Accelicare Sports Chiropractic Performance Therapy

Today's Date: _____ **Patient SS#**_____ **Patient Office ID**:_____

Patient Name_____ **Employer**_____
Address: _____ **Address:** _____
_____ _____
City State Zip City State Zip
Sex ☐ M ☐ F Age_____ Date of Birth _____☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
Home Phone_____ Work Phone _____Cell _____
Best time and place to reach you _____ Email: _____
Occupation_____ Employer Phone_____
Spouse's Name_____Spouse's Birthdate _____
Spouse'sOccupation_____Spouse's Employer_____
How did you hear of Healing Touch? ☐ Advertisement ☐ Friend ☐ At an Event ☐ Other:_____
Whom may we thank for referring you?_____

In Case of Emergency contact

Name_____ Relationship_____ Home Phone_____ Work Phone _____

Insurance Information

Subscriber's Name: _____ Birth Date_____ Relationship to Patient _____
Insurance Company Name:_____ Policy#_____
Insurance Company Address: _____ Group/Claim # _____
_____ SS#_____

Is patient covered by additional insurance? ☐ Yes ☐ No
Subscriber's Name: _____ Birth Date_____ Relationship to Patient _____
Insurance Company Name:_____ Policy#_____
Insurance Company Address: _____ Group/Claim # _____
_____ SS#_____

For No Fault and Worker's Compensation:

Attorney Information (for personal injury, WC, No Fault)

Name:: _____ Contact Person:_____
Address:_____ Phone: _____
_____ Fax: _____
City State Zip Date of Injury:_____ State: _____ Time: _____

Informed Consent to Care

(Patient: Please discuss any questions or concerns with the Doctor before signing this consent.)

I hereby request and consent to the performance of Manipulation (adjustments) and other procedures including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor named above.

I have had the opportunity to discuss with the doctor and/or with other office or clinic personnel the purpose and benefits of Manipulations (adjustments) and other treatments outlined below. Alternatives to treatment have been reviewed.

I understand that I will be receiving one or more of the following treatments: Manipulation/ Mobilization Therapy, Hot/Cold packs, Ultrasound , Myofascial Release, Traction, EMS, Therapeutic exercises, Massage, Graston Technique, and/or Kinesiology Taping.

I understand that Manipulation is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the treatment that I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

Signature of Patient X_____ Date _____ Doctor's Signature _____ Date _____
(or guardian)

SIGNATURE ON FILE

I authorize use of this form on all my insurance submissions. I authorize release of information to all my insurance companies. I understand that I am financially responsible for all charges whether or not paid by the insurance companies. I authorize my doctor to act as my agent in helping me obtain payment from my Insurance Companies. I authorize payment direct to my doctor. I permit a copy of this authorization to be used in place of the original.

Signature of Patient X_____ Date _____ Doctor's Signature _____ Date _____
(or guardian)

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Chief Complaint Questionnaire

1. Reason for visit or your Chief Complaints

_____

2. What do you hope will happen as a result of this visit?

_____

3. When did your symptoms appear? When did you realize it's time to see a doctor for this problem? Pick one

☐ I don't know how it began ☐ It comes and goes ☐ I've had it a long time (about _____ years)

☐ Specific injury (date of injury _____) ☐ When did the symptom begin?

4. Explain how the injury happened

_____

_____

_____

5. Overall my state of health is ☐ Excellent ☐ Good ☐ Fair ☐ Improving Failing

6. Rate the severity of your **low back** pain on a scale from 1 (least pain) to 10 (severe pain)

1. Right now _____/10 2. At its worst today _____/10 3. At its worst overall since beginning _____/10
4. How often do you have this pain Daily? ☐ Constant (76-100%) ☐ Frequent (51-75%) ☐ Occasional (26- 50%) ☐ Intermittent (25% or less)

7. Rate the severity of your ☐ Hip, ☐ Thigh, ☐ Knee, ☐ Ankle, and/or ☐ Foot pain on a scale from 1 (least pain) to 10 (severe pain)

1. Right now _____/10 2. At its worst today _____/10 3. At its worst overall since beginning _____/10
4. How often do you have this pain daily? ☐ Constant (76-100%) ☐ Frequent (51-75%) ☐ Occasional (26- 50%) ☐ Intermittent (25% or less)

8. Rate the severity of your **neck pain** on a scale from 1 (least pain) to 10 (severe pain)

1. Right now _____/10 2. At its worst today _____/10 3. At its worst overall since beginning _____/10
4. How often do you have this pain daily? ☐ Constant (76-100%) ☐ Frequent (51-75%) ☐ Occasional (26- 50%) ☐ Intermittent (25% or less)

9. Rate the severity of your ☐ Shoulder, ☐ Arm, ☐ Elbow, ☐ Forearm, ☐ Wrist, and/or ☐ Hand pain on a scale from 1 (least pain) to 10 (severe pain)

1. Right now _____/10 2. At its worst today _____/10 3. At its worst overall since beginning _____/10
4. How often do you have this pain daily? ☐ Constant (76-100%) ☐ Frequent (51-75%) ☐ Occasional (26- 50%) ☐ Intermittent (25% or less)

10. Rate the severity of your _____ **pain** on a scale from 1 (least pain) to 10 (severe pain)

1. Right now _____/10 2. At its worst today _____/10 3. At its worst overall since beginning _____/10
4. How often do you have this pain daily? ☐ Constant (76-100%) ☐ Frequent (51-75%) ☐ Occasional (26- 50%) ☐ Intermittent (25% or less)

11. Do you have the following problems? Please Checkmark your answer (R= right, L=Left, B=Both)

Weakness ☐None ☐__Shoulder ☐__Arms ☐__Elbow ☐__Forearm ☐__Wrist ☐__Hand ☐__Elbow
☐__Hip ☐__Thigh ☐__Knee ☐__leg ☐__Ankle ☐__Foot ☐__Toes

Numbness (loss of feeling) ☐None ☐__Shoulder ☐__Arms ☐__Elbow ☐__Forearm ☐__Wrist ☐__Hand ☐__Elbow
☐__Hip ☐__Thigh ☐__Knee ☐__leg ☐__Ankle ☐__Foot ☐__Toes

Tingling (Pins & Needle Sensation) ☐None ☐__Shoulder ☐__Arms ☐__Elbow ☐__Forearm ☐__Wrist ☐__Hand ☐__Elbow
☐__Hip ☐__Thigh ☐__Knee ☐__leg ☐__Ankle ☐__Foot ☐__Toes

12. Is your pain worse at night ☐ Yes ☐ No. Does your pain awaken you from sleep? ☐ Yes ☐ No
13. Does coughing affect your pain ☐ Yes ☐ No. Do your legs hurt/tire when you walk far? ☐ Yes ☐ No
14. Lost or gained weight recently? ☐ Yes ☐ No. Experienced night sweats ☐ Yes ☐ No
15. Been out of the country ☐ Yes ☐ No. Lost bladder or bowel control ☐ Yes ☐No
16. Had trouble with sexual function ☐ Yes ☐ No. Seen a primary care physician in last year ☐ Yes ☐ No
17. Since your problem began, the condition has? ☐ Increased ☐ Decreased ☐ Not Changed
18. Does your problem "flare up" and get worse at any point? _____

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19. Are your complaints affecting your ability to work or otherwise be active? ☐ No effect on my activity level ☐ I have some physical restrictions ☐ I Need limited assistance with common everday tasks ☐ I have a significant inability to function without assistance ☐ Totally disabled(impaired) and cannot care for self

20. Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

21. Type of complaint: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting ☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other _____

22. What makes your problems Worse**:** ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down ☐ Lifting ☐ Twisting ☐ Movement ☐ Rising from a chair

23. What makes your problems *Better*: ☐ *Sitting* ☐ *Standing* ☐ *Walking* ☐ *Bending* ☐ *Lying Down* ☐ *Lifting* ☐ *Twisting* ☐ *Movement* ☐ *hot shower/hot pack* ☐ *cold pack* ☐ *rise from chair* ☐ *physical activity*

24. When you wake up, the problem is ☐ BETTER ☐ WORSE ☐ NO CHANGE

25. As the day goes along the problem gets ☐ BETTER ☐ WORSE ☐ NO CHANGE

26. How often do you have this pain? ☐ Constant (76-100%) ☐ Frequent (51-75%) ☐ Occasional (26- 50%) ☐ Intermittent (25% or less)

27. Have you ever injured this area before? ☐ Yes ☐ No If yes, how many times have you experienced this problem? ☐ 1-4 ☐ 5-8 ☐ >8

28. What treatment have you already received for your current condition?

☐ Medications ☐ Surgery ☐ Chiropractic Services ☐ Physical Therapy ☐ Other _____

29. Name, address, and telephone number of doctor(s)/healthcare providers who have treated you for this condition:

PCP Dr. _____ Dr. _____ Dr. _____

_____ _____ _____

_____ _____ _____

City State Zip City State Zip City State Zip

30. Current Medications, including vitamins, supplements, and over-the-counters

Medication Name	**Reason**	**Medication Name**	**Reason**
1)		5)	
2)		6)	
3)		7)	
4)		8)	

31. **Surgeries (Date & Reason):** (Please include all surgeries, especially spine procedures) _____

_____

_____

32. **Hospitalizations (Date & Reason)** _____

_____

_____

33. **Fractures/Dislocations/Falls/Car Accidents/Trauma (Date & Reason):** _____

_____

_____

34. **Known Allergies** _____

35. Please circle all the conditions that you have currently or had previously.

☐ Heart attack	☐ Emphysema	☐ Heart murmur	☐ Angina	☐ Asthma
☐ High Blood Pressure	☐ Anemia	☐ Stroke/TIA	☐ Bleeding disorder	☐ Varicose Veins
☐ Sexual difficulty	☐ Stomach ulcer	☐ Enlarged prostate	☐ Duodenal problems	☐ Menstrual problems
☐ TB	☐ Colon problems	☐ Migraine Headaches	☐ Diabetes	☐ HIV/AIDS
☐ Hepatitis	☐ Scoliosis	☐ Cirrhosis	☐ Prosthetic joints/pins/screws	
☐ Kidney stones	☐ Kidney infection	☐ Psoriasis	☐ Depression	
☐ Degenerative Arthritis	☐ Rheumatoid Arthritis	☐ Cancer type:_____		

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Vital Information

"Please approximate to the best of your abilities:"

Blood Pressure: ____/____mm/Hg **Weight:** _____lbs. **Height____'____"**

Exercise Activity

36. Do you do any exercise on a regular basis? ☐ Yes ☐ No Days/Week____ If yes, specify _____
37. Are you a member of a gym/fitness facility? ☐ Yes ☐ No Which?_____

WORK ACTIVITY

☐ Sitting ☐ Standing ☐ Light Labor ☐ Heavy Labor

HABITS

☐ Smoking Packs/Week_____ If yes, last chest x-ray? _____

☐ Smokeless Tobacco If yes, last dental visit _____ ☐ Used to smoke but quit…how long Ago? _____

☐ Alcohol Drinks/Week _____ ☐ Coffee/Caffeine Cups/Day _____

☐ High Stress Level Reason_____

Female Health Questions

40. Do you have an OB/GYN Provider? If yes, who _____ Last visit _____
41. Are you pregnant? ☐ Yes ☐ No No Have you ever been pregnant? ☐ Yes ☐ No If yes, how many pregnancies _____
42. Complications during pregnancy/delivery? ☐ Yes ☐ No If yes describe_____
43. Children and age(s)?_____
44. Date of LMP _____ 45. Birth Control? Method _____
46. Have you ever had a PAP smear? ☐ Yes ☐ No If yes, approx. date _____
47. Have you ever had a mammogram? ☐ Yes ☐ No
48. Any history of breast, ovarian, cervical, uterine cancers/polyps/growths in you or family? ☐ Yes ☐ No
49. Ever had a routine or baseline EKG done? ☐ Yes ☐ No 50. CRP/Homocysteine levels? ☐ Yes ☐ No
51. Have you checked your Cholesterol levels? ☐ Yes ☐ No 52. Do you perform monthly breast self exams? ☐ Yes ☐ No

Male Health Questions

53. Have you ever had a digital prostate exam? ☐ Yes ☐ No
54. PSA Test? Blood test for prostate cancer ☐ Yes ☐ No
55. Do you perform testicular self exams? ☐ Yes ☐ No
55. Ever had a routine/baseline EKG done? ☐ Yes ☐ No
56. Checked Cholesterol level? ☐ Yes ☐ No
57. Checked CRP/Homocysteine levels? ☐ Yes ☐ No

PLEASE FILL OUT PAIN DIAGRAM ON NEXT PAGE

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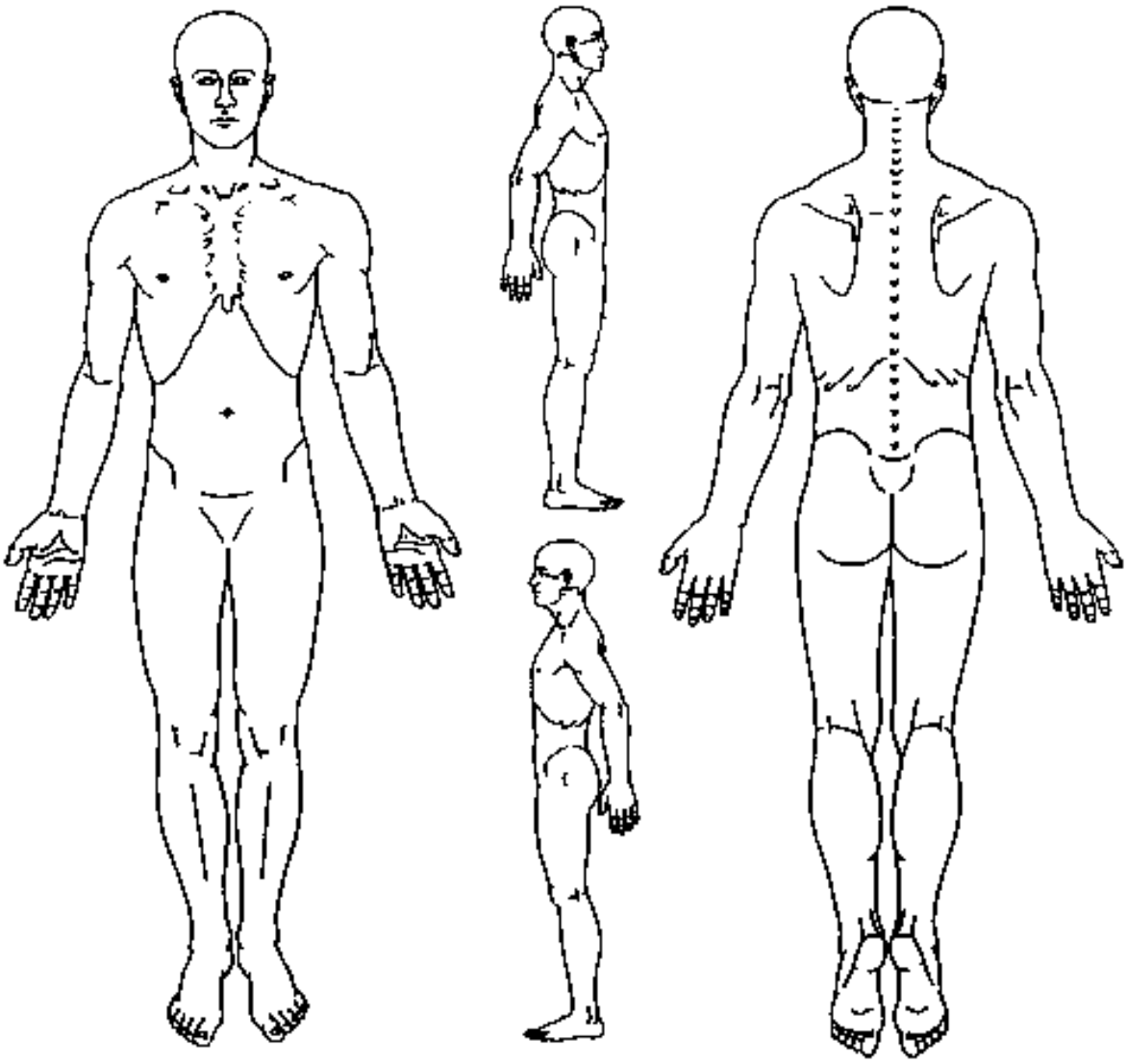
Pain Diagram



A = ACHE	**P** = PINS & NEEDLES	**B** = BURNING
S = STABBING	**N** = NUMBNESS	**O** = OTHER

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