NEW PATIENT INTAKE FORMS

Date:_____

Patient Name:_____ **Age:**_____ **DOB:**_____

Address:_____**City:**_____**State:**_____ **Zip:**_____

Email Address:_____**Home Ph.#:**_____

Cell Phone#:_____**Subscribe to Email list for announcements/info? (Yes / No)**

Occupation:_____**Employer:**_____**Full /Part Time?:**_____

Name of Spouse:_____**Spouse's Occupation:**_____**Employer:**_____

How many children (optional)?_____

EMERGENCY CONTACT:_____**Relationship:**_____**Ph #:**_____

Family Medical Doctor:_____**Office Ph.#:**_____

When doctors work together, you receive the best care. Do we have your permission to contact your medical physician, if necessary, regarding your care at this office? (circle one) YES NO

How did you hear about us? (circle one):

Patient Google Search Yelp Facebook Twitter Website High School Other (please specify)

Whom may we thank for referring you to our office?:_____

PATIENT INITIALS:_____**DATE:**_____

Foundation Sport & Spine
415 W Golf Road, Suite 12, Arlington Heights, IL 60005. Ph. (847) 342-3000 Fax: (847) 342-3495

Foundation Sport & Spine
Patient History Form (1 of 2)

History of Present Illness:

Chief Complaint/Purpose of this appointment:_____

Date symptoms appeared or accident occurred:_____ **Due to (circle):** Sport Work Auto Other

Briefly Describe: _____

Have you ever had the same or similar condition?:_____ **If yes, when?:**_____

Please Describe:_____

Date of Last Physical Exam:_____ **Days of Work/Sport missed:**_____

Have you seen other Physicians/Therapists? for this condition?_____

Past Medical History:

Please check if you now, or ever, have experienced the following (H-history of, P-presently having)

Constitutional:
____Cancer
____Allergies
____Fever or Chills
____ Weight Loss or Gain
____Night Sweats
____Fatigue
____Insomnia or sleep changes
____Other:_____

Cardiovascular:
____Heart Disease
____High Cholesterol/Triglycerides
____High/Low Blood Pressure
____Stroke
____Rheumatic Fever
____Chest Pain
____Irregular/Rapid Heartbeat
____Fainting/Lightheadedness
____Ankle Swelling
____Varicose Veins
____Other:_____

Pulmonary:
____Asthma
____COPD
____Tuberculosis (TB)
____Pneumonia
____Difficulty Breathing
____Shortness of Breath
____Wheezing
____Chronic Cough/Phlegm
____Coughing up blood
____Other:_____

Endocrine:
____Diabetes I / II (circle one)
____Thyroid Disease
____Heat or Cold Intolerance
____Increased Thirst
____ Other:_____

Gastrointestinal:
____Appendicitis
____Jaundice/Hepatitis/Cirrhosis
____Ulcers
____Gallbladder Disease
____Colon Polyps
____Hemorrhoids
____Poor Appetite
____Abdominal Pain
____Black or bloody stool
____Frequent bloating or gas
____Frequent nausea or vomiting
____Frequent diarrhea or constipation____Incontinence
____Difficult Swallowing
____Other:_____

Neurological/Psychological:
____Epilepsy/Seizures
____Headaches
____Weakness
____Numbness/tingling
____Dizziness
____Arm/Leg Pain
____Tremor or twitching
____Depression/Anxiety
____Other:_____

Musculoskeletal:
____Fracture/Dislocation
____Sprain/Strain
____Arthritis
____Scoliosis/Spinal curve
____Neck Pain
____Upper back pain
____Low back pain
____Swollen/Painful Joint(s)
____TMJ/TM Joint pain
____Other:_____

Genitourinary
____Urinary Infection
____Kidney stones/disease
____Sexual difficulties
____Frequent urination
____Painful urination
____Bloody/discolored urine
____STD/STI
____Other:_____

Eye, Ear, Nose, Throat:
____Glaucoma
____Poor Vision
____Pain in eye
____Deafness
____Sinusitis
____Dental Problems
____Hoarseness
____Nosebleeds
____Other:_____

PATIENT INITIALS:_____**DATE:**_____

Foundation Sport & Spine
Patient History Form (2 of 2)

Past Medical History (continued):

Please check if you now, or ever, have experienced the following (H-history of, P-presently having)

Blood/Lymph:
____Anemia
____Bleeding Disorder
____Enlarged/Swollen lymph nodes
____Other:_____

Skin:
____Changing mole/skin tag
____Concern about skin lesion
____Itching or rash
____Pressure ulcers
____Fungal infection
____Other:_____

Childhood Diseases:
____Measles
____Mumps
____Chicken Pox
____Rheumatic Fever
____Other

Male Specific:
____Prostate Disease
____Testicular Pain or swelling
____Impotence/Erectile Dysfunction
____Difficulty Urinating
____Urgency
____Weak/abnormal stream
____Other:_____

Female Specific:
Date last normal menstrual period began:
_____
____Live Births
____C-Sections?
____Tearing/Episiotomy?
____Painful periods
____Irregular or heavy periods
____Breast Pain/palpable lump
____Hot flashes
____Other:_____

FAMILY HISTORY:
____Cancer
If yes, type and whom?
_____
____Stroke
____High blood pressure
____Heart disease
____Diabetes I / II (circle)
____Thyroid Disease
____Kidney Disease
____Neurological Disease
____Psychiatric Disease
____Other:_____

SCAR HISTORY:_____

_____

_____

Please list any history of trauma, injuries, major illnesses, intubation, auto accidents or surgeries:

_____

Have you been treated by a physician in the past year? If yes, for what?_____

_____

Have you ever been treated by a chiropractor? (list experience)_____

_____

What medications are you currently taking?_____

_____

What vitamins/supplements are you currently taking?_____

_____

Do you have any allergies?_____

Social History:

Do you drink alcoholic beverages?_____If so, how many per week?_____

Do you/did you use smoke or tobacco products?_____If so, how much?_____

Do you exercise? Please describe:_____

Describe your dietary habits:_____

PATIENT INITIALS:_____**DATE:**_____

Foundation Sport & Spine
Chiropractic Informed Consent Form (1 of 2)

Chiropractic Care: The practice of chiropractic medicine utilizes many standard examination and testing procedures that are common among the medical field, such as physical examination, orthopedic, neurological testing, palpation, soft tissue correction, and rehabilitative procedures. What sets chiropractic healthcare apart is that it seeks to restore health through natural means without the use of medicine or surgery. Chiropractic care seeks to remove offensive stresses (subluxations) to the nervous system and thereby allow the body to use its own inherent recuperative powers to heal itself.

The goal of the chiropractic care in our clinic is to find and address the offending tissues or any functional articular lesion (sometimes known as a vertebral subluxation). As those are corrected, we then seek to find the faulty muscle and movement patterns, help the body reprogram and reinforce proper movement patterns, and then to add stability, strength, and power to the whole system. Overall, the success of this process of healing and re-injury prevention depends on the patient's environment, underlying causes, physical, and spinal condition. Because of this complexity, no doctor can promise specific results within a given time frame.

Diagnosis: Doctors of Chiropractic medicine are highly trained in diagnosis in general, and chiropractic diagnosis in particular. However, they are not internal medicine specialists. Every patient should be aware and mindful of his or her own symptoms, and should seek out other opinions if he or she has any concern as to the nature of his or her total condition. You should always let your chiropractor know of these concerns also, so they may express an opinion as to whether or not you should seek out other medical care, and may even be able to recommend and refer you to another physician/specialist. Still, it is your responsibility to make the final decision.

Treatment/Therapy: The primary therapy used in chiropractic treatment will likely be spinal manipulative therapy or adjustments. Adjustments are usually performed by hand, but are sometimes performed using hand-guided instruments. A chiropractic adjustment is a quick, short, and precise movement applied to a specific point of contact on a joint to create motion where it is lacking, thereby addressing and correcting the osteo-ligamentous portion of the VSC, and restoring proper joint function. The adjustment may or may not create an audible "pop" or "click," similar to the sensation experienced when you "crack" your knuckles. You will also likely experience a sense of movement, relief, or a "weight coming off" in the area(s) adjusted. It will rock your world.

Probability and Nature of Inherent Risks of Chiropractic Adjustment and Treatment: As with any health care procedure, there are certain complications that may arise during chiropractic manipulative therapy. Chiropractic adjustments are usually beneficial and rarely cause a problem. Complications, though rare, include but are not limited to fractures, disc injuries, dislocations, cervical cord compression (myelopathy), or separations. Occasionally, after manipulation and therapy, you may experience muscle strain, new or increased radicular tingling, numbness or pain. It is not uncommon for you to experience soreness or stiffness following the first few days of treatment.
Some types of manipulation to the neck (cervical spine adjusting) have been associated with injuries to arteries in the neck, or other causes leading or contributing to rare but serious complications including stroke, paralysis, or neurological dysfunction.

The relationship between cervical manipulation and strokes is the subject of tremendous disagreement among the medical community. However, the incidence of strokes is extremely rare, and it is estimated that they occur between one in one million and one in five million cervical adjustments. Some types of manipulation to the low back (lumbar spine adjusting) have been associated with injuries to the distal end of the spinal cord, or other causes leading or contributing to a rare but serious complication that if not addressed as a surgical emergency, could lead to prolonged or permanent loss of bowel and bladder function, and a saddle-like numbness/tingling/pain. It is your responsibility to report any of these rare symptoms to your chiropractic physician immediately, so that immediate action may be taken to prevent long-term complications.

Availability and Nature of Other Treatment Options: Other treatments for your condition may include self-administered, over-the-counter analgesics and rest; medical care and prescription drugs (such as muscle relaxers and anti-inflammatory/pain-killers), hospitalization, and/or surgery. If you choose any of the other treatment options for your condition, you should be aware that there are risks and benefits of such options and you should discuss those with your primary medical physician, should you pursue any of those treatment methods.

Risks and Dangers of Remaining Untreated: If you choose to remain untreated, that decision may result in persistent pain, increasing pain, increased loss of function, formation of further adhesions in joints, between muscles and muscles, between nerves and muscles, or even organ dysfunction to which said nerves communicate with. The sum of any or all of these potential results of remaining untreated may contribute to a pain reaction, which may further reduce your mobility and may cause a worsening of your condition. Additionally, if you decide to remain untreated, this may complicate or make future treatment difficult and less effective, the longer treatment is postponed.

DO NOT SIGN BELOW UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE STATEMENTS.
PLEASE CHECK THE APPROPRIATE BOX AND SIGN BELOW.

I have read [ ] or have had read to me [ ] the above explanation of chiropractic adjustments and the related treatments. I have discussed options, goals, and risks of various treatment options, and alternative treatment options with Dr. Porcher, and have had my questions answered to my satisfaction. By signing below I state that it is in my best interest to undergo the treatment recommended. I have been informed of the benefits, risks, and alternatives, and I hereby give my consent to chiropractic treatment.

Patient's Name (please print)	**Doctor's Name**
Patient's Signature	**Doctor's Signature**
Signature of Parent/Guardian (if patient is under 18 years of age)	**Date**
Date	

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Foundation Sport & Spine
Consent for Purposes of HIPAA (privacy and your personal information)

I,_____ (print name) consent to Foundation Sport & Spine, Ltd.'s ("the Practice's") use and disclosure of my Protected Health Information for the purpose of providing treatment to me, for purposes relating to the payment of services rendered to me, and for the Practice's general healthcare operations purposes. Healthcare operations purposes shall include, but are not limited to, quality assessment activities, credentialing, business management and other general operation activities. I understand that the Practice's diagnosis or treatment of me may be conditioned upon my consent as evidenced by my signature on this document.

For purposes of this Consent, "Protected Health Information" means any information, including my demographic information, created or received by the Practice, that relates to my past, present, or future physical or mental health or condition; the provision of health care to me; or the past, present, or future payment for the provision of health care services to me; and that either identifies me or from which there is a reasonable basis to believe the information can be used to identify me.

I understand that I have the right to request a restriction on the use and the disclosure of my Protected Health Information for the purposes of treatment, payment, or healthcare operations of the Practice, but the Practice is not required to agree to these restrictions. However, if the Practice agrees to a restriction that I request, the restriction is binding on the Practice.

I understand that I have a right to review the Practice's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes my rights and the Practice's duties regarding the types of uses and disclosures of my Protected Health Information.

I have the right to revoke this consent, in writing, at any time, except to the extent that the Physician or the Practice has acted in reliance on this consent.

_____	_____
Signature of Patient/Personal Representative	Date
_____	_____
Name of Patient/Personal Representative	Description of Personal Rep.'s Authority

Patient or Responsible Party Name:

Name of Health Plan or Insurance Company:

Insurance ID:

NOTICE OF NON - COVERAGE UNDER PRIVATE INSURANCE OR HEALTH PLAN

NOTE: If your private insurance carrier or health plan doesn't pay for services rendered, **you are responsible to pay.** Your private insurance carrier or health plan does not pay for everything, even some care that you and/or your health care provider have good reason to think you need. Your carrier or plan does not pay for care that is determined to be "medically unnecessary" or "experimental and/or investigational," even if you and your health care provider deem care to be necessary and its effectiveness substantiated.

To the best of our information (including information that may have been provided by your insurance carrier or health plan if applicable), we expect and believe your private insurance carrier or health plan may not pay for the: P**roprioceptive Deep Tendon Reflex/ Neurokinetic Therapy (neurological correction) $35**

Active Release Techniques/ Soft tissue release therapy (muscle correction) $30
Therapeutic exercises (active rehab therapy) $30
Examinations/ Reexaminations: New patients $90-$125 Existing Patients $45-$55

The date or dates of the procedure(s) is/are: **TBD**
The expected cost of the procedure(s) is/ are: **Listed above per 10 minutes, approximately (except in the case of examinations, which are based on time and complexity of clinical decision making.)**

WHAT IS NEEDED FROM YOU:

- Read this notice so you can make an informed decision about your care.
- Ask any questions that you may have after you finish reading.
- Choose an option below about whether to receive the procedure(s) listed above.

_____ **OPTION 1:** I want the procedure(s) listed above. You (health care provider) may ask to be paid now, but I also want my private insurance carrier or health plan to be billed for an official decision on payment, which is sent to me on an explanation of benefits. **I understand that if my private insurance or health plan does not pay, I am responsible for payment.** I can appeal to my private insurance carrier or health plan by following the directions on the explanation of benefits. If the insurance company does pay, you (health care provider) will refund any payments I made to you, less co-pays, coinsurance or deductibles.

_____ **OPTION 2:** I want the procedure(s) listed above, but do not bill my private insurance carrier or health plan. Your health care provider may ask to be paid now, because I am responsible for payment. I cannot appeal if my private insurance carrier or health plan is not billed.

_____ **OPTION 3:** I do not want the procedure(s) listed above. I understand with this choice I am not responsible for payment and I cannot appeal to see if my private insurance carrier or health plan would pay.

Signing below now means that I have received and understood this notice prior to the services being rendered. My health care provider will receive and retain a copy of this notice.

_____ _____ _____

Signature of Patient or Authorized Representative/Responsible party | Print Name | Date

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