SPINE, SPORT AND INJURY THERAPY CENTER
CONFIDENTIAL HISTORY FORM

NAME

DATE OF BIRTH

PHONE

EMAIL

ADDRESS

CITY

STATE

ZIP

M

F

OCCUPATION

MARITAL STATUS:

SINGLE

MARRIED

HOW DID YOU HEAR ABOUT OUR OFFICE?

FAMILY MEDICAL DOCTOR

PREVIOUS CHIROPRACTOR

EMERGENCY CONTACT NAME

PHONE

RELATIONSHIP

DESCRIBE WHAT YOU WOULD LIKE HELP WITH? (PLEASE LIST ALL)

WHEN AND HOW DID IT BEGIN?

ANY CONDITIONS THAT YOU ARE CURRENTLY SUFFERING FROM OR HAVE SUFFERED FROM?
(*DIABETES, ARTHRITIS, HYPERTENSION, CANCER, ETC.*)

MEDICATIONS / SUPPLEMENTS

SURGERIES / MEDICAL PROCEDURES / TRAUMAS

HEALTH PROFESSIONALS ALREADY CONSULTED FOR YOUR CURRENT PROBLEM

WHAT WAS DONE?

DID THEY HELP?

HAVE YOU HAD A PREVIOUS DIAGNOSIS? YES / NO - WHAT WAS IT?

SPINE, SPORT AND INJURY THERAPY CENTER
CONFIDENTIAL HISTORY FORM

ARE YOUR PROBLEMS: ◯ 1. GETTING WORSE? ◯ 2. GETTING BETTER? ◯ 3. STAYING THE SAME?

WHAT MAKES IT WORSE?

WHAT MAKES IT BETTER?

PLEASE SELECT THE NUMBER THAT BEST DESCRIBES HOW YOU FEEL TODAY:

◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10

NO PAIN *MODERATE PAIN* *WORST PAIN*

WHAT NUMBER WOULD DESCRIBE HOW YOU FELT A WEEK AGO? _____ A MONTH AGO?

TODAY'S FUNCTION RATING: *(ABILITY TO SHOP, COOK, CLEAN, WALK, CLIMB STAIRS, DRIVE, WORK, PLAY, SOCIALIZE)*

◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10

FULLY ACTIVE *MODERATE* *LIMITED FUNCTION* *FALL IMPAIRMENT*

WHAT ACTIVITIES DOES THIS PROBLEM PREVENT YOU FROM DOING, EITHER PARTIALLY OR TOTALLY THAT YOU WOULD LIKE TO BE ABLE TO DO AGAIN?

IF YOUR PROBLEM(S) DON'T IMPROVE, WHAT DO YOU SEE HAPPENING IN THE FUTURE?

ON A SCALE OF 1 TO 10, 10 BEING THE HIGHEST, HOW COMMITTED ARE YOU TO GETTING THIS PROBLEM CORRECTED WITHOUT THE USE OF DRUGS OR SURGERY?

PLEASE TELL US ANYTHING ELSE YOU WOULD LIKE US TO KNOW ABOUT YOUR HEALTH OR THE PROBLEMS YOU WANT HELP WITH:

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE. I UNDERSTAND THAT I AM LIABLE FOR ALL CHARGES FOR SERVICES RENDERED AND I AGREE TO NOTIFY DR. MARK SCHMALL OF ANY CHANGES OF MY HEALTH CONDITION IN THE FUTURE:

SIGNATURE: DATE:

SPINE, SPORT AND INJURY THERAPY CENTER
CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

NAME

DATE OF BIRTH

ADDRESS

PHONE

DEPENDENT CHILDREN

SECTION B: TO THE PATIENT - PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: by signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Spine, Sport and Injury Therapy Center, (563)484-7806, spineportinjury@gmail.com

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the contact person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue to treat you if you revoke this Consent.

SECTION C: SIGNATURE

I have had full opportunity to read and consider the contents of this Consent form and Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

SIGNATURE:

DATE:

IF THIS CONSENT IS SIGNED BY A PERSON REPRESENTATIVE ON BEHALF OF THE PATIENT, COMPLETE THE FOLLOWING:

PERSONAL REPRESENTATIVE'S NAME:

RELATIONSHIP TO PATIENT:

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT

SPINE, SPORT AND INJURY THERAPY CENTER
CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

CONSENT & DISCLOSURES

Consent to Treat
I consent to and authorize the practitioners of Spine, Sport and Injury Therapy Center to furnish me and/or my dependents with necessary healthcare. This healthcare may include laboratory testing and other diagnostic procedures as required.

Request of Medical Information
I consent to and authorize the practitioners of Spine, Sport and Injury Therapy Center to disclose all or part of my, and/or my dependents medical records to any mutually agreed upon referral physician.

Insurance Authorization and Assignment of Benefits
I consent to and authorize the practitioners of Spine, Sport and Injury Therapy Center to furnish medical information to any third party who may be responsible for payment of all or part of my charges incurred with the practitioners of Spine, Sport and Injury Therapy Center.

I authorize my insurance company or any responsible third party to pay benefits directly to Spine, Sport and Injury Therapy Center.

Financial Responsibility
I understand that I am financially responsible for the payment of medical charges incurred on my behalf with the practitioners of Spine, Sport and Injury Therapy Center regardless of third party coverage.

I have read and understand all of the above listed contents and disclosures.

SIGNATURE: DATE:

PATIENT'S PRINTED NAME

OFFICE USE

FUNCTIONAL RATING INDEX
FOR USE WITH NECK AND/OR BACK PROBLEMS ONLY

In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities. For each item below, please select the number that most closely describes your condition right now.

1. PAIN INTENSITY

☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
NO PAIN	*MILD PAIN*	*MODERATE PAIN*	*SEVERE PAIN*	*WORST POSSIBLE PAIN*

2. SLEEPING

☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
PERFECT SLEEP	*MILDLY DISTURBED SLEEP*	*MODERATELY DISTURBED SLEEP*	*GREATLY DISTURBED SLEEP*	*TOTALLY DISTURBED SLEEP*

3. PERSONAL CARE (WASHING, DRESSING, ETC.)

☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
NO PAIN, NO RESTRICTIONS	*MILD PAIN, NO RESTRICTIONS*	*MODERATE PAIN, NEED TO GO SLOWLY*	*MODERATE PAIN, NEED SOME ASSISTANCE*	*SEVERE PAIN, NEED 100% ASSISTANCE*

4. TRAVEL (DRIVING, ETC.)

☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
NO PAIN ON LONG TRIPS	*MILD PAIN ON LONG TRIPS*	*MODERATE PAIN ON LONG TRIPS*	*MODERATE PAIN ON SHORT TRIPS*	*SEVERE PAIN ON SHORT TRIPS*

5. WORK

☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
CAN DO USUAL WORK PLUS UNLIMITED EXTRA WORK	*CAN DO USUAL WORK; NO EXTRA WORK*	*CAN DO 50% OF USUAL WORK*	*CAN DO 25% OF USUAL WORK*	*CANNOT WORK*

6. RECREATION

☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
CAN DO ALL ACTIVITIES	*CAN DO MOST ACTIVITIES*	*CAN DO SOME ACTIVITIES*	*CAN DO A FEW ACTIVITIES*	*CANNOT DO ANY ACTIVITIES*

7. FREQUENCY OF PAIN

☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
NO PAIN	*OCCASIONAL PAIN; 25% OF THE DAY*	*INTERMITTENT PAIN; 50% OF THE DAY*	*FREQUENT PAIN; 75% OF THE DAY*	*CONSTANT PAIN; 100% OF THE DAY*

8. LIFTING

☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
NO PAIN WITH HEAVY LIFTING	*INCREASED PAIN WITH HEAVY WEIGHT*	*INCREASED PAIN WITH MODERATE WEIGHT*	*INCREASED PAIN WITH LIGHT WEIGHT*	*INCREASED PAIN WITH ANY WEIGHT*

9. WALKING

☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
NO PAIN; ANY DISTANCE	*INCREASED PAIN AFTER 1 MILE*	*INCREASED PAIN AFTER 1/2 MILE*	*INCREASED PAIN AFTER 1/4 MILE*	*INCREASED PAIN WITH ALL WALKING*

10. STANDING

☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
NO PAIN AFTER SEVERAL HOURS	*INCREASED PAIN AFTER SEVERAL HOURS*	*INCREASED PAIN AFTER 1 HOUR*	*INCREASED PAIN AFTER 1/2 HOUR*	*INCREASED PAIN WITH ANY STANDING*

NAME PRINTED:	SIGNATURE:	DATE:	TOTAL SCORE: