THE CENTER FOR
SPINE, SPORT & PHYSICAL MEDICINE

New Patient Intake Form

Name (first, last, preferred): _____ Today's Date: _____

Address: _____ Date of Birth: ____/____/____

City: _____ State: _____ Zip: _____ □ Male □ Female

I give The Center for Spine, Sport and Physical Medicine permission to leave messages pertaining to my appointment: □ Yes □ No

Home Phone: _____ Cell Phone: _____

Work Phone: _____ E-mail: _____

Would you like to receive text or email appointment reminders? □No □ Yes, email □ Yes, text

If yes for text reminders, who is your cell phone provider: _____

How did you hear about us? _____

Emergency Contact: _____ Relationship: _____

Phone: _____ □ Home □ Cell □ Work

INSURANCE INFORMATION

Insurance Company: _____

ID#: _____ Group # (Include any letters): _____

Primary Policy Holder's Name: _____ Policy Holder's DoB: ____/____/____

Relationship to Policy Holder: □ Self □ Spouse □ Child

Secondary Insurance Company: _____

ID#: _____ Group # (Include any letters): _____

Primary Policy Holder's Name: _____ Policy Holder's DoB: ____/____/____

Relationship to Policy Holder: □ Self □ Spouse □ Child

Did this condition arise as a result of a motor vehicle accident or work injury? □ No □ Yes

Claim #: _____ Date of Injury: ____/____/____

Adjuster's Name: _____ Phone #: _____

Claim's Address: _____

Have you retained an attorney? □ No □ Yes:

Attorney's Name: _____ Phone #: _____

HEALTH HISTORY

Have you been hospitalized overnight and/or had any prior surgeries? □ No □ Yes, Please list below: _____

_____

_____

Are you currently taking prescription medication? □ No □ Yes Please List: _____

_____

Please list any allergies (environmental, food, medications, latex, other): _____

_____

Do you smoke? □ No □ Yes How many cigarettes/packs per day? _____ For how long? _____

Do you drink alcohol? □ No □ Yes How often? _____

Do you use drugs/substances not prescribed by a physician? □ No □ Yes Please describe: _____

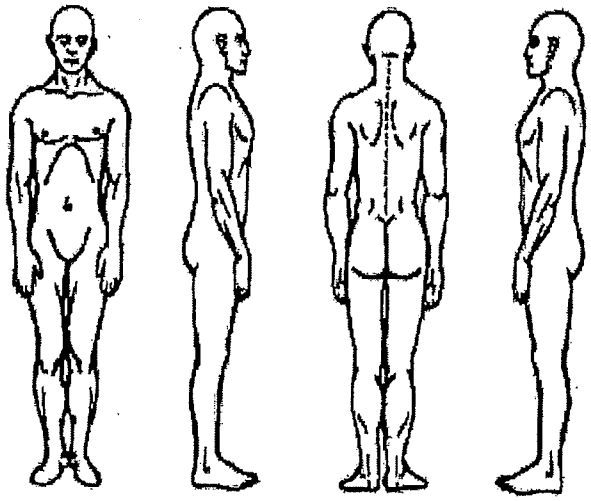
_____

Is there a family history of cancer or other disease? □ No □ Yes Please list: _____

_____

Pain Diagram: Please mark the areas of complaint on the diagram using the symbols on the left

Aching ^^^
Numbness +++
Pins and Needles OOO
Burning XXX
Stabbing /////



Severe Pain

No Pain

Please indicate the severity of your pain currently on the line above

X_____ Date: _____

Signature of Patient/Parent/Legal Guardian

DO NOT SIGN THIS FORM IF YOU ARE UNDER 18 – MINOR'S MUST HAVE A PARENT/GAURDIAN SIGN.

REVIEW OF SYSTEMS

Please mark all that apply:

General-
- ☐ Weight loss or gain
- ☐ Fatigue
- ☐ Fever or chills
- ☐ Weakness
- ☐ Trouble sleeping

Skin-
- ☐ Rashes or Itching
- ☐ Change in color
- ☐ Change in hair or nails
- ☐ Non-healing sores
- ☐ Dryness
- ☐ Change in appearance of mole
- ☐ Breast pain
- ☐ Breast lump(s)
- ☐ Breast discharge

Eyes-
- ☐ Wear glasses/contacts
- ☐ Vision loss/changes
- ☐ Pain
- ☐ Redness
- ☐ Blurry or double vision
- ☐ Flashing lights
- ☐ Specks
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Eye disease or injury

Ears- Nose – Throat-
- ☐ Bleeding gums
- ☐ Bad breath or bad taste
- ☐ Mouth sores
- ☐ Dry mouth
- ☐ Hoarseness
- ☐ Sore throat or voice change
- ☐ Swollen glands in neck
- ☐ Hearing loss
- ☐ Ringing in ears
- ☐ Earache
- ☐ Sinus problems
- ☐ Stuffiness
- ☐ Drainage
- ☐ Itching
- ☐ Nosebleeds

Respiratory-
- ☐ Persistent cough
- ☐ Coughing up blood
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Asthma
- ☐ Painful breathing

Cardiovascular-
- ☐ Hypertension
- ☐ Chest pain or discomfort
- ☐ Sudden changes in heartbeat
- ☐ Shortness of breath with activity
- ☐ Difficulty breathing
- ☐ Swelling on feet, ankles, hands
- ☐ Heart trouble

Gastrointestinal-
- ☐ Stomach pain
- ☐ Heartburn
- ☐ Change in appetite
- ☐ Nausea or vomiting
- ☐ Blood in stool
- ☐ Change in bowel habits
- ☐ Painful bowel movements
- ☐ Constipation
- ☐ Diarrhea

Genitourinary-
- ☐ Sexual difficulty
- ☐ Kidney stones
- ☐ Burning or painful urination
- ☐ Blood in urine
- ☐ Incontinence
- ☐ Change in force or strain with urination
- ☐ Frequency urination

Woman Only-
- ☐ Irregular periods
- ☐ Painful periods
- ☐ Vaginal discharge
- ☐ Date of last menstrual period: _____

Neurological-
- ☐ Frequency or recurrent headaches
- ☐ Lightheadedness or dizziness
- ☐ Fainting
- ☐ Convulsions or seizures
- ☐ Numbness or tingling

Hematologic-
- ☐ Swollen glands
- ☐ Ease of bruising or bleeding
- ☐ Anemia
- ☐ Phlebitis
- ☐ Transfusion
- ☐ Slow to heal after cuts

Endocrine-
- ☐ Thyroid problems
- ☐ Diabetes
- ☐ Excessive thirst or urination
- ☐ Cold extremities
- ☐ Heat or cold intolerance
- ☐ Change in glove or hat size
- ☐ Dry skin
- ☐ Glandular or hormonal problems

Mind/Stress-
- ☐ Nervousness
- ☐ Depression
- ☐ Sleep problems
- ☐ Memory loss or confusion

Musculoskeletal-
- ☐ Stiffness or swelling of joints
- ☐ Weakness of joints or muscle
- ☐ Muscle pain or cramps
- ☐ Neck pain
- ☐ Upper or mid-back pain
- ☐ Low back pain
- ☐ Joint pain
- ☐ Difficulty walking

X_____ Date: _____

Signature of Patient/Parent/Legal Guardian

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FINANCIAL POLICY Please read and initial each statement:

_____ **Payment is due at time of service unless arrangements have been made in advance.** You are financially responsible to us for all cash fees, co-payments, and any amount your insurance company deems your responsibility such as deductibles and co-insurance, as well as denials for services not covered under your policy. We accept Visa, Discover, MasterCard, American Express, check, and cash. Please note: if paying by check, you agree to pay in full all dishonored checks plus a processing fee.

_____ **Not all insurance plans cover all services.** In the event that your insurance plan determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receipt of statement from our office.

_____ We file insurance claims with your individual insurance company as a courtesy to you. However, your insurance policy is a contract between you and your insurance company. **As the patient, you are ultimately responsible to us for payment for services rendered.**

_____ We verify your insurance benefits as a courtesy to you. **Verification of benefits does not guarantee payment by your insurance company** as there may be other restrictions included in your policy not given to our staff in the verbal or written benefit description. **It is your responsibility to understand your benefits** and what is covered under your plan.

_____ It is your responsibility to **inform us of any changes in your insurance coverage.** Timely filing deadlines do exist and you will be financially responsible for any charges that are incurred as a result.

Only after exhausting our internal attempts for payment, we will send a delinquent account to our collection agency or small claims court. Any collection fees, court costs, or reasonable attorney fees are the responsibility of the adult person(s) named on the account. Monthly service fee of 1.5% per month or 18% annum will be assessed on all past due accounts. You will be required to pay your account in full before scheduling another appointment if your account is in collections.

CANCELLATION AND MISSED APPOINTMENT POLICY

In order to better serve our patients and ensure that our providers are compensated for their time, we require at least 24-hour advanced notice if you will be unable to attend your appointment.

A cancellation that is less than 24 hours prior to your scheduled appointment will be considered a missed appointment and you will be responsible for the missed appointment. Missed charges cannot be submitted to insurance or injury claims and will be collected as follows:

30 minute massage therapy session	$40.00
60 minute massage therapy session	$75.00
90 minute massage therapy session	$105.00
Acupuncture appointment	$75.00
Chiropractic appointment	$50.00

I have read and understand the above FINANCIAL POLICY and CANCELATION POLICY and I agree to be bound by its terms.

Name of Patient (PLEASE PRINT):_____

X_____ Date: _____

Signature of Patient/Parent/Legal Guardian

DO NOT SIGN THIS FORM IF YOU ARE UNDER 18 – MINOR'S MUST HAVE A PARENT/GAURDIAN SIGN.

Please read and initial each statement:

CONSENT TO TREATMENT

_____ I hereby give permission to the doctor to release any information requested by my insurance company, physicians, or other health care providers acquired in the course of my examination and treatment. I also give consent to submit request(s) for any information from my insurance company, physicians, or other health care providers. I hereby authorize and direct my insurance benefits to be paid directly to the doctor. I am financially responsible for non-covered services. I hereby give permission to the doctor and/or therapist to administer treatment and perform such general procedures as he/she may deem necessary in the diagnosis and/or treatment of my condition or that of my minor child. I fully understand that this consent will remain in effect until revoked in writing. I have read and I do understand and agree to the above statements.

_____ **Dry Needling:** I understand that dry needling is performed by insertion of a disposable, stainless steel needles(s) through the skin at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to dry needling treatment.

By signing below, I do hereby voluntarily consent to being treated with dry needling by Dr. Joel Carmichael and/or Dr. Jon Seeman. I understand that I may ask to stop the above therapy if it becomes uncomfortable, and I may ask my doctor for a more detailed explanation of this therapy.

NOTICE OF PRIVACY POLICY

_____ I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your NOTICE OF PRIVACY PRACTICES wherein a more detailed description of the uses, examples of and disclosures of my personal health information ("PHI") exists. I understand that this organization has the right to change its NOTICE OF PRIVACY PRACTICES from time to time and that I may contact this office at any time if I wish to obtain a current copy of the NOTICE OF PRIVACY PRACTICES.

I have read and understand the above CONSENT TO TREAMENT and NOTICE OF PRIVACY POLICY and I agree to be bound by its terms.

Name of Patient (PLEASE PRINT):_____

X_____ Date: _____

Signature of Patient/Parent/Legal Guardian

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Back Index

Form BI100

rev 3/27/2003

Patient Name _____ **Date** _____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain is very severe and does not vary much.

Sleeping

⓪ I get no pain in bed.
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

Sitting

⓪ I can sit in any chair as long as I like.
① I can only sit in my favorite chair as long as I like.
② Pain prevents me from sitting more than 1 hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

Standing

⓪ I can stand as long as I want without pain.
① I have some pain while standing but it does not increase with time.
② I cannot stand for longer than 1 hour without increasing pain.
③ I cannot stand for longer than 1/2 hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

Walking

⓪ I have no pain while walking.
① I have some pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

Personal Care

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing and dressing without help.
⑤ Because of the pain I am unable to do any washing and dressing without help.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

Traveling

⓪ I get no pain while travelling.
① I get some pain while travelling but none of my usual forms of travel make it worse.
② I get extra pain while travelling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while travelling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

Social Life

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
③ Pain has restricted my social life and I do not go out very often.
④ Pain has restricted my social life to my home.
⑤ I have hardly any social life because of the pain.

Changing degree of pain

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back Index Score _____

Neck Index

Form N1-100

rev 3/27/2003

Patient Name _____ *Date* _____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
③ The pain is fairly severe at the moment.
④ The pain is very severe at the moment.
⑤ The pain is the worst imaginable at the moment.

Sleeping

⓪ I have no trouble sleeping.
① My sleep is slightly disturbed (less than 1 hour sleepless).
② My sleep is mildly disturbed (1-2 hours sleepless).
③ My sleep is moderately disturbed (2-3 hours sleepless).
④ My sleep is greatly disturbed (3-5 hours sleepless).
⑤ My sleep is completely disturbed (5-7 hours sleepless).

Reading

⓪ I can read as much as I want with no neck pain.
① I can read as much as I want with slight neck pain.
② I can read as much as I want with moderate neck pain.
③ I cannot read as much as I want because of moderate neck pain.
④ I can hardly read at all because of severe neck pain.
⑤ I cannot read at all because of neck pain.

Concentration

⓪ I can concentrate fully when I want with no difficulty.
① I can concentrate fully when I want with slight difficulty.
② I have a fair degree of difficulty concentrating when I want.
③ I have a lot of difficulty concentrating when I want.
④ I have a great deal of difficulty concentrating when I want.
⑤ I cannot concentrate at all.

Work

⓪ I can do as much work as I want.
① I can only do my usual work but no more.
② I can only do most of my usual work but no more.
③ I cannot do my usual work.
④ I can hardly do any work at all.
⑤ I cannot do any work at all.

Personal Care

⓪ I can look after myself normally without causing extra pain.
① I can look after myself normally but it causes extra pain.
② It is painful to look after myself and I am slow and careful.
③ I need some help but I manage most of my personal care.
④ I need help every day in most aspects of self care.
⑤ I do not get dressed, I wash with difficulty and stay in bed.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
④ I can only lift very light weights.
⑤ I cannot lift or carry anything at all.

Driving

⓪ I can drive my car without any neck pain.
① I can drive my car as long as I want with slight neck pain.
② I can drive my car as long as I want with moderate neck pain.
③ I cannot drive my car as long as I want because of moderate neck pain.
④ I can hardly drive at all because of severe neck pain.
⑤ I cannot drive my car at all because of neck pain.

Recreation

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

Headaches

⓪ I have no headaches at all.
① I have slight headaches which come infrequently.
② I have moderate headaches which come infrequently.
③ I have moderate headaches which come frequently.
④ I have severe headaches which come frequently.
⑤ I have headaches almost all the time.

~~Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100~~

Neck Index Score _____