibles, co-pays, and non-covered charges.

REFERRALS Some insurance companies require you as the policy holder to obtain a referral from your primary care physician, or student health center prior to receiving treatment at our office. It is your responsibility to obtain this documentation and present it to our office at the time of service. If this information is not obtained, you will be responsible for the entire balance of your account.

CO-PAYS Co-pays are due at the time of service.

CASH PLANS Cash plans are available to patients who do not have insurance or wish not to bill to insurance. These plans differ and can be discussed with your doctor. Cash plan payments are due at the time of service.

SUPPLEMENTS/MERCHANDISE Payments for supplements and merchandise purchased in our office are due at the point of sale. We cannot bill insurance, worker's compensation, or personal injury accounts for these items. These charges are the patient's responsibility and are not covered by any insurance carrier. These items include but are not limited to, swiss balls, DVDs, supplements, water pillows, back packs, braces, heel lifts, orthotics, and cold packs.

UNPAID/OUTSTANDING BALANCES We ask that full payment be made at the time of service unless prior arrangements have been made, either with your doctor or our billing office. If you have a deductible plan, once insurance has paid you will be mailed a statement: Prompt and timely payment is appreciated. You may call our billing office to set up a payment plan if necessary. Any overdue balances will be sent to collections.

RETURNED CHECKS The charge for a returned check is $30. This will be applied to your account in addition to the original amount owed.

MISSED APPOINTMENTS We ask that you keep all scheduled appointments. In the event that you are unable to keep your appointment we ask that you provide at least a 12 hour notice.

I have read Physicians HealthSource's Patient Financial Policy and acknowledge my responsibility with my signature below.

_____

Signature (Patient, Parent, or Legal Guardian)

_____

Print Name (Patient, Parent, or Legal Guardian)

_____

PHS Staff Witness

_____

Date