Spine & Sports Therapy - New Patient History

Name _____ Sex: M / F Today's Date_____

Address _____ City _____State _____ Zip _____

Phone: Home _____ Work _____ Cell _____ Email _____

Date of Birth_____ Age_____ Marital Status: S / M / W / D Spouse's Name _____

Referred by _____

1. **COORDINATION OF CARE / EMERGENCY CONTACT:**

Family Medical Doctor _____ Phone # _____

Emergency Contact _____ Phone # _____ Relation _____

2. **REASONS FOR VISIT:**

Primary Complaint: _____

Secondary Complaint: _____

Have you ever received Chiropractic Care? Yes / No

If yes, ***when***? _____

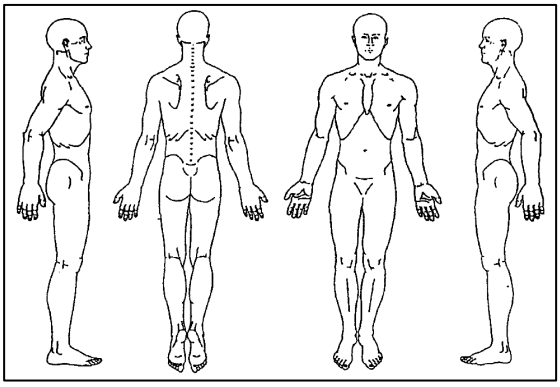
Do you have any concerns about Chiropractic Care? Yes / No

If yes, ***please let us know***? _____

_____

_____

DRAW YOUR PAIN:



3. **PAST HEALTH HISTORY:**

A. List any previous injuries (muscle pulls, ankle sprains, dislocations, slip/falls, etc.):

_____

A. Have you ever been in any Automobile Accidents? When? _____

B. **Have you ever broken any bones? Which?** _____

C. **Current Medications:** _____

D. **Past Surgeries & Dates:** _____

4. **FAMILY HEALTH HISTORY:**

Do you have any relatives who have the same condition or symptoms? Yes / No If yes, what is their relation to you?

_____

5. **SOCIAL AND OCCUPATIONAL HISTORY:**

A. **Profession:** _____

B. **Recreational activities:** _____

C. **Hobbies:** _____

_____

_____

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Rescheduling, Missed Appointment & Cancellation Policy (Patient's Initials _____)

We want to thank you for choosing us as your repetitive, overuse sports injury specialists. In order to provide you and our other patients with the upmost care, we request that you respect our policy regarding rescheduling, missed appointments and/or cancelled appointments. Please remember that we reserve dedicated appointment times for you and your care. Therefore, we request at least 24 hours notice in order to reschedule or cancel your appointments. The 24 hour advanced notice will enable us to offer your appointment slot to another patient. When you reschedule, cancel or miss your appointment at the last minute, everyone loses – you, our doctor/therapist and others who would have liked to have had your slot.

Our clinic reserves the right to charge a fee of $95.00 for rescheduled, missed and cancelled appointments, with less than 24 hours notice. Our clinic requires that an active Credit Card be on file for every patient and your signature approval to charge for rescheduled, missed and cancelled appointments, with less than 24 hours notice. If you are uncomfortable with using a credit card, you can write us a check for $95.00 as an appointment deposit. We will not use your credit card or deposit for payment of services for any other purpose than stated in this policy, without your approval. Thank you for understanding, approving and respecting our policies as well as for your trust in our care.

Please fill in the blanks completely prior to your initial exam.

Credit Card Number: _____ **CSV:** _____ **Expiration Date:** _____

Signature Approval: _____ **Date:** _____

HIPAA Notice (Patient's Initials _____)

It is important to know how your Health Information is going to be used in our clinic as well as your rights concerning your patient records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the **HIPAA NOTICE** that is available to you at the front desk before signing this consent. **No one will receive your medical records without your knowledge and consent.** We do recognize email as medium for digital consent and signature.

Patient/Office Agreement: I, the patient, understand and agree to allow this clinic to use my Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. I also understand that in accordance with clinic operations that my appointment confirmation notice, appointment reminder notice, payment receipts, clinic notices and patient correspondence will primarily occur via email.

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Informed Consent (Patient's Initials _____)

Even though only a portion of our sports injury care is chiropractic, we still are trained and licensed as Doctors of Chiropractic by background. The majority of concern and questions arise from the chiropractic manipulation component of our care, such as: ***What is the risk of injury or complications from manipulation?*** Please read the explanation below:

Nature of Manipulation (the Chiropractic Adjustment):

In Chiropractic (chi·ro: hands / prac·tic: the practice of) we use our hands or occasionally a mechanical instrument to gently mobilize or manipulate joints that are not moving as well as they should. Manipulation is often, but not always, accompanied by an audible "pop", precisely the same experience you have experienced in the past if you have ever "cracked" your knuckles. It is important that you know we are NOT "Cracking Bones", Moving Something from Out of Place Into Place or Moving Something from In Place to Out of Place. The sound you hear is simply a release of the suction, much like pulling suction cups apart, that is created between joint surfaces as a result of compression and muscle tension. This joint suction is not natural and the need for frequent manipulation dissipates as we fix muscle patterns that are imbalanced. ***Research and our clinical experience verifies that manipulation/mobilization immediately improves joint motion/flexibility, reduces pain and increases muscle strength.***

Risks Associated with Manipulation:

There are risks associated with any medical treatment or medication, the treatment modality of manipulation is not without its risks. Even though these risks are minimal, we feel we have a duty to inform you of the risks and answer any questions or concerns you might have prior to administering treatment. We hope that this information will allow you to have more confidence in us and trust our expertise and judgment when it comes to delivering the best care possible for your condition. We also hope, by informing you, that you will be more relaxed when receiving care, rather than wondering what the possibility of risk might be with receiving chiropractic care.

The risk of chiropractic care is so rare that Chiropractors (DC) pay 1/10 of the premiums a General Practitioner (MD) pays for the same level of malpractice coverage (1 Million / 3 Million) from the same insurance company (low premiums = low risk). The lists of possible risks associated with manipulation are extensive but rare: (see "Probability of Risk" for odds). The risks and complications associated with joint manipulation can include but are not limited to: fractures, disc injuries, dislocations, muscle strain, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy, costovertebral/costocartilage strains and separations. Some manipulation techniques have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Also, following the first few chiropractic treatments, it is not uncommon for a patient to feel some stiffness and/or soreness as we get joints and muscles released (soreness feels analogous to the soreness from a good solid workout).

Probability of Risk with Manipulation (The Fine Print)

Fractures are rare occurrences and generally result from some underlying weakness of the bone, which we will check for during the taking of your history and during examination and X-ray. Chiropractic manipulations causing strokes have been the subject of tremendous controversy within and without the profession with one prominent authority saying that there is at most a One-In-One Million to One-in-Ten Million chance of such a complication occurring, which could be compared to the risk of being struck by lightening or dying from taking an Advil. Since even minimal risks should be avoided if possible, please let us know if you smoke, have elevated blood cholesterol, lipid disorders or Coronary Artery Disease –CAD, experience fainting or dizziness, or experience bouts of blurred vision or lightheadedness. These signs and symptoms may leave you at risk if undisclosed to us prior to manipulation of the cervical spine. The other complications associated with manipulation, listed in the previous paragraph, are also generally described as "rare" based on our research.

Additional Treatment Modalities We Use (The Fun Stuff!):

In conjunction with chiropractic and osteopathic manipulation, we will use some or all of the following treatment modalities in order to help you achieve faster, more long lasting results (decreased pain and improved flexibility and strength) than experienced in most standard chiropractic offices: ***Myofascial Release Therapy, Trigger Point Release, Positional Release Therapy (Strain/Counter Strain), Transverse Friction Massage, Active Release, Percussive Therapy, Post-Isometric Stretching, Eccentric Stretching, Craniosacral Therapy, Acupressure/Acupuncture, Cryotherapy, Heat Therapy, Laser Therapy, Micro current and Kineseotaping***. These treatments modalities may involve the following risks, which are minimal in nature: Post-treatment soreness, stiffness or occasional bruising due to deep tissue massaging.

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Financial Responsibility, Authorization & Release (Almost Finished…) (Patient's Initials _____)

I acknowledge that I am financially responsible for all charges, whether or not I receive reimbursement from any insurance company. I hereby authorize 3DS Group, P.A. (DBA - Spine & Sports Therapy) to release any and all information necessary to help me secure reimbursement from my insurance company and accept the responsibility for any fees associated with providing such information. Spine & Sports Therapy will make available any and all patient records, directly to the patient, for their use in securing insurance reimbursement. ***Spine & Sports Therapy will NOT provide patient records to insurance companies or other third parties.***

I understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. I understand that interest is charged on overdue accounts at the annual rate of 18%.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

I have read or have had read to me the above explanation of the above policies and informed consents. I have had all of my questions or concerns answered to my satisfaction. By signing below, I state that I have weighed the possible risks involved with undergoing care with the above modalities and have myself decided that it is in my best interest to proceed with an examination. I understand that care will not be provided without a report of findings, financial consultation and a signature acceptance of a treatment plan. Having been informed of the risks, I hereby give my consent to proceed with the examination and report of findings.

DATE _____

_____
Printed Name

_____
Signature

_____
Signature of Parent/Guardian
(only if you are a minor)

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