

Today's Date: ____/____/____



PATIENT & HEALTH INFORMATION

WELCOME: The doctors and staff welcome you and want to provide you with the best care possible. We will conduct a thorough history and physical examination to decide if we can assist you with your care. If we do not believe that your condition will respond to our treatments, we will refer you to the appropriate healthcare provider. If you are a candidate for our treatments, a customized plan will be recommended to fit your individual needs.

INSTRUCTIONS: Please complete the following questions to the best of your ability. Be as descriptive as possible and check all descriptors that apply. If you have questions, please ask a staff member for assistance or clarification.

First Name: _____

Middle Name: _____

Last Name: _____

Birth Date: ____/____/____ Gender: _____

Address: _____

City: _____

State: _____ Zip Code: _____

Primary Phone: _____

Work Cell Home

Secondary Phone: _____

Work Cell Home

Email: _____

Employment Status: _____

Business Name: _____

Business Phone number: _____

Business Address: _____

City: _____ State: _____ Zip Code: _____

Occupation/ Title: _____

Type of Work: _____

Is it OK to contact you at work? Yes No

EMERGENCY CONTACT INFORMATION

First Name: _____

Last Name: _____

Phone Number: _____

Relationship: _____

Address: _____

City: _____

State: _____ Zip Code: _____

HEALTH INSURANCE INFORMATION

Who, besides yourself is responsible for your bill? _____

Current Insurance Company: _____

Insurance Phone Number: _____

Insurance Policy Number: _____

Policy Subscriber Name: _____ Policy Subscriber Birthday: ____/____/____

WHAT IS THE REASON FOR YOUR VISIT?

When did your symptoms appear? _____

Is this condition getting? Better Worse No Change

Please check the types of pain that apply to you: Sharp Dull Throbbing Numbness Aching
 Shooting Burning Tingling Cramps Stiffness Swelling Other _____

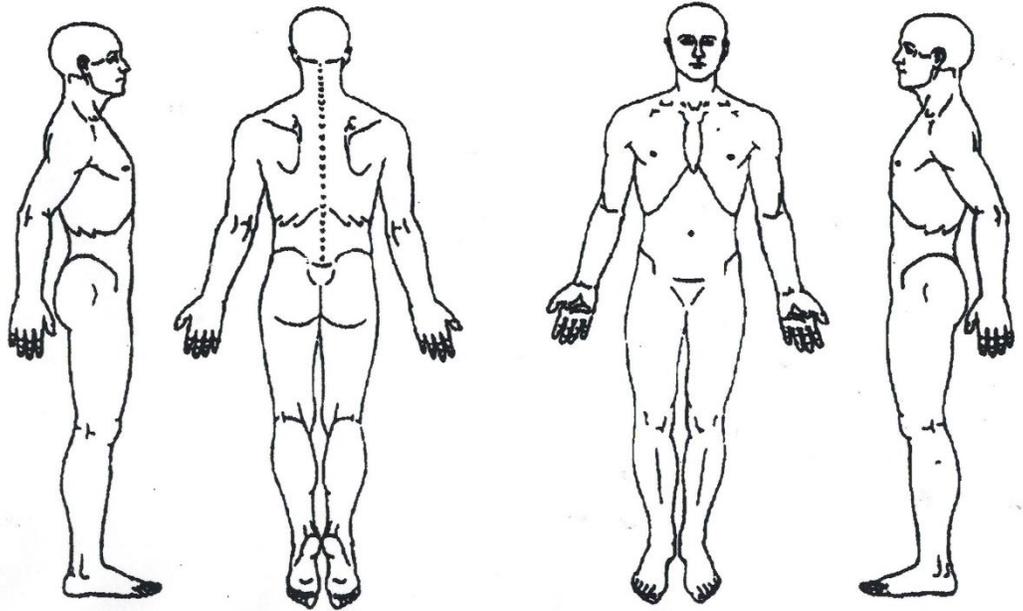
Is the pain: Consistent Come and go

Does it interfere with you? Work Sleep Daily Routine Recreation Other _____

Please check the following movements or activities that are painful for you to perform:

Sitting Standing Walking Bending Lying Down Other _____

Circle the area(s) of complaint(s) and grade the intensity of pain in each area using 0-10 scale, with 10 being the highest level of pain.



Is the condition due to an accident? Yes No

If yes, what type of accident Auto Work Home Other _____

ACCEPTANCE AS A PATIENT

I understand and agree that South West Health Professional Center (SWH) has the right to (1) accept or refuse me as a patient at any time before treatment begins, (2) terminate my care as a patient if in the course of treatment, I choose to not follow the treatment plan for my condition, or (3) be referred out to another health provider as the doctors deem medically necessary. I understand that the taking of a history and the conducting of a physical examination are not considered treatment, but are part of the process of gathering information so that the doctors can determine whether to accept me as a patient.

HEALTH HISTORY

This section will identify key factors and indicators about your history that may impact or contribute to your current health condition. Please give us information on those that apply to you.

- Please list any medications or nutritional supplements that you are currently taking
- Please list doctors or providers that you have seen for this condition or for any conditions that you may be currently treating with and the type of treatments provided
- Surgeries (Please list all surgical procedures that you have had in the past)
- Childhood Illnesses (Please list any illnesses that you have had as a child)
- Adult Illnesses (Please list any illnesses that you have had as an adult)
- Family History (Please list any genetic illnesses in your family)
- Injuries (Please list any significant injuries, falls, trauma, or accidents that you have had in the past)
- Non-Drug Allergies and how you react to those substances

Do you have, or have you ever had any of the following health problems? (Check all that apply)

- | | | |
|--|--|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> Sports Injuries |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Digestion Problems | <input type="checkbox"/> Auto Accidents |
| <input type="checkbox"/> Trouble Breathing | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Other Accidents/Falls |
| <input type="checkbox"/> Tiredness/Fatigue | <input type="checkbox"/> Liver/Gall Bladder Problems | <input type="checkbox"/> Work Injuries |
| <input type="checkbox"/> Frequent Colds/Flus | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Unable to Work |
| <input type="checkbox"/> Sinus Infections | <input type="checkbox"/> Constipation | <input type="checkbox"/> Painful Joints |
| <input type="checkbox"/> Headaches/ Migraine | <input type="checkbox"/> Pain with stools | <input type="checkbox"/> Fractured Bones |
| <input type="checkbox"/> Concussion | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Sore Muscles |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Bladder Problems | <input type="checkbox"/> Shoulder Pain/Stiffness |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Incontinence | <input type="checkbox"/> Elbow Pain/Stiffness |
| <input type="checkbox"/> Difficulty Concentrating | <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Wrist/Hand Pain or Stiffness |
| <input type="checkbox"/> Memory Loss/Forgetful | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Hip Pain or Stiffness |
| <input type="checkbox"/> Vision/Eye Problems | <input type="checkbox"/> Impotence (ED) | <input type="checkbox"/> Knee Pain or Stiffness |
| <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Menstrual Problems (PMS) | <input type="checkbox"/> Ankle/Foot Pain or Stiffness |
| <input type="checkbox"/> Ear Problems | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Neck Pain/Stiffness |
| <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Depression | <input type="checkbox"/> Numbness/Tingling Arm(s) |
| <input type="checkbox"/> High / Low Blood Pressure | <input type="checkbox"/> Emotional Disorders | <input type="checkbox"/> Upper Back Pain or Stiffness |
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Irritability | <input type="checkbox"/> Mid Back Pain or Stiffness |
| <input type="checkbox"/> Circulation Problems | <input type="checkbox"/> Mood Disorders | <input type="checkbox"/> Low Back Pain or Stiffness |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Pain shooting down leg(s) |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Stress | <input type="checkbox"/> Trouble Walking |
| <input type="checkbox"/> Poor Diet | <input type="checkbox"/> Excessive Sweating | <input type="checkbox"/> Pain w/coughing |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Achiness / General Pain | <input type="checkbox"/> Pain w/sneezing |

INFORMED CONSENT DOCUMENT

PATIENT NAME: _____

Read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

One of the treatments that we may employ at South West Health Professional Center is spinal and or extremity manipulative therapy. Other treatments include, acupuncture with or without electric stimulation, instrument assisted soft tissue techniques, myofascial release, sports taping techniques, spinal decompression, massage therapy, electrical modalities, ice and moist heat, cupping, gua-sha, tui-na (Chinese manipulative therapy), infrared light, moxibustion, strength and conditioning exercises, activity advice ,Chinese herbal supplements and nutritional counseling.

Risks:

Chiropractic and acupuncture care are generally safe methods of treatment for certain conditions. As with any healthcare procedure, there are certain complications which may arise during sports chiropractic manipulative therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations. 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.

Acupuncture may have some side effects including bruising, numbness, dizziness, and fainting. Unusual risks of acupuncture include infection and organ puncture. This facility utilizes sterile, disposable needles and maintains a clean and safe environment with a 0.0% incidence rate for both unusual risks. Burns and scarring are potential risks of moxibustion, infrared light and cupping. Petechiae (clusters of small red or purple spots) are an expected response to cupping and gua-sha.

We will make every reasonable effort during the examination to screen for contraindications to manipulative therapy and acupuncture to ensure that you are a candidate for treatment; however, if you have a condition that would otherwise not come to our attention, it is your responsibility to inform us.

The probability of those risks occurring.

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. Strokes have been the subject of tremendous disagreement. The incidences of strokes are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options.

Other treatment options for your condition may include:

- Self-administered, over-the-counter (OTC) analgesics and rest
- Medical care and prescription drugs such as NSAIDS, 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.

The risks and dangers attendant to remaining untreated.

Remaining untreated may allow the formation of adhesions and reduce 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.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.
PLEASE THEN, SIGN BELOW.

I have read or have had read to me the above explanation of the sports chiropractic adjustment, acupuncture and related treatment. I have discussed it with my attending sports chiropractor and acupuncturist and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated: _____

Patient's Name (print): _____

Patient's Signature: _____

Doctor's Name (print): _____

Doctor's Signature: _____

Signature of Parent or Guardian (if a minor): _____

South West Health Spine & Sport Financial Agreement

At South West Health Spine & Sport, we want you to fully understand what your financial requirements are. If you have any questions about your account, please ask to speak to our billing department.

As a courtesy, we will bill your PPO insurance company for your healthcare services. We are currently contracted with Blue Shield of California until December 31st, 2019 and are out-of-network with all other insurances. There's a possibility that you have out of network benefits to cover the service. Please contact our billing department for details. We ARE NOT contracted with Medicare. We DO NOT bill for massage therapy as insurance carriers do not reimburse for those codes any longer.

If we are not included in your insurance coverage, cannot verify coverage, or you do not have insurance, payment in full is expected at the time of service. We offer a time of service discount off of our regular fees. Please inquire with the front desk for details. For your convenience we accept all credit cards, HSA debit cards, personal checks and cash. If you have a financial hardship, special arrangements for a payment plan may be made with our billing department. We do require a payment each month on your account until the balance is paid.

We collect co-payment and any deductible due at the time of visit. If your insurance company denies payment for a service, we will bill you for the balance due. Any amount not paid by your insurance company within 30 days may be billed to you for payment.

For patients involved in a third-party auto accident claim in which there is no med-pay policy or health insurance, payment in full is expected at the time of service or you have the option of retaining a personal injury attorney that we approve of.

Our staff reviews and updates insurance information on a regular basis as insurance plans and benefits change often and we want to make sure that your coverage information is accurate.

Cancellation Policy:

At South West Health Spine & Sport, we take your time very seriously in that we schedule appointments with the expectation that you will be seen by the doctor at your scheduled appointment time. We request you be present for your appointment on a timely basis. In the event that we do not receive **24 hours notice** of your intent to change your appointment time, a cancellation fee will be imposed as follows. Please note, Monday appointments require 48 hours cancellation notice as our office is closed on Sundays. **I am aware there is a fee of \$50.00 for missed or late cancelled chiropractic or acupuncture appointments and a fee of \$30.00 per 1/2 hour for late cancellations or missed massage appointments.**

I, _____, have read and understand the South West Health Spine & Sport Financial Agreement. I understand that I am ultimately responsible for all charges to my account.

Patient Signature: _____ Date: _____