

CONFIDENTIAL REGISTRATION FORM

PLEASE PRINT

Date _____

PATIENT INFORMATION											
Patient's Last Name	First	Middle Int.			<input type="checkbox"/> Mr.	<input type="checkbox"/> Miss	<input type="checkbox"/> Single	<input type="checkbox"/> Mar			
					Mrs.		<input type="checkbox"/> Div	<input type="checkbox"/> Sep	<input type="checkbox"/> Wid		
Home Phone No. ()	Cell Phone No. ()	Birth Date / /		Age	Sex		<input type="checkbox"/> M <input type="checkbox"/> F				
Street Address	Apt#.	City	State	Zip Code	Email Address						
Occupation					Employer						
The best way to contact me is (circle one): Home Cell Email											
Whom may we thank for referring you?											
<input type="checkbox"/> Dr. _____			<input type="checkbox"/> Insurance Plan		<input type="checkbox"/> Patient _____						
<input type="checkbox"/> Close to home/work			<input type="checkbox"/> Internet site - Yelp/Google/Ours/Other: _____			<input type="checkbox"/> Other _____					
Primary Care Physician (PCP)			PCP Address			PCP Phone ()					
May we keep your PCP informed about your treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No											
IN CASE OF EMERGENCY											
Name of Local Friend or Relative				Relationship to Patient			Phone No. ()				
ABOUT YOUR CONDITION											
In general, would you say your overall health right now is: Excellent / Very Good / Good / Fair / Poor											
How would you describe your chief complaint at this time?											
How long have you had your symptoms?					Are they changing? Improving / Unchanging / Worsening						
Symptoms started as a result of: <input type="checkbox"/> no apparent reason											
Have you had these symptoms before? YES NO If so, how many episodes? 1-5 6-10 11+											
What makes your symptoms worse?											
What makes your symptoms better?											
How often do you experience your symptoms? <input type="checkbox"/> Constantly (76-100% of the day) <input type="checkbox"/> Frequently (51-75 % of the day) <input type="checkbox"/> Occasionally (26-50% of the day) <input type="checkbox"/> Intermittently (0-25% of the day)											
Average Pain Intensity											
	None								Unbearable		
Last 24 hrs:	0	1	2	3	4	5	6	7	8	9	10
Past week:	0	1	2	3	4	5	6	7	8	9	10
How much have your symptoms interfered with your usual daily activities? (including both work outside the home and housework) <input type="checkbox"/> Not at all <input type="checkbox"/> A little bit <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit <input type="checkbox"/> Extremely											
Treatments Tried: Chiropractic / Medication / Physical Therapy / Surgery / Self-care / Other:											
Have you had special imaging for your symptoms? YES NO If yes: Xray / MRI / CT / US / Other: When:											
Is this a result of a recent Accident? YES NO If yes, when and explain:											

SOCIAL HISTORY

Habits:

- Smoking: _____ pack(s) a day for ____ year(s)
 Alcohol: _____ drinks per week
 Caffeine Drinks: _____ cups per day
 High Stress Level Reason: _____

Exercise level within the last 6 months?

- None **Type:**
 1-2 times per week
 3-5 times per week
 Daily

What is your ACTIVITY LEVEL? (circle best)

1. Sedentary (Office worker getting little or no exercise)
2. Moderately active (eg. Construction worker or person running one hour daily)
3. Vigorously active (eg. Agricultural worker (non mechanized) or person swimming two hours daily)
4. Extremely active (eg. competitive athlete)

What percent of your day are you: sitting _____% standing _____% walking _____% manual labor _____%

Family History

Do any diseases run in your family? _____

Have any relatives ever suffered a stroke? _____

PAST MEDICAL HISTORY

Please tell us about any hospitalizations, serious illness or surgeries:

Please list any auto accidents or trauma (e.g. fractures, head injuries, dislocations, etc...)

List your prescribed medications, over-the-counter medications, herbs, vitamins and inhalers:

Name	Dosage	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please provide details of any known allergies. (e.g. latex, medications, foods)

Allergen	Reaction
_____	_____
_____	_____

MEN: Date of last prostate exam: _____ History of prostate problems? _____
Difficulty with urination? Yes No Excessive urination? Yes No

WOMEN: Are you pregnant? Yes No
pregnancies _____ # Birth children _____ # Cesarean sections _____

1. PATIENT SPECIFIC FUNCTIONAL SCALE (PSFS)

3P FORM

We would like to know what 3 activities in your life you are unable to do or are having the most difficulty with as a result of your chief problem. Please list your 3 activities on the left and rate them on the right.

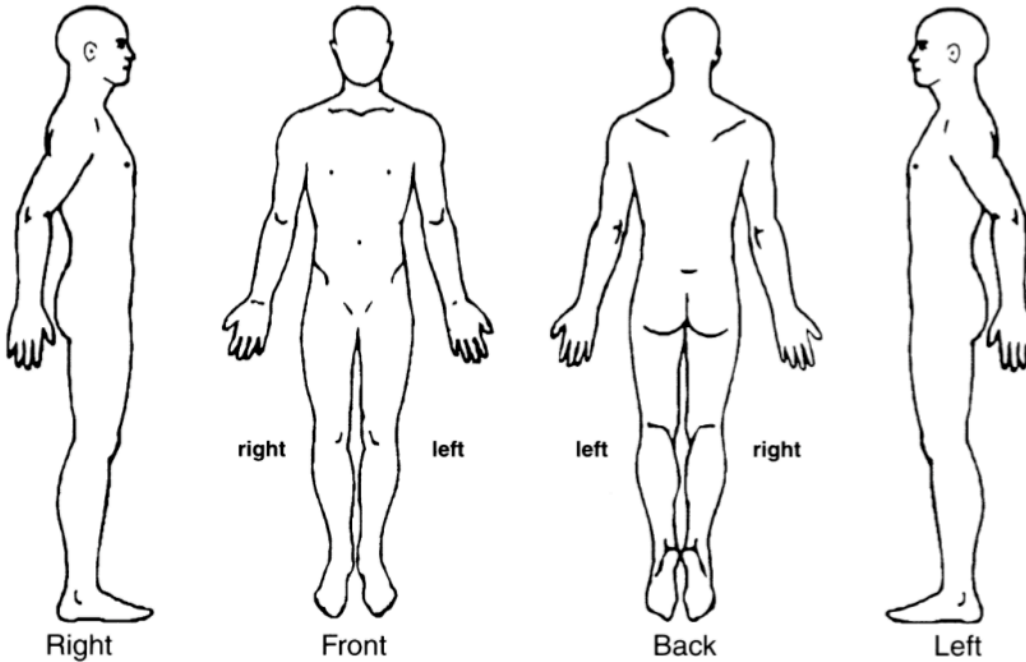
	Unable to perform activity										Able to perform activity at same level as before injury or problem	
1. _____	0	1	2	3	4	5	6	7	8	9	10	
2. _____	0	1	2	3	4	5	6	7	8	9	10	
3. _____	0	1	2	3	4	5	6	7	8	9	10	

2. PAIN DIAGRAM

Please mark the areas on the picture below that correspond to the areas of your body where you feel the described sensations. Use appropriate symbols. Mark the areas of radiation (traveling pain) include all affected areas.

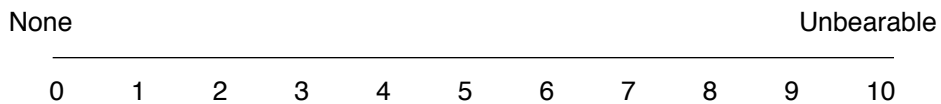
DO NOT SIMPLY CIRCLE THE AREA OF INVOLVEMENT.

Numbness ----- Pins & Needles 00000 Burning XXXXX Aching ***** Stabbing /////



3. PAIN SCALE

Please indicate the average intensity of your symptoms.





FINANCIAL POLICY

I, the undersigned, have insurance coverage with _____ and assign directly to Advantage Health & Wellness, PC dba Chicago Spine + Sports, Douglas Krebs, DC, Chicago Family Chiropractic Care, Thomas Donahue, DC all medical benefits, if any, otherwise payable to me for services rendered. 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 to secure payment of benefits. I authorize the use of this signature on all my insurance submissions.

INSURANCE AUTHORIZATION OF TREATMENT

1. I am ultimately responsible for full payment for any and all services rendered.
2. I am considered as a CASH patient until I have provided completed insurance forms, and that your office has qualified and accepted my coverage, otherwise I pay at the time of service.
3. I must pay deductibles, co pays and coinsurance at the time of service.
4. Insurance Benefits quoted by my insurance company are NOT a guarantee of payment.
5. Chicago Spine + Sports makes every attempt to receive authorization of treatment from insurance companies for treatment received at our facility. However, there may be times when the insurance company does not provide this authorization in a timely manner. CSS will submit claims as a courtesy to me. If my insurance carrier has not paid a claim within the terms of the contract within 60 days of submission, CSS will submit an appeal one (1) time. If the claim is not paid within 30 days of the appeal I will be responsible for taking an active part in the recovery of my claim. After 90 days, I will be responsible for the balance and I authorize the use my credit card, (if supplied) to collect full payment, otherwise I must remit payment in full upon receipt of the statement.
6. If statement is not paid within 60 days of being billed, any unpaid balance will be turned over to a collection agency. This is our standard for all delinquent accounts.
7. If my account is turned over to collections, I agree to pay all court costs and 33% of attorney fees.
8. I understand that I can be charged a \$50.00 NO SHOW fee for any appointment not canceled in advance.

Patient Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

CONSENT FOR USE OF PHI FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS (HIPPA)

I consent to the use or disclosure of my protected health information (PHI) by Chicago Spine + Sports for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations. I understand that my diagnosis or treatment by Chicago Spine + Sports staff may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Chicago Spine + Sports is not required to agree to the restrictions that I may request. However, if Chicago Spine + Sports agrees to a restriction that I request, the restriction is binding on Chicago Spine + Sports.

I have the right to revoke this consent, in writing, at any time, except to the extent that Chicago Spine + Sports has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Chicago Spine + Sports' Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the clinic. The Notice of Privacy Practices for Chicago Spine + Sports is posted in the reception area. This Notice of Privacy Practices also describes my rights and Chicago Spine and Sports' duties with respect to my protected health information.

Chicago Spine + Sports reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Patient Signature

Printed Name

Date

Informed Consent to Physical Medicine, Joint Manipulation and Manual Therapy

Please read this entire document prior to signing. It is important that you understand the information it contains. Please feel free to ask questions and to review any information if anything is unclear.

• **As part of your analysis, examination and treatment, you are consenting to the following procedures**

Spinal Manipulative Therapy	Extremity Joint Manipulation	Range of Motion/Neurological Testing
Muscle Strength Testing	Orthopedic Testing	Motion Palpation
Muscular Palpation	Vital Signs	Hot/Cold Therapy
SASTM	Electrical Stimulation Therapy	Postural Analysis
Trigger Point Therapy	Kinesio Taping Therapy	Radiographic Studies
McKenzie Evaluation/Treatment	Myofascial Release Therapy	Ultrasound Therapy
Massage Therapy	Intersegmental Traction	Stretching/Strengthening Exercises

• **The material risk inherent in Instrument-Assisted Soft Tissue Mobilization (SASTM)/Myofascial Release Therapy**

Instrument-Assisted Soft Tissue Mobilization is a soft tissue treatment method that utilizes instruments that enables clinicians to effectively detect and treat scar tissue and restrictions that affect normal function. You will often physically move the region of the body getting worked on through active ranges of motion. SASTM may be uncomfortable in some regions of the body (like the burn experienced while lifting weights) and may produce soreness and bruising post-treatment for up to 1-3 days.

• **The material risk inherent in McKenzie Mechanical Diagnosis and Therapy**

McKenzie Mechanical Diagnosis and Therapy is a diagnostic and therapeutic system used to identify and treat spinal and extremity conditions based on identifying the patient's initial baselines (symptoms, mechanical and neurological deficits) and then introducing progressive and specific load to the area in question and observing any changes made to the initial baselines. Through observation and testing, a reductive movement/load can be identified that produces noted and drastic improvements to the patient's symptoms and mechanical and neurological deficits. Through the testing procedures, patients may experience temporary stiffness and strain while performing some of the specific loading strategies that commonly last 10-15 minutes but can last up to 1-2 days.

• **The nature of spinal/extremity joint manipulation**

After a full evaluation of your condition, the doctor may make the decision that manipulative therapy would be beneficial to assist your recovery. If joint manipulation is used, the doctor would use his hands in such a way as to move your joints to restore range of motion, proper function and reduce the perception of pain. You may feel a click or pop, similar to someone cracking their knuckles, and you may feel movement of the joint.

• **The material risk inherent in joint manipulative therapy and ancillary procedures**

As with any health care procedure, there are certain complications which may arise following joint manipulation therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscular strain or cervical myelopathy. Some types of manipulation of the neck have been associated with injuries to the arteries of the neck leading to or contributing to serious complications including stroke. Some patients will feel some soreness and stiffness following the first twenty four to forty eight hours following their first and/or second treatment utilizing joint manipulation. Your doctor will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to his attention, it is your responsibility to inform him.

• **The probability of those risks occurring**

Fractures are rare occurrences and generally result from some underlying weakness of the bone which is checked for during the taking of your history and during examination and x-ray. Stroke has been a subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical manipulations. The other complications are also described as rare.

• **The availability and nature of other treatment options**

Other treatment options for your condition may include: Self administered, over-the-counter analgesics and rest; Medical care and prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; Hospitalization or Surgery. If you chose to use one of the other treatment options, you should be aware that there are risks and benefits of such options and you may wish to discuss those with your primary care physician or specialist.

• **Procedures you would like excluded from your treatment**

If there are any procedures previously listed that you would explicitly request not to be employed in your treatment please list these below. We will gladly employ other treatment options to in an attempt to reach the same results.

• **The risks of and dangers of remaining untreated**

Remaining untreated may allow the formation of adhesions and reduced mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

Patient Signature

Date