ADVANCED HEALTHCARE

Patient Information

Appointment Date: _____

Last Name:_____ First Name:_____ Middle Name:_____

Mailing Address: _____

City:_____State:_____Zip:_____

Phone: (H) _____ (M) _____(W) _____

EmailAddress:_____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated SS#:_____

Date of Birth: _____ Gender at Birth: ❑ M ❑ F Preferred Pronouns:_____

Occupation: _____ Employer: _____

How did you hear about our practice? _____

Emergency Contact:_____ Relation: _____
Phone #: (H) _____ (Cell) _____ (W) _____

Accident Information

Is this visit due to an accident? ❑ Yes ❑ No If yes, what type? ❑ Auto ❑ Work ❑ Other: _____
Has it been reported? ❑ Yes ❑ No If yes, to whom? _____

Insurance Information

Do you have health insurance? ❑ Yes ❑ No Name of Carrier: _____
Do you have secondary insurance? ❑ Yes ❑ No Name of Carrier: _____
Policy Holder Name: _____ DOB: _____
Relationship to patient (if other than self): _____ Phone #:_____

PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR INSURANCE CARD(S)

Assignment and Release (insured patients)

I certify that I (or my dependent) have insurance coverage and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PHYSICIAN/MEDICAL PRACTICE, INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary, including diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of the signature on all insurance claims, including electronic submissions.

SIGNATURE _____ **DATE:** _____

INFORMED CONSENT TO CARE

A patient coming to the doctor gives him/her permission and authority to care for them in accordance with appropriate test, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the physician. This office does not perform breast, pelvic, prostate, rectal, or full skin evaluations. These examinations should be performed by your family physician, GYN, and dermatologist to exclude cancers, abnormal skin lesions that should undergo biopsy/removal or other treatments. 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 also 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, medicines, or allergies.

I agree to settle any claim or dispute I may have against or with any of these persons or entities, whether related to the prescribed care or otherwise, will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

I have read and understand the above consent form.

Signature: X_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have reviewed the Notice of Privacy Practices of Advanced Healthcare PLLC.
(Please initial one of the following options and sign below.)

_____I wish to receive a paper copy of Privacy Notice.

_____ I do not request a copy of the Privacy Notice at this time. I acknowledge that I can request a copy at any time. If I should have a question in regard to my rights, I may speak with the Privacy Officer about my concerns.

I acknowledge that it is the policy of this office to leave reminder messages on my answering machine or with another person in my home. I may make a request of an alternative means of communication (within reason) in writing.

_____ _____
Signature of Patient *(Or Guardian / relationship to patient)* Date

_____ _____
Witness (Office Staff) Date

Name: _____ DOB: _____ Date: _____

Health History

Medical History:

- ❑ Arthritis
- ❑ Herniated Disc
- ❑ Migraines
- ❑ Osteoporosis
- ❑ Pinched nerve
- ❑ Ulcers
- ❑ Bleeding Disorders
- ❑ Heart Disease
- ❑ High Cholesterol
- ❑ Hypertension
- ❑ Pacemaker
- ❑ Stroke
- ❑ Cancer
- ❑ Diabetes
- ❑ Fibromyalgia
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Rheumatoid Arthritis
- ❑ Thyroid Issues

Please Describe (if applicable): _____

Are you currently under drug and/or medical care? ❑ Yes ❑ No Who is your primary care doctor? _____

Please all medications: (*Be sure to include dosage and frequency*) _____

Supplements (*vitamins/herbs/minerals*): _____

Allergies: _____

Surgeries and/or hospitalizations (*type & date*): _____

Approximate Date of last Flu vaccine: _____

WOMEN ONLY Date of LMP: _____ ***Any possibility of pregnancy***? ❑ Yes ❑ No

Is there a family history of any of the following conditions? (Indicate family members including parents, grandparents & siblings):

- ❑ Heart Disease _____
- ❑ Diabetes _____
- ❑ Other _____
- ❑ Cancer _____
- ❑ Arthritis _____

Intake of following: Cigarettes _____ packs/day Alcohol_____ drinks/week Caffeine _____ cups/day

Exercise frequency: ❑Never ❑Daily ❑ Weekly_____ ❑Walks ❑Runs ❑Swims_____

Occupation: _____ Does work mostly involve: ❑ Sitting ❑ Standing ❑ Light Labor ❑ Heavy Labor

Notes:

Name: _____ DOB: _____ Date: _____

Review of Systems: Please check all that apply

Neurological
- ❑ Migraines
- ❑ Headaches
- ❑ Slurring of Speech
- ❑ Ringing in Ear(s)
- ❑ Pins & Needles- Arms
- ❑ Pins & Needles- Legs
- ❑ Cold Hands/Feet
- ❑ Dizziness

Ear/Nose/Throat
- ❑ Altered taste/smell
- ❑ Night Blindness
- ❑ Sore Throat
- ❑ Gingivitis
- ❑ Nose Bleeds
- ❑ Loss of Smell
- ❑ Loss of Taste
- ❑ Blurred Vision

Cardiovascular
- ❑ Chest Pain
- ❑ Heart Palpitations
- ❑ Swelling in hands/feet
- ❑ Anemia

Respiratory
- ❑ Recurrent Resp Infections
- ❑ Allergies
- ❑ Asthma
- ❑ Chest Congestion
- ❑ Wheezing
- ❑ Frequent Sneezing
- ❑ Shortness of Breath

GI
- ❑ Stomach Pains/Cramping
- ❑ Constipation
- ❑ Reflux /Heartburn
- ❑ Bloating
- ❑ Gas
- ❑ Nausea/Vomiting

Musculoskeletal
- ❑ Joint Pain
- ❑ Arthritis
- ❑ Chronic Pain
- ❑ Muscle Aches
- ❑ Jaw Problems
- ❑ Tension

Skin/Hair/Nails
- ❑ Eczema
- ❑ Dermatitis
- ❑ Excessive Sweating
- ❑ Rashes
- ❑ Brittle Nails
- ❑ Hair Loss
- ❑ Easy Bruising
- ❑ Increased Bleeding
- ❑ Numbness/Tingling

Emotional/Mental
- ❑ Depression
- ❑ Anxiety
- ❑ Nervousness
- ❑ Mood Swings
- ❑ Irritability
- ❑ Memory Loss
- ❑ Confusion

Energy
- ❑ Fatigue
- ❑ Hyperactivity
- ❑ Restlessness
- ❑ Insomnia
- ❑ Decreased Libido
- ❑ Stress

Weight
- ❑ Decreased Appetite
- ❑ Weight Gain
- ❑ Inability to Lose Weight
- ❑ Food Cravings
- ❑ Binge Eating
- ❑ Water Retention
- ❑ Sudden Weight Loss

Genitourinary
- ❑ Uterine Fibroids
- ❑ Ovarian Cysts
- ❑ Cancer
- ❑ Prostate Problems

Other Symptoms Not Listed: _____

ADVANCED HEALTHCARE

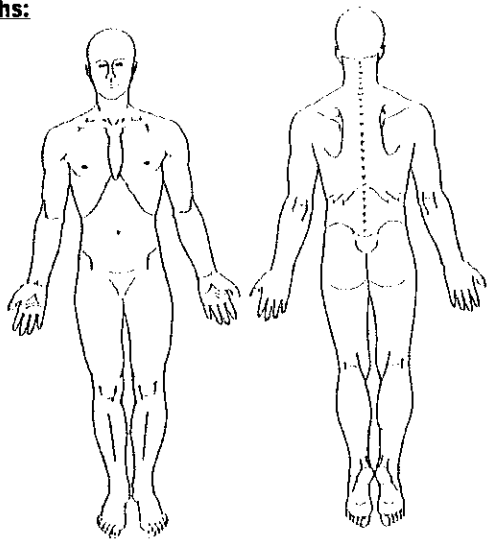
Health Questionnaire
Rev 05.26

Name: _____ DOB: _____ Age: _____ Date: _____

Occupation: _____ # Hours/Week Currently Working: _____

Check off any of the following symptoms you have experienced in the past 6 months:

☐Neck Pain
☐Headaches
☐Tension across top of shoulders
☐Numbness/Tingling in arms/hands
☐Carpal Tunnel
☐Pain between shoulder blades
☐Difficulty sleeping
☐Allergies
☐Low Back Pain
☐Numbness/Tingling in legs/feet
☐Pain in legs
☐Pain in feet
☐Fibromyalgia
☐Tired/Fatigued
☐Digestive problems
Other _____



(Circle areas of symptoms/pain/discomfort)

Which of the above is the worst/most concerning symptom?

_____

How long have you had it? _____

How frequently do you experience it:

☐Constant (100%-75%) ☐Frequent (75%-50%)
☐Intermittent (50%-25%) ☐Occasional (25%-1%)
Times per Week _____ Times per Month _____

What does it feel like? (Circle all that apply)

Sharp, Dull, Achy, Burning, Numb/Tingling, Shooting, Tightness, Throbbing
Other: _____

Discomfort increases with: (Circle all that apply)

Movement, Applied pressure, Prolonged sitting, Coughing/Sneezing
Other: _____

What have you tried that has helped this problem? (Circle all that apply)

Ice, Heat, Rest, Over the counter meds, Stretching, Chiropractic, PT
Other: _____

▶Medication helped:	Little	Some	Much
▶Exercise helped:	Little	Some	Much
▶Physical Therapy helped:	Little	Some	Much
▶Nutrition helped:	Little	Some	Much
▶Chiropractic helped:	Little	Some	Much
▶Stretching helped:	Little	Some	Much

Does this cause you to be?

☐Moody
☐Irritable
☐Interrupt sleep
☐Restricted in your daily activities

Does this affect your work?

☐Decision making
☐Poor attitude
☐Decreased productivity
☐Exhausted at the end of the day
☐Unable to work long hours

Does this affect your life?

☐Lose patience with spouse/children
☐Restricted household duties
☐Hinders ability to exercise/sports
☐Interferes with hobbies/activities

What activities do the above issues limit you from performing to the best of your ability?

_____

Signature: _____ Date: _____

ADVANCED HEALTHCARE

Rev 05.26

Office & Financial Policies

OFFICE POLICIES AGREEMENT

Please initial ALL sections:

_____ **PAYMENT:** Payment for all services are due in full at the time services are rendered. If your account should go to collections for any reason, it will be the patient's responsibility for any court costs, attorney's fees, and or collection costs incurred in collecting the account balance.

_____ **TEAM APPROACH:** Our staff consists of doctors with a variety of specialties, so if necessary, multiple doctors may Be working on your individual case. All doctors in our office hold an active license. You could be treated by any or all of them.

_____ **NO CELL PHONES:** To create a healthier, healing environment, we ask that you not use cell phones at anytime while in the office. If you need to make/take a call, please step outside.

_____ **PATIENT MISSED APPOINTMENT POLICY:**

- It is our wish that every one of our patients receive the very best care and service possible. Your treatment plan consists of a specific series of treatment given over a pre-planned time span. If you do not follow this plan, then you will not receive the desired, best results.
- If we did not insist that you meet all your appointments, we would be doing you a disservice. We care about you and the success of your program here. Therefore, we have a few simple rules that we insist you follow.
- We recommend all patients set up either a text or email reminder (see form below).
- If you become ill, we still want you to come in, because treatments and spinal manipulations will help you recover.
- If you are unable to make it due to an emergency, please call us and let us know so we can reschedule your appointment.
- Apart from unexpected emergencies, we require that you notify us at least 24 hours in advance as to any appointment changes.
- All cancelled or missed appointments must be rescheduled and made up within one week to stay on track with your care plan.
- There is a $35.00 charge for no call/no show massages. You will be considered a "no show" if you do not call the office and reschedule at least 30 minutes prior to closing the night before your scheduled massage. The missed appointment charge will be auto debited from your credit card/bank account on file. If you have purchased a group-on massage and are a no call/no show as described above you will forfeit the massage.

I have read, understand, and agree to follow the above policy.

Patient Name: _____ **Signature:** _____ **Date:**_____

Staff Name: _____ **Signature:** _____ **Date:**_____

Appointment Reminders by Text Message and Email:

❑ TEXT MESSAGE: Cell Phone Number:_____

❑ EMAIL: E-mail address: _____

ADVANCED HEALTHCARE

Rev 05.26

Office & Financial Policies

FINANCIAL POLICIES AGREEMENT

_____ **PAYMENT:** Payment for services are due in full at the time services are rendered. If your account should go to collections for any reason, it will be the patient's responsibility for any court costs, attorney's fees, and or collection costs incurred in collecting the account balance.

_____ **PATIENT COOPERATION and NO GUARANTEE OF RESULTS:** It is illegal and highly unethical for any doctor to guarantee results for any health care condition. However, we can speak of our experience and the success rate our office has had. We assure you that we as an office will do everything in our power to ensure you have a favorable outcome. In order to get the best results, please follow the visit frequency laid out in your care plan along with all healthcare provider recommendations. Patients recognize this agreement is not a guarantee of results and deals solely with the services to be rendered and the fees to be paid for the care as provided. The patient's payment obligation is not contingent upon the outcome of care.

_____ **SUBSEQUENT INJURIES:** The care the patient is to receive under this care plan has been determined based upon the patient's present condition. If a new injury or condition arises during treatment provided for in this care plan, the current care will be suspended until such time as the subsequent problem has resolved, or maximum medical improvement has been obtained. Notify the office immediately if you have any type of accident whether work, auto, or home related.

_____ **POSSIBLE ADDITIONAL CHARGES:** Additional items needed to support the patient's care such as orthopedic support, orthotics, cervical pillow, additional diagnostic testing, exercise materials, laboratory tests, x-rays and/or analysis, nutritional support and other similar things will be separately charged for and payment for said care shall be due at the time received by the patient. Only items clearly stated in the patient's Doctor Ordered Treatment Plan will be covered under the agreement.

_____ **NON-REFUNDABLE ITEMS**: All Durable Medical Equipment and nutritional supplements are non-returnable and non-refundable once they leave the office whether they have been opened or not.

_____ **MISSED APPOINTMENT FEE**: There is a $35.00 charge for no call/no show massages. You will be considered a "no show" if you do not call the office and reschedule at least 30 minutes prior to closing the night before your scheduled massage. The missed appointment charge will be auto debited from your credit card/bank account on file. If you have purchased a group-on massage and are a no call/no show as described above you will forfeit the massage.

I acknowledge that I have read & understood all the financial policies & agree to abide by all the terms above.

Patient Name: _____ **Signature:** _____ **Date:** _____

Neck Disability Index

This questionnaire has been designed to give us information as to how your neck pain has affected your ability to manage in everyday life. Please answer every section and **mark in each section only the one box that applies to you**. We realize you may consider that two or more statements in any one section relate to you, but please just mark the box that most closely describes your problem.

Section 1: Pain Intensity

- ❑ I have no pain at the moment
- ❑ The pain is very mild at the moment
- ❑ The pain is moderate at the moment
- ❑ The pain is fairly severe at the moment
- ❑ The pain is very severe at the moment
- ❑ The pain is the worst imaginable at the moment

Section 2: Personal Care (Washing, Dressing, etc.)

- ❑ I can look after myself normally without causing extra pain
- ❑ I can look after myself normally, but it causes extra pain
- ❑ It is painful to look after myself and I am slow and careful
- ❑ I need some help but can manage most of my personal care
- ❑ I need help every day in most aspects of self care
- ❑ I do not get dressed, I wash with difficulty and stay in bed

Section 3: Lifting

- ❑ I can lift heavy weights without extra pain
- ❑ I can lift heavy weights, but it gives extra pain
- ❑ Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently placed, for example on a table
- ❑ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
- ❑ I can only lift very light weights
- ❑ I cannot lift or carry anything

Section 4: Reading

- ❑ I can read as much as I want to with no pain in my neck
- ❑ I can read as much as I want to with slight pain in my neck
- ❑ I can read as much as I want with moderate pain in my neck
- ❑ I can't read as much as I want because of moderate pain in my neck
- ❑ I can hardly read at all because of severe pain in my neck
- ❑ I cannot read at all

Section 5: Headaches

- ❑ I have no headaches at all
- ❑ I have slight headaches, which come infrequently
- ❑ I have moderate headaches, which come infrequently
- ❑ I have moderate headaches, which come frequently
- ❑ I have severe headaches, which come frequently
- ❑ I have headaches almost all the time

Section 6: Concentration

- ❑ I can concentrate fully when I want to with no difficulty
- ❑ I can concentrate fully when I want to with slight difficulty
- ❑ I have a fair degree of difficulty in concentrating when I want to
- ❑ I have a lot of difficulty in concentrating when I want to
- ❑ I have a great deal of difficulty in concentrating when I want to
- ❑ I cannot concentrate at all

Section 7: Work

- ❑ I can do as much work as I want to
- ❑ I can only do my usual work, but no more
- ❑ I can do most of my usual work, but no more
- ❑ I cannot do my usual work
- ❑ I can hardly do any work at all
- ❑ I can't do any work at all

Section 8: Driving

- ❑ I can drive my car without any neck pain
- ❑ I can drive my car as long as I want with slight pain in my neck
- ❑ I can drive my car as long as I want with moderate pain in my neck
- ❑ I can't drive my car as long as I want because of moderate pain in my neck
- ❑ I can hardly drive at all because of severe pain in my neck
- ❑ I can't drive my car at all

Section 9: Sleeping

- ❑ I have no trouble sleeping
- ❑ My sleep is slightly disturbed (less than 1 hr sleepless)
- ❑ My sleep is mildly disturbed (1-2 hrs sleepless)
- ❑ My sleep is moderately disturbed (2-3 hrs sleepless)
- ❑ My sleep is greatly disturbed (3-5 hrs sleepless)
- ❑ My sleep is completely disturbed (5-7 hrs sleepless)

Section 10: Recreation

- ❑ I am able to engage in all my recreation activities with no neck pain at all
- ❑ I am able to engage in all my recreation activities, with some pain in my neck
- ❑ I am able to engage in most, but not all of my usual recreation activities because of pain in my neck
- ❑ I am able to engage in a few of my usual recreation activities because of pain in my neck
- ❑ I can hardly do any recreation activities because of pain in my neck
- ❑ I can't do any recreation activities at all

Score: ____ /50

Transform to percentage score x 100 = _____% points

Name:_____ Date:_____

Oswestry Low Back Pain Disability Index

This questionnaire has been designed to give us information as to how your back or leg pain is affecting your ability to manage in everyday life. Please answer by **checking ONE box in each section for the statement** which best applies to you. We realize you may consider that two or more statements in any one section apply but please just shade out the spot that indicates the statement which most clearly describes your problem.

Section 1 – Pain intensity

- ❑ I have no pain at the moment
- ❑ The pain is very mild at the moment
- ❑ The pain is moderate at the moment
- ❑ The pain is fairly severe at the moment
- ❑ The pain is very severe at the moment
- ❑ The pain is the worst imaginable at the moment

Section 2 – Personal care (washing, dressing etc)

- ❑ I can look after myself normally without causing extra pain
- ❑ I can look after myself normally but it causes extra pain
- ❑ It is painful to look after myself and I am slow and careful
- ❑ I need some help but manage most of my personal care
- ❑ I need help every day in most aspects of self-care
- ❑ I do not get dressed, I wash with difficulty and stay in bed

Section 3 – Lifting

- ❑ I can lift heavy weights without extra pain
- ❑ I can lift heavy weights but it gives extra pain
- ❑ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently placed eg. on a table
- ❑ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
- ❑ I can lift very light weights
- ❑ I cannot lift or carry anything at all

Section 4 – Walking

- ❑ Pain does not prevent me walking any distance
- ❑ Pain prevents me from walking more than 1 mile
- ❑ Pain prevents me from walking more than ½ mile
- ❑ Pain prevents me from walking more than 100 yards
- ❑ I can only walk using a stick or crutches
- ❑ I am in bed most of the time

Section 5 – Sitting

- ❑ I can sit in any chair as long as I like
- ❑ I can only sit in my favorite chair as long as I like
- ❑ Pain prevents me sitting more than one hour
- ❑ Pain prevents me from sitting more than 30 minutes
- ❑ Pain prevents me from sitting more than 10 minutes
- ❑ Pain prevents me from sitting at all

Section 6 – Standing

- ❑ I can stand as long as I want without extra pain
- ❑ I can stand as long as I want but it gives me extra pain
- ❑ Pain prevents me from standing for more than 1 hour
- ❑ Pain prevents me from standing for more than 30 minutes
- ❑ Pain prevents me from standing for more than 10 minutes
- ❑ Pain prevents me from standing at all

Section 7 – Sleeping

- ❑ My sleep is never disturbed by pain
- ❑ My sleep is occasionally disturbed by pain
- ❑ Because of pain I have less than 6 hours sleep
- ❑ Because of pain I have less than 4 hours sleep
- ❑ Because of pain I have less than 2 hours sleep
- ❑ Pain prevents me from sleeping at all

Section 8 – Sex life (if applicable)

- ❑ My sex life is normal and causes no extra pain
- ❑ My sex life is normal but causes some extra pain
- ❑ My sex life is nearly normal but is very painful
- ❑ My sex life is severely restricted by pain
- ❑ My sex life is nearly absent because of pain
- ❑ Pain prevents any sex life at all

Section 9 – Social life

- ❑ My social life is normal and gives me no extra pain
- ❑ My social life is normal but increases the degree of pain
- ❑ Pain has no significant effect on my social life apart from limiting my more energetic interests eg, sport
- ❑ Pain has restricted my social life and I do not go out as often
- ❑ Pain has restricted my social life to my home
- ❑ I have no social life because of pain

Section 10 – Traveling

- ❑ I can travel anywhere without pain
- ❑ I can travel anywhere but it gives me extra pain
- ❑ Pain is bad but I manage journeys over two hours
- ❑ Pain restricts me to journeys of less than one hour
- ❑ Pain restricts me to short necessary journeys under 30 minutes
- ❑ Pain prevents me from travelling except to receive treatment

Score: ____ /50

Transform to percentage score x 100 = _____% points

Name:_____ Date:_____