**New Patient Information**

**Please Print all Answers**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Name |  | Age |  | Sex |  | Date |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Address |  | City |  | Zip |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Phone |  | | Work |  | Cell |  |
| Best time to Call | |  | Which # |  | E-mail |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Social Security # |  | Birthdate |  | Family Doctor |  |

|  |  |  |
| --- | --- | --- |
| Married Single Sep Divorced Widowed | Spouse’s Name |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Employer |  | Spouse's Employer |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Employer Address |  | Spouse’s Birthdate |  | | |
| Employer Phone |  | Spouse’s Social Security # | |  |  |

|  |  |
| --- | --- |
| Parent's Employer If Patient Is Minor / Child |  |

|  |  |
| --- | --- |
| Parents Social Security # If Patient Is Child |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Emergency: Who Do We Call? |  | Relationship |  |

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Name of Relative or Friend Not Living with You | | |  | | | | Phone |  | |  |
|  | | | | | | | | | | |
| **HEALTH INSURANCE INFORMATION** | | | | | | | | | | |
| Name of Insurance Company |  |  | |  | Group Number |  | | |  | |

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Name of Insured (Policy Holder) | | | |  |  |  | Policy Number | |  |  |
| Insured Birthdate | | | |  |  |  |  | |  |  |
|  | | | | | | | | | | |
| **ACCIDENT INSURANCE INFORMATION** | | | | | | | | | | |
| Name of YOUR Auto Insurance Company | | | | |  |  |  |  |  |  |
| Agent Name |  | | |  |  |  | Adjuster’s Name | |  |  |
| Accident Claim Number | | |  |  |  |  | Phone Number | |  |  |
| Name of LIABLE Insurance Company | | | | |  |  | Adjuster’s Name | |  |  |
| Claim Number |  | |  |  |  |  | Phone Number | |  |  |
| Attorney Name | |  |  |  |  |  | Phone Number | |  |  |
|  | | | | | | | | | | |
| **WORK OR INJURY INSURANCE INFORMATION** | | | | | | | | | | |
| Employer or Responsible Party | | | |  |  |  |  | |  |  |
| Contact Person | |  |  |  |  |  | Phone Number | |  |  |
|  | | | | | | | | | | |
| Please provide the receptionist with your driver’s license & insurance card to be photocopied for your permanent medical record. | | | | | | | | | | |

Welcome to our practice We will strive to help restore or improve your health but there are no guarantees or promises of improvement or complete recovery. Patients are encouraged to leave valuables at home or with an accompanying family member or friend. This Facility shall not be liable for the loss of or damage to any personal property including, but not limited to money, credit cards, clothing, jewelry, glasses/contacts, dental devices, hearing aids, furs, documents or any other items.

Your signature on this document fully authorizes our staff & doctors to perform any examinations, diagnostic tests &/or treatment as we may consider medically necessary & to release all information pertinent to your health, insurance or benefits to any & all applicable parties on your behalf. Our office and staff are committed to providing all patients regardless of race, color, national origin, age, sex, disability or religious or political beliefs quality health care services delivered with dignity and concern. HIPAA requires that we have you read & sign the federally governed Health Care Privacy Notice. This Notice is detailed on page -3- of this document. The Health Care Privacy Notice will explain when, where and why your confidential health information may be used, stored and/or shared and is a part of this document that is a permanent part of your medical records which is maintained in this office. You may receive a free photocopy of this document that you have signed just by asking one of our staff.

Your signature on this document confirms that you have read, understand and agree to comply with all of the terms & conditions of the Health Care Privacy Notice and all policies, consents, terms & conditions regarding your responsibilities to this Facility and that you grant the physicians, therapists and/or all staff of this Facility to use and share your confidential health information with others in order to treat you and/or in order to arrange for payment of your bill and/or for issues that concern this Facility operations and responsibilities. Please direct any questions or concerns to a member of our staff. We encourage questions and/or concerns to avoid misunderstandings. Office hours allow our patients convenience to schedule appointments before & after work as well as during lunch. If you must miss an appointment please notify us. If you do not show up for your scheduled appointment you will be charged $50.00 as a missed appointment fee that you must pay before you are seen or treated again. As a courtesy for you, we may call you on the telephone, text or email when an appointment is missed and/or you have not been in for a while. If you do not wish for us to call you or mail you reminder cards please let us know in writing for your file.

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- |
| **HEALTH CARE PRIVACY NOTICE – INFORMED CONSENT – ASSIGNMENT OF BENEFITS – AUTHORIZATION & LIEN** |

This office is committed to providing patients with quality health care services delivered with dignity and concern. Fulfilling this commitment requires the efforts of the doctors, therapists, staff and patient working together as a team to obtain the maximum results. Patient satisfaction is a vital interest to our staff.

This Facility is required by law to abide by the terms of this Health Care Privacy Notice as well as other applicable federal and state laws governing privacy practices in health care. Our Facility may change and/or modify the terms of this Notice at any time without additional notice to you except to publicly post in our Facility and/or make available to patients any updated notices. Photocopy of this Notice is available to you upon request. The term Facility refers to this office or clinic. The term Provider refers to doctors and/or licensed professionals of this Facility. Our Facility & staff are committed to maintaining the privacy of your protected health information (PHI). PHI is information about you, including demographic information that may identify you and that may be related to your present, future and past physical or mental health or condition and the care and treatment you receive from our practice. This Notice describes how medical information about you may be used and disclosed and how you can obtain access to this information. Please read this Notice and direct questions, misunderstandings or concern to the Compliance Officer of this Facility.

Our Facility may use & disclose your PHI for health care delivery purposes. Your PHI may be used and/or disclosed without your written authorization by the doctors and staff of this Facility for the purposes of your care and treatment; paying your health care bills; and to support the operations of this practice. Your doctor and the staff will take all reasonable measures to maintain the confidentiality of your PHI. The Privacy Rule allows you the right to review and receive copies of your health care records as it relates to your health care. The request must in writing, allowing your provider 30 days to respond. Your provider may deny your request if it will cause harm to you or to another person. Your provider may charge a copy fee, which will be in compliance with State law. Your provider will comply with any reasonable request to have confidential communication by alternative means or at an alternative location if not doing so endangers you. You may request to have an amendment placed in your record if you disagree with anything in your record. This does not mean that anything will be removed or changed and the provider has the right to respond with a rebuttal statement if he/she feels it is necessary. You may revoke authorization, in writing, at any time, except in the event that the provider has acted as indicated in the doctor’s Authorization Notice. You have the right to file a written complaint with our Compliance Officer if you believe that any of your privacy rights have been violated. You can obtain a complaint form from the Compliance Officer and/or the Office of the Civil Rights. All complaints must be filed within 180 days of when you knew or should have known that the violation occurred. The Privacy Law prohibits our Facility from taking any retaliatory actions against anyone who files a complaint. A more detailed, updated & comprehensive Health Care Privacy Notice is available for your review in this Facility.

I understand that this Facility, its doctors & staff are accepting my case based on examination findings & believe the outlined treatment should produce change and/or improvement. However as with any diagnostic test, procedure, examination or doctors care a guarantee of improvement or complete recovery cannot be made and it is even possible that no change will occur. I further understand that in the practice of chiropractic, massage therapy & therapy modalities there are some risks including but not limited to fractures, disk injuries, strokes, dislocations, sprains-strains, burns, myelopathy and/or other injuries or side effects which cannot be pre-determined. I do not expect the doctor/provider to be able to anticipate and explain all risks and/or complications, and I wish to rely on the doctor/provider to exercise judgment during the course of the procedure(s) which the doctor/provider feels at the time is in my best interest. If you have a condition that would otherwise not come to the Doctor’s attention it is your responsibility to inform the Doctor.

Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination and X-ray. Stroke and /or vertebral artery dissection caused by chiropractic manipulation of the neck has been the subject of ongoing medical research and debate. The most current research on the topic is inconclusive as to a specific incident of this complication occurring. If there is a causal relationship at all it is extremely rare and remote. Unfortunately, there is no recognized screening procedure to identify patients with neck pain who are at risk of a vertebral artery stroke.

Other treatment options for your condition may include: • Self-administered, over-the-counter analgesics and rest • Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers • Hospitalization • Surgery. If you chose to use one of the above noted “other treatment” options you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

Patients have the right to refuse treatment, but must be aware of the probable consequences of refusing treatment and/or failing to cooperate with the prescribed treatment. Should you refuse and/or fail to comply with prescribed treatment your provider will discuss specific consequences with you. Therefore I give my full consent to the doctor/provider to render treatment on me or the minor for whom I am legally responsible by a health care provider of this Facility.

**I hereby consent to have my physician and other staff at Arkansas Physical Medicine and Rehabilitation communicate with me by email, standard SMS/text messaging or voice mail regarding various aspects of my health care, which may include, but shall not be limited to, test results, appointments, and billing. I understand that email, standard SMS/text messaging or voice mail are not confidential methods of communication and may be insecure. I further understand that, because of this, there is a risk that email, standard SMS/text messaging or voice mail regarding my medical care might be intercepted, read or listened to by a third party. Appointment reminders and private health information will be communicated to you by email, standard SMS/text messaging and voice mail based on your specific written authorization. You have the option to opt out of any of those methods at any time by notifying our office in writing.**

**Assignment of Benefits**

I, the assignee, being the patient or legal guardian for said minor listed below, do hereby irrevocably authorize, direct and transfer assignment of all rights and all benefits and causes of action, and give a full lien to the office named above and listed below, hereinafter referred to as the “Facility” against any & all insurance benefits, proceeds of any settlement, judgment or verdict which may be paid to the undersigned as a result of the injuries or illness for which I have been treated by the Facility. This is an assignment of my rights and benefit. In the event my insurance company is obligated to make payment to me upon charges made by the Assignee for its service and the company fails or refuse to make timely complete payments. I authorized Assignee to prosecute said cause of action either in my name or Assignee’s name and further to make timely, complete payment, I authorize Assignee to compromise, settle or otherwise resolve said cause of action as they see fit.

**Direction of Payment**

I, the assignee further authorizes any and all insurance company, attorney and any & all third party payer to pay directly to the Facility all sums of money due them for any & all services rendered to me or minor by whom I am responsible for by reason of accident, illness and by any & all reason of any other bills that are due or may become due, and to withhold such sums from any health & accident, workers compensation and or including all insurance or third party benefits. I hereby irrevocably authorize and direct you, my insurance company and or my attorney to pay directly to Arkansas Physical Medicine and Rehabilitation (Assignee) such sums as may be due and owing Assignee for the service rendered to me both by reasons of accident or illness and by reason of any other bills that are due Assignee. I hereby authorize any insurance company to pay directly to Assignee the amount of this and or any future bills for service rendered to me and to release any information requested that is pertinent to my case to my insurance company or attorney involved in this case.  Assignee agrees that this Facility & staff may deliver medical records, consultations, depositions and/or court appearances which must be paid in full in advance and authorizes this Facility to release any information pertinent to said health care to any insurance company, adjuster, attorney or legal service bureau to facilitate collections under the terms of this document. Assignee grants the Facility a full power of attorney to endorse &/or sign my name on any & all checks for payment of any indebtedness owed this office & assignee.

**Letter of Protection**

I hereby authorize and direct that my lawyer, if I am represented by counsel, SHALL withhold such sums from any disability benefit, medical payment benefits, no fault benefits, or any other insurance obligated reimbursement from any settlement, judgement or verdict on my behalf as may be necessary to reimburse Assignee for service provided to me.

I HEREBY FURTHER GIVE AN IRREVOCABLE LIEN to said Assignee against any and all insurance benefits named herein and any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of the injuries or illness for which I have been treated by the Assignee. In the event that I do not have insurance coverage, I understand that I remain personally responsible for payment of service rendered; I also agree to pay in a current manner any difference between the total charges and the amount paid by the insurance company directly to Assignee.

**PIP LOG & DEC Sheet Request**

I HEREBY AUTHORIZE THE ASSIGNEE TO REQUEST A COPY OF THE APPLICABLE INSURANCE POLICY AND DECLARATION PAGE WHICH REFLECTS THE POLICY LIMITS AVAILABLE AT THE TIME OF THE ACCIDENT, AND THE APPLICABLE PIP LOG TO BE PROVIDED TO THE ASSIGNEE upon request. This request is authorized pursuant to the terms of my policy. I hereby authorize this assignee to request and received a copy of my PIP log REFLECTS THE POLICY LIMITS AVAILABLE AT THE TIME OF THE ACCIDENT, AND THE APPLICABLE PIP LOG TO BE PROVIDED TO THE ASSIGNEE upon request. This request is authorized pursuant to the terms of my policy. I hereby authorize this assignee to request and received a copy of my PIP log periodically as they deem to be necessary.

**Reservation of Benefits**

Be further advised that I AM HEREBY PLACING YOU ON NOTICE THAT SHOULD YOU (THE INSURANCE COMPANY/CARRIER)DENY, REDUCE OR FAIL TO PAY ANY PART OF, OR AN ENTIRE BILL WHICH WAS SUBMITTED ON MY BEHALF FROM THIS PROVIDER, I(THE ASSIGNOR) AS WELL AS THE ASSIGNEEE ARE REQUESTING IN ADVANCED THAT YOU RESERVE OR SET ASIDE THE AMOUNT YOU REDUCED OF DENIED UNTIL THE DISPUTE IS RESOLVED. Should you submitted a check to Assignee which is less than the contractual amount and contains any language referring to payment ad “Full and Final Payment”, I have instructed Assignee to return the check to you (the carrier) and consider the bill still due and owing (a late payment). Additionally SHOULD THE REMAINING AMOUNT OF MY BENEFIT APPROACH AND THE AMOUNT WHERE THERE WOULD BE INSUFFICIENT FUNDS TO PAY THE AMOUNT YOU REDUCED, DENIED OR FAILED TO PAY, PLEASE NOTIFY ME (THE ASSIGNOR) AND THE ASSIGNEE OF THIS FACT. Should my benefits exhaust; please notify me (the assignor) and assignee promptly.

**Severability Clause**

If any term or provision of this Assignments, Lien and Authorization of the application thereof to any person or circumstances shall to any extend be invalid or unenforceable the remainder of this Assignment, Lien and Authorization or the application of such term or provision to persons or circumstances other than those as to which it is held invalid or unenforceable, shall not be affected thereby, and each term and provision of this Assignment, Lien and Authorization shall be valid and enforced to the fullest extent of the Law.

|  |
| --- |
| **INSURANCE BENEFITS – CREDIT POLICIES – PAYMENT TERMS & CONDITIONS** |

As a courtesy, the Facility will obtain a verification of applicable insurance benefits as they are quoted to us but some third party payers misquote benefits, coverage and liability. Our Facility & staff are not responsible for what a third party payer and/or representative may tell us. Any contractual, written, verbal or other obligations or arrangements between you and an attorney, insurance company, liable or third party payer are between you and said person.

1. Our Facility will file initial insurance claims for you. Secondary claim submission and/or additional reports or documents sent for your benefit may result in an additional filing or medical report charges, which you are responsible to pay. Co-pays, deductibles and all non-covered services are due the day the service is rendered.
2. Patients are responsible for charges on all service(s) and/or product(s) which may exceed the maximum allowable and/or when a third party and/or insurance carrier

does not reimburse this Facility enough to meet our cost of service.

1. All account balances, including automobile and work injury claims must be paid in full within 90 days of treatment. Patients are fully responsible for all money owed this office and such payment is not contingent on any settlement, claim, judgment, or verdict by which they may eventually recover said fee and it is also regardless of any attorney liens or pending settlement(s). If a third party payer fails to pay said balance in full within the 90-day period, the patient must pay the balance in full. Assignee is fully responsible for all money owed this Facility for any and all treatment, products & services rendered to the patient or minor shown below.
2. A non-discriminatory “Time of Service Discount” is offered to anyone who pays for services the day they are rendered. The “TOS” is only offered on the day the service is rendered. This discount does not apply to orthopedic supports, orthotics, physical therapy equipment rentals or purchases, vitamins, supplements, ointments, acupuncture treatments, weight loss programs, psychological counseling services and massage therapy.
3. A service charge is computed by a ‘periodic rate’ of 1 % per month – 12% per annum & is added to all balances owed 60+ days. Any balance past due 90 days or more may be submitted to an attorney and/or agency for legal collection for which the undersigned agrees to be 100% responsible for all monthly service charges, interest, costs related to but not limited to all collection related expenses, attorney fees, court & filing fee’s. Returned checks, debit & credit charges made payable to this Facility for insufficient funds, stop payments or other reasons of non-payment will be assessed a $35.00 charge.
4. Patients are eligible for a maximum $250 personal credit limit when approved. For your convenience we accept most major credit & debit cards.
5. I authorize APMR and or its agents to request information from credit reporting agencies for all purposes it deems necessary in order to collect on my account.
6. I authorize the use of my email address for appointment reminders, balance inquires or other promotional information from my doctor.

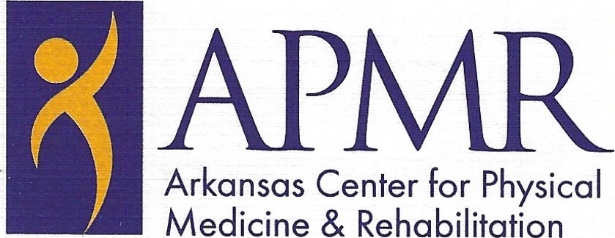
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| **PATIENT CONSENT & SIGNATURE** |

By my signature below I acknowledge that I have read or have had read to me and have received a photocopy upon my request of this document including the Health Care Privacy Notice, Facility terms & conditions, credit policies and Informed Consent and fully understand and have had all of my questions answered to my satisfaction. A photocopy of this document shall be considered as effective and valid as an original.

|  |  |  |
| --- | --- | --- |
|  | Acct # |  |

Print Name of Patient

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Signature (if minor, parent must sign) |  | Date |



636 W. Broadway, North Little Rock, AR 72114

501-374-1153 Office

501-374-6213 Fax **AUTHORIZATION FOR RELEASE OF INFORMATION**

**Section A: COMPLETE FOR ALL AUTHORIZATIONS:**

I HEREBY AUTHORIZE the use or disclosure of my individually identifiable health information (PHI) as described below. I understand that this authorization is voluntary. I understand that, if the organization authorized to release my PHI is not a health plan or health care provider, the released PHI may no longer be protected by federal privacy regulations.

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID Number/ DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Persons/ organizations authorized to release your PHI: ARKANSAS CENTER FOR PHYSICAL MEDICINE & REHABILITATION

Persons/ organizations authorized to receive your PHI: ARKANSAS CENTER FOR PHYSICAL MEDICINE & REHABILITATION

Specific description of PHI to be released (including dates): All medical records, including: SOAP/ Chart Notes, Reports, Letters, Lab results, Prescriptions, Patient History, Review of Symptoms, Referrals, X-rays, Images, & Image discs.

Specific regulations you want placed on release of your PHI: None. Please send all records.

I understand that this will expire on \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_. \_\_\_\_\_\_\_: initials

I understand that that I may revoke this authorization at any time by notifying the releasing organization in writing, but my revocation will not affect any releases mad or other actions taken before the date of my revocation. \_\_\_\_\_\_\_: Initials

**Section B: COMPLETE IF RELEASE IS REQUESTED BY HEALTH CARE PROVIDER**

To be completed by provider before Patient signs

\_\_\_\_\_ Requested for own use \_\_\_\_Request for use and disclosure by another provider/plan

The use or disclosure for which this request is made is: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

As the Provider, we will not receive financial or other compensation in exchange for using or disclosing health information described above.

To be completed by Patient prior to signing

I understand that I am not required to sign this authorization form \_\_\_\_\_: Initials

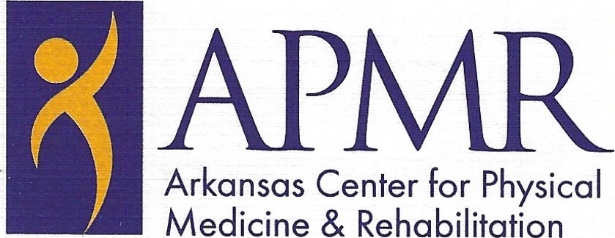
I understand that my health care and the payment for my health care will not be affected if I do not sign this form \_\_\_\_\_: Initials

I understand that I may see and copy the PHI to be released pursuant to this form if I so request, and that I will receive a copy of this form after I sign it \_\_\_\_\_: Initials

**Section C: COMPLETE FOR ALL AUTHORIZATIONS**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Signature of Patient or Patients Representative \_\_\_\_\_\_\_\_\_\_\_\_\_Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Printed Name or Patients Representative \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship



636 W. Broadway, North Little Rock, AR 72114

501-374-1153 Office

501-374-6213 Fax

**INSURANCE SECURITY AGREEMENT & LETTER OF PROTECTION**

1. Insurance credit application:

Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ hereby applies to Dr. Steven Bennett and Arkansas Physical Medicine and Rehabilitation, 636 W Broadway, North Little Rock, AR 72114, Telephone (501)374-1153/ Fax (501)473-6213 (herein called “Medical Provider”); for secured insurance credit regarding all medical bills that were caused by the injury accident which occurred on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, 21\_\_\_.

1. Insurance secured credit: The person(s) and/or business(es) responsible for causing my injuries is/are covered by insurance. The insurance companies responsible for ultimately paying for the cost of the medical care are: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (herein called “insurance company”).

Patient authorizes said Medical Provider to send Patient’s Medical records and bills for payment to:

1. Each of said person(s) and/or business(es).
2. To the insurance company that insures each of them, and
3. To the Patient’s medical insurance company, if any, that covers Patient’s injuries from this accident.

To further provide insurance-security to said Medical Provider, patient promises to file a lawsuit against any person or business covered by liability insurance and/or their insurance company that denies payment, in whole or in part, for Patient’s medical bills.

1. Attorney representation to secure payment of medical bills by insurance company:
2. Patient understands that Patient may have to hire an attorney to secure payment from an insurance company, and if so, Patient authorizes and directs said attorney to promptly sign this agreement.
3. Patient authorizes Medical Provider to send medical records, reports, and bills to said attorney.
4. Patient authorizes and directs the Patient’s attorney, if any, or the insurance company to give to Medical Provider from the Insurance settlement or recovery an amount to pay Patient’s medical bills in full, promptly upon a settlement or recovery being received.
5. Charges for medical services:

Medical Provider promises to bill a reasonable and customary amount for all medical services provided and agrees to send a copy of all ills to Patient and/or Patient’s attorney.

1. Assignment of benefits and Lien:

Patient directs his/her attorney to withhold the full amount of the medical bills and services including those for treatments heretofore and thereafter rendered, as well as for any reports: coping fees: liens; filing fees: (and any monies/balances due from depositions, court appearances or standby court appearance fees) from any recovery obtained from insurance company and/or responsible party(s) via settlement, arbitration or court determination and within 14 days of receipt, to send payment directly to Medical Provider. Patient gives Physician a lien on such recovery to secure payment of all medical bills and services. Patient agrees that this assignment of benefits, grant of a medical lien and execution of this agreement are irrevocable and cannot be withdrawn or changed by Patient in the future.

1. Patient responsibility:

Patient understands and agrees that Patient is 100% directly and fully responsible to pay Medical Provider for all medical services rendered and bills issued pursuant to this Insurance Security Agreement:

1. Even if any Insurance company denies payment in whole or in part for such medical services.
2. Even if a judge, jury or arbitrator renders a decision in Patient’s lawsuit or claim that the insurance company for said person or entity is not responsible for payment of Patient’s Medical Bills.

Patient agrees to comply with any payment plan agreement that may be made between Patient and Medical Provider.

1. Lawsuit to collect debt:

If insurance company does not pay this insurance secured credit and the Patient fails to pay 100% for all medical services provided and a lawsuit is filed against Patient to collect the medical bills, the prevailing party shall be entitled to recover reasonable attorney’s fees and costs of suit according to law. In consideration of Medical Provider filing insurance claims versus payment in full, patient waives the benefits of the statute of limitations as a defense to any debt collection lawsuit that may be filed by Medical Provider against Patient in the future to collect medical bills and services now owed or hereafter incurred.

1. Insurance security agreement & Letter of Protection by attorney:
2. Persons(s) and/or business(es) that caused and/or are legally responsible for said Patient’s injuries is/are covered by liability insurance.
3. Patient promises to send all medical bills, reports and records to said insurance company for payment.
4. Patient agrees to be fully bound by all the terms and conditions stated in this Insurance Security Agreement and Letter of Protection.
5. Patient agrees to withhold full payment for all medical bills from any recovery and send full payment to Medical Provider within 14 days of disbursement of any money received from recovery.
6. In the event of substitution of attorneys, Patient agrees to notify the new attorney and Medical Provider of any substitution of attorney and to direct the new attorney to sign this Insurance Security Agreement and Letter of Protection.
7. Facsimile:

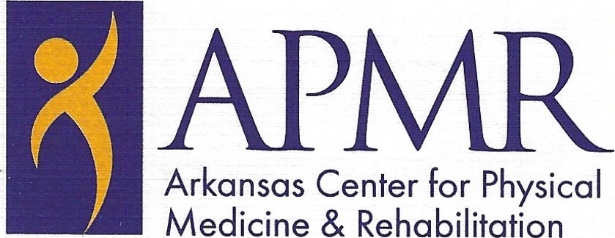
It is agreed that a faxed copy shall have the same validity as the original hereof.

Dated this \_\_\_\_\_\_\_day of\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, 20\_\_\_\_\_\_\_.

Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Attorney: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



636 W. Broadway, North Little Rock, AR 72114

501-374-1153 Office

501-374-6213 Fax

WORKERS COMPENSATION QUESTIONNAIRE

Employee Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employee Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sex □M □F

Employer’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer’s Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer’s Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of Business\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Workers Compensation Insurance Carrier\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Injury occurred? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Time of Injury \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_AM/PM

Address Injury occurred at:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was Employer notified of this injury □Yes □ No Was an Attorney retained: □Yes □No

Attorneys Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Attorneys Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Attorneys Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently in litigation for this injury? □Yes □No □Maybe

How did the injury occur? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What injuries were suffered? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When was your last day of work? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When did you return to work? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When was your first examination>\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who examined you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is their degree, if know: □D.C. □M.D. □D.O. □D.D.S.

What was the diagnosis provided? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE \_\_\_\_\_\_\_\_\_\_\_\_ PATIENT ID \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you received any treatments prior to this office visit? □Yes □No

What treatments did you receive? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever injured this area of your body before? □Yes □No

If yes, when were you first injured? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did you lose time from work? □Yes □ No

If you lost time from work with injuries, please list doctor(s) consulted: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any other injuries or illnesses that affect your employment? □Yes □ No

If yes; please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In your work, do you favor one part of your body more than others: □Yes □ No

If yes; please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a history of absenteeism caused from accidents on the job: □Yes □ No

Have you ever had a Workers Compensation claim before? □Yes □ No

Before the injury were you capable of working on an equal basis with others your age? □Yes □ No

Are your work activities restricted as a result of this accident? □Yes □ No

Since this injury are your symptoms: □Improving □getting worse □the same

PATIENT NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE \_\_\_\_\_\_\_\_\_\_ PATIENT ID \_\_\_\_\_\_\_\_\_\_\_

**DIRECT ASSIGNMENT OF BENEFITS AND RIGHTS**

**PROVIDER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

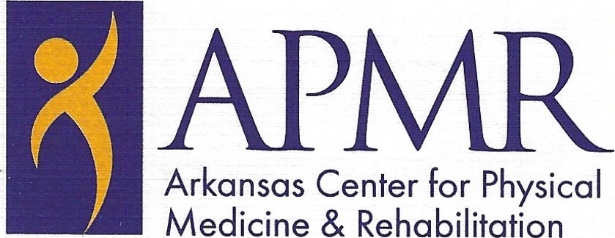
**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

In consideration of your undertaking to render care, I agree to the following:

1. RELEASE OF INFORMATION: You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney or adjustor to process any claim for reimbursement of charges incurred by me at your treatment facility.
2. RIGHT TO RECEIVE INFORMATION: I authorize my chiropractic provider the authority to affix my signature as noted below to obtain medical information from any hospital, medical provider, etc. as necessary as it relates to the care being provided by my chiropractic doctor.
3. RIGHT TO RECEIVE PAYMENT: I irrevocably authorize and assign to you, the chiropractic provider, the right to receive direct payment from my attorney or any insurance company which may become obligated to pay me any sums. I further authorize the endorsement of my name to any draft containing my name to which you are legally entitled.
4. ASSIGNMENT OF RIGHT TO SUE: In the event any insurance company or attorney obligated by contractual agreement to make payment to me for your service charges refuses to make such payment upon demand by you, I irrevocably hereby assign and transfer to you the cause of action that exists in my favor against any such company or attorney and authorize you to prosecute said action either in my name or your name as you otherwise resolve said claim as you see fit. I understand that whatever amounts you do not collect from said insurance proceeds (whether it be all or part of what is due) shall by paid by me.
5. I also assign to you, the chiropractic provider, and grant the right of lien against all claims against any third party whose negligence may have caused my injury, including the insurance, up to the among of the bill for treatment, as it relates to my healthcare as provided by you. I fully understand that health insurance write offs are not taken on in personal injury/ auto accident cases.
6. I waive the Statue of Limitations regarding my doctor’s right to recover from me directly.
7. I hereby acknowledge that I am receiving (or about to receive) healthcare services from Arkansas Center for Physical Medicine & Rehabilitation and am advised that they are willing to wait for payment for these services, provided there continues to be a reasonable chance that payment will be made either by insurance proceeds or out of the settlement of a liability claim. I understand that if it is determined either (a) there is no insurance company obligated to pay for the services, or if the insurance company involved refuses to acknowledge an assignment to the doctor(s) or make other provisions for the protection of the interest of the doctor(s); or b)If a liability claim exists and my attorney refuses to agree to protect the interest of the doctor(s) or if I have not engaged the services of an attorney, payment for services rendered by the above named doctor(s) will be made on a current basis and my account paid in full immediately. In any event, I hereby promise to pay my bill in full within (10) days from the date my liability claim is settled or after the passage of three (3) months from the date of my last treatment, whichever comes first.
8. If any payment for any services rendered under this agreement becomes delinquent, the patient or patient’s guardian shall be responsible for payment of any and all court costs, attorney fees, service of process fees and any additional reasonable costs incurred in order to collect or that are associated with collecting monies due on the patient’s account.

Dated this \_\_\_\_day of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, 20\_\_\_\_\_\_\_\_

Patients Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Witness\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



636 W. Broadway, North Little Rock, AR 72114

501-374-1153 Office

501-374-6213 Fax

**CONTRACT**

We are pleased that you have chosen Arkansas Center for Physical Medicine and Rehabilitation (APMR) for your healthcare needs. We look forward to seeing you. In consideration for our agreement to provide Chiropractic services to you, you agree to the following terms of this contract:

1. Each account will be paid in full after services are rendered, unless other arrangements have been made with APMR.
2. You agree to pay for all services if the insurance states the service is “not covered”.
3. At any time during care, if your insurance benefits are exhausted you agree to set up satisfactory payment arrangements with APMR for the remaining balance on your account.
4. In the event you do not pay your account as agreed, and the account is turned over for bad debt collection, you agree to be responsible for all cost of collecting your account. In order for APMR to receive 100 % of charges for services rendered APMR will add 50% collection fees, mailing fees, court cost and attorney fees to the balance of the delinquent principle owed.
5. All prepaid packages are non-refundable. To offer these reduced prices on packaged time, we are not able to offer refunds. Should you not use all of your package treatment it could be shared with another person such as your spouse, child, or friend. It could be gifted or purchased by another person should you desire. Any funds not used after one year from initial payment will be forfeited.
6. In the event you are unable to make an appointment, a 24-hour notice is required. You agree to pay a missed appointment fee should a 24-hour notice not be given.
7. You agree that in the event suit must be brought to collect any balance due, the proper jurisdiction and revenue for such suit will be in Pulaski County, Arkansas.
8. You agree that APMR or its agents may request information from credit reporting agencies for all purposes it deems necessary I order to collect your account.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

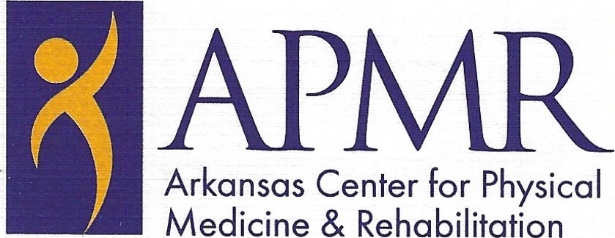
Patient Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

APMR Witness Date

THIS IS A LEGALLY BINDING CONTRACT, CONTACT AN ATTORNEY IF YOU DO NOT UNDERSTAND THE TERMS.

PATIENT ID# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



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**Release of information & Password**

According to the Federal Government and the Privacy Act, this form will protect your private information from being given to anyone without prior permission.

Please provide us with a password that no one else will be able to identify. This password will give us security when contacting you or when you contact us for health or financial information. Please choose one of the following questions and provide us with an answer.

Thank you!

1. What is your mother’s maiden name?
2. What street did you live on as a child?
3. What was the first car you owned?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature Date

**I hereby authorize the following individual(s) to access all health information regarding my account. For example: this would include anyone such as a spouse or children. They will be required to present the appropriate identification and know the password to obtain any information. Please list all individuals below:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\*\*\*\*If you choose Not to list anyone, they will not be able to obtain any information without your written consent. \*\*\*\*\***

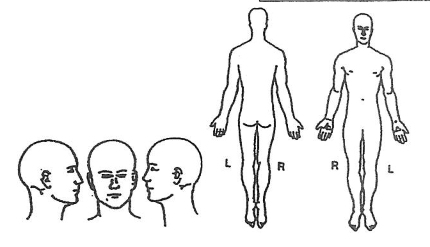
**Patient ID# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

ARKANSAS CENTER FOR PHYSICAL MEDICINE & REHABILITATION 501)374-1153

636 WEST BROADWAY, NORTH LITTLE ROCK, AR 72114 501)374-6213 FAX

PAIN DRAWING

CIRCLE LOCATIONS OF YOUR SYMPTOMS ON THE BODY DRAWING. Outline using the symbols for the type of sensation.



Pain ……………

Numbness +++++++

Burning ///////////

Ache XXXXXX

Describe your pain (check All that apply): Onset of Pain:

\*Constant \*Sudden

\*Intermittent \*Gradual

\*Recurring

\*Stabbing

\*Dull Ache

\*Sharp

\*Deep Ache

\*Throbbing

\*Tingling

\*While Resting

\*Daily

\*During Exercise

\*Nightly

\*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

On a scale of 1 to 10- Rate your pain level \_\_\_\_/10 (1= no pain. 10= emergency room)

What, if anything, gives you relief?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IF YOUR PROBLEM OR SYMPTOMS ARE DUE TO AN ACCIDENT OR INJURY PLEASE COMPLETE THIS SECTION

□AUTO COLLISION Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time\_\_\_\_\_\_\_\_\_\_ am/pm Location\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□OTHER INJURY

DESCRIBE INJURY AND HOW IT OCCURRED: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ACCIDENT REPORTED TO: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE REPORTED \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*No Restrictions \*Missed \_\_\_\_\_\_ Days of work or school \*I felt fine before the injury

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SYMPTOM SURVEY

What is your chief problem or symptom? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What caused the problem or symptom to occur? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When did the problem or symptom begin? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you seen another Dr. for this issue? \*NO \*YES Who were you seen by? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What tests/ procedures have been performed? \*X-Ray \*CT \*MRI \*Surgery \*Hospitalization \*\_\_\_\_\_\_\_\_\_\_

Have you had this problem /symptom in the past? \*NO \*YES If yes, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you tried any other treatments for this? \*NO \*YES If yes, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is the problem/ symptom getting worse? \*NO \*YES If yes, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CHECK ALL THAT APPLY TO YOU NOW AND IN THE PAST:

\*Arthritis/ Gout \*Depression/ Anxiety \*Pregnancy \*Seasonal Allergies \*Headaches

\*Eye Pain/ Strain \*Dizziness \*Seizures \*Ringing in ears \*Blurred Vision

\*Jaw Pain \*Bleeding gums \*Neck Pain/ spasm \*Chronic fatigue \*Heart Disease

\*Gall Stones \*Swallowing difficulty \*Thyroid Problems \*Chest Pain \*Chest congestion

\*Anemia \*Hypertension \*Stroke \*kidney stones \*Pancreatitis

\*Shortness of Breath \*Irregular Heart Beat \*HIV/ Aids \*Asthma/ bronchitis \*mid back pain

\*Abdominal Pain \*Wrist or hand pain \*low back pain \*hip/ knee/ leg pain \*foot / ankle pain

\*Skin Problems \*Diabetes \*Groin/ rectal pain \*female disorders \*urinary problems

\*Shoulder/ Elbow Pain \*Broken Bones \*digestive problems \*nausea/ vomiting \*Irregular bowels

PATIENT & FAMILY HISTORY

What is your occupation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □Full Time □Part Time

What is your employment status? □working □sick leave □Unemployed □Retired □temp disabled

□perm disabled \* Last day worked\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use tobacco □NO □YES EXPLAIN:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use alcohol □NO □YES EXPLAIN:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

History of substance abuse? □NO □YES EXPLAIN:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List past surgeries: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List drug allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List current & past medications/ Drugs:

Drug Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List physicians you have seen in the last 5 years:

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason for visit\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason for visit\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason for visit\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason for visit\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History:**

Father \*Living age\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \*Deceased cause of death\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mother \*Living age\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \*Deceased cause of death\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Brother \*Living age\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \*Deceased cause of death\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Brother \*Living age\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \*Deceased cause of death\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sister \*Living age\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \*Deceased cause of death\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sister \*Living age\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \*Deceased cause of death\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*other problems not listed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ARKANSAS PHYSICAL MEDICINE AND REHABILITATION

PATIENT CONFIDENTIAL HEALTH HISTORY

PATIENT NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PATIENT ID#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IN ORDER TO OFFER YOU THE BEST CARE, WE NEED TO UNDERSTAND YOUR GENERAL HEALTH STATUS. PLEASE ANSWER THE FOLLOWING QUESTIONS BY CHECKING THE BOXES AS INDICATED;

C= CURRENTLY HAVE THIS CONDITION P= PREVIOUSLY HAD A PROBLEM IN THE PAST N= NEVER HAD THE CONDITION.

***GENERAL***

C P N

1. □ □ □ FEVER

2. □ □ □ CHILLS

3. □ □ □ NIGHT SWEATS

4. □ □ □ LOSS OF SLEEP

5. □ □ □ FATIGUE

6. □ □ □ NERVOUSNESS

7. □ □ □ WEIGHT LOSS/ GAIN

8. □ □ □ ALLERGIES

9. □ □ □ BLEEDING PROBLEMS

10. □ □ □ ANEMIA

11. □ □ □ DIABETES

12. □ □ □ CANCER

13. □ □ □ THYROID DISEASE/GOITER

14. □ □ □ ALCOHOLISM

15. □ □ □ DRUG ABUSE

***EAR, NOSE, THROAT***

16. □ □ □ POOR VISION

17. □ □ □ EYE PAIN

18. □ □ □ HEARING PROBLEMS

19. □ □ □ NOSEBLEEDS

20. □ □ □ NOSE PROBLEMS

21. □ □ □ SINUS TROUBLE

22. □ □ □ DENTAL PROBLEMS

23. □ □ □ HOARSENESS

24. □ □ □ TONSILECTOMY

***RESPIRATORY***

25. □ □ □ DIFFICULTY BREATHING

26. □ □ □ SHORTNESS OF BREATH

27. □ □ □ CHRONIC COUGH

28. □ □ □ SPITTING PHLEGM

29. □ □ □ SPITTING BLOOD

30. □ □ □ WHEEZING/ASTHMA

31. □ □ □ PNEUMONIA

32. □ □ □ TUBERCULOSIS

***CARDIOVASCULAR***

33. □ □ □ IRREGULAR HEART BEATS

34. □ □ □ HIGH BLOOD PRESSURE

35. □ □ □ CHEST PAIN

36. □ □ □ HEART PROBLEMS

37. □ □ □ ANKLE SWELLING

38. □ □ □ VARICOSE VEINS

39. □ □ □ RHEUMATIC FEVER

40. □ □ □ STROKE

***SKIN***

41. □ □ □ ITCHING

42. □ □ □ BRUISING EASILY

43. □ □ □ CHANGE IN MOLE(S)

44. □ □ □ SKIN CANCER

45. □ □ □ HAIR/NAIL CHANGES

46. □ □ □ SCARS

***GASTROINTESTINAL***

**C P N**

47. □ □ □ POOR APPETITE

48. □ □ □ POOR DIGESTION

49. □ □ □ DIFFICULTY SWALLOWING

50. □ □ □ BELCHING OR GAS

51. □ □ □ FREQUENT

52. □ □ □ NAUSEA/VOMITING

53. □ □ □ VOMITING BLOOD

54. □ □ □ PAIN OVER ABDOMEN

55. □ □ □ STOMACH ULCER

56. □ □ □ BLACK OR BLOODY STOOL

57. □ □ □ LIVER PROBLEMS

58. □ □ □ GALL BLADDER PROBLEM

59. □ □ □ JAUNDICE

60. □ □ □ DIARHEA

61. □ □ □ CONSTIPATION

62. □ □ □ BLOATING

63. □ □ □ HEMORRHOIDS

64. □ □ □ APPENDICITIS

65. □ □ □ HERNIA

***GENITOURINARY***

66. □ □ □ FREQUENT URINATION

67. □ □ □ PAINFUL URINATION

68. □ □ □ BLOOD IN URINE

69. □ □ □ URINARY TRACT INFECTION

70. □ □ □ KIDNEY STONES

71. □ □ □INABILITY TO

CONTROL URINATION

72. □ □ □DIFFICULTY STARTING URINATION

73. □ □ □GET UP AT NIGHT

TO URINATE

74. □ □ □SEXUALLY TRANSMITTED DISEASES

75. □ □ □ SEXUAL DIFFICULTIES

76. DATE OF LAST COLONOSCOPY \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***MEN ONLY***

77. □ □ □ TESTICULAR PROBLEMS

78. □ □ □ PROSTATE PROBLEMS

79. DATE OF LAST PROSTATE EXAM\_\_\_\_\_\_\_\_\_\_\_

***WOMEN ONLY***

80. □ □ □ PAINFUL PERIODS

81. □ □ □ EXCESSIVE FLOW

82. □ □ □ IRREGULAR CYCLES

83. □ □ □ VAGINAL BURNING/ITCHING

84. □ □ □ HOT FLASHES

85. DATE OF LAST MENSTRUAL CYCLE

86. DATE OF LAST PAP SMEAR \_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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***MEN & WOMEN***

87. □ □ □ BREAST LUMP OR PAIN

***NEUROLOGICAL***

88. □ □ □ WEAKNESS

89. □ □ □ TWITCHING

90. □ □ □ TREMOR

91. □ □ □ HEADACHE

92. □ □ □ FAINTING

93. □ □ □ DIZZINESS

94. □ □ □ CONVULSIONS

95. □ □ □ EPILEPSY/ SEIZURES

96. □ □ □ NUMBNESS/ TINGLING

97. □ □ □ ARM/ LEG PAIN

98. □ □ □ MENTAL DISORDER

***MUSCULOSKELETA*L**

99. □ □ □ NECK STIFFNESS/ PAIN

100. □ □ □ PAIN BETWEEN SHOULDERS

101. □ □ □ LOW BACK PAIN

102. □ □ □ PAINFUL JOINTS

103. □ □ □ MUSCLE ACHE/SOARNESS

104. □ □ □ SPINAL CURVATURE

105. □ □ □ ARTHRITIS

***EXERCISE***

106. □ □ □ NONE

107. □ □ □ 1- 2 TIMES A WEEK

108. □ □ □ 3- 5 TIMES A WEEK

109. □ □ □ 6- 7 TIMES A WEEK

MEDICATION(S):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NUTRITIONAL SUPPLEMENTS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PAST CHIROPRACTIC HISTORY\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***HABITS***

110. □ □ □ SMOKING \_\_\_# PACKS/DAY

111. □ □ □ DRINKING ALCOHOL

112. □ □ □ RECREATIONAL DRUG USE

113. □ □ □ CAFFEINE

114. □ □ □ SOFT DRINKS 115. □ □ □ ARTIFICIAL SWEETNER

***TRAUMA***

116. □ □ □ CAR ACCIDENT

117. □ □ □ MAJOR FALL

118. □ □ □ BROKEN BONES

119. □ □ □ HEAD TRAUMA

120. □ □ □ SPORTS

***FAMILY HISTORY***

121. □ DIABETES

122. **□**  THYROID DISEASE/ GOITER

123. □ TOBERCULOSIS

124. □ KIDNEY DISEASE

125. □ HIGH BLOOD PRESSURE

126. □ HEART DISEASE

127. □ CANCER

128. □ MUSCLE, BONE OR NERVE DISEASE

129. □ LUNG DISEASE

130. □ ULCER

131. □ ARTHRITIS

132. □ SEIZURE/ STROKE

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT SIGNATURE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

REVIEWED BY ATTENDING PHYSICIAN\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_