BACK IN ACTION
physical therapy

PATIENT INTAKE & HEALTH HISTORY

Today's Date

Tell Us About Your Condition

Patient Name	Reason for Visit
Is your condition due to an accident? ☐ *No* ☐ *Work* ☐ *Auto* ☐ *Other (explain)*	When did your symptoms appear?
How did this problem begin (falling, lifting, etc.)?	

Tell Us About the Pain

Rate the severity of your pain on a scale from 0 to 10

☐ *0 - No Pain* ☐ *1* ☐ *2 - Minor Discomfort* ☐ *3* ☐ *4 - Major Discomfort* ☐ *5* ☐ *6 - Slightly Intense* ☐ *7* ☐ *8 - Very Intense* ☐ *9* ☐ *10 - Unbearable*

Is the pain getting worse?	What type(s) of pain are you experiencing?
☐ *Yes* ☐ *No*	☐ *Sharp* ☐ *Dull* ☐ *Throbbing* ☐ *Numbness* ☐ *Aching* ☐ *Shooting* ☐ *Burning* ☐ *Tingling* ☐ *Cramps* ☐ *Swelling* ☐ *Other (explain)*

How often do you experience your symptoms?

☐ *Constant (75-100% of the day)* ☐ *Occasional (25-50% of the day)*
☐ *Frequent (50-75% of the day)* ☐ *Intermittent (0-25% of the day)*

Does it interfere with your...

☐ *Work* ☐ *Sleep* ☐ *Daily Routine* ☐ *Recreation*

What activities are painful to perform? ☐ *Sitting* ☐ *Standing* ☐ *Walking*
☐ *Bending* ☐ *Lying Down* ☐ *Other (explain)*

What aggravates your condition (working, exercizing, etc)?

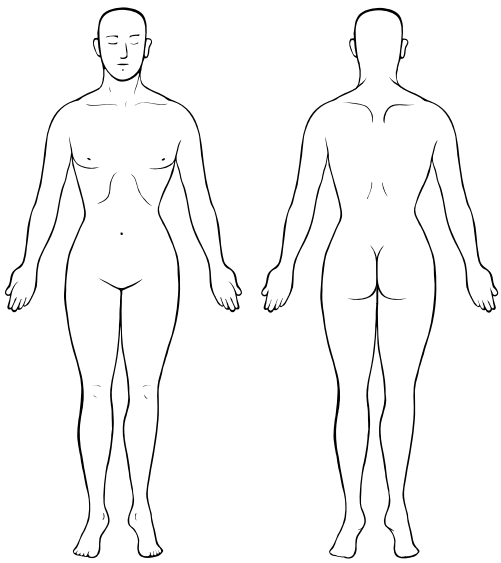
What makes your pain better (ice, heat, massage, etc.)?

What treatments have you already received for your condition?

☐ *None* ☐ *Medication* ☐ *Surgery* ☐ *Physical Therapy*
☐ *Chiropractic* ☐ *Other (explain)*

Please name any other doctors who have treated your condition

*Mark an **X** on this picture where you are having pain, numbness, or tingling.*



Your Health History

WHEN WAS THE DATE OF YOUR LAST...

Physical Exam	Spinal Exam	Blood Test	Urine Test	Spinal X-Ray	MRI or CT Scan

HAVE YOU HAD ANY OF THESE INJURIES OR SURGERIES IN THE LAST 5 YEARS?

Falls	Date
Head Injuries	Date
Broken Bones	Date
Dislocations	Date
Surgeries	Date
Do you have any metal in your body (besides dental fillings)?	

PLEASE REVIEW THE FOLLOWING LIST OF MEDICAL PROBLEMS AND MARK ALL THAT APPLY TO YOU. PLEASE REVIEW CAREFULLY. MEDICAL CONDITIONS THAT DO NOT SEEM RELATED TO YOUR CURRENT SITUATION COULD RESULT IN A SERIOUS COMPLICATION IF YOU DO NOT LET US KNOW.

Cardiovascular / Respiratory

- ☐ *Heart murmur/irregular beat*
- ☐ *Heart pacemaker/defibrillator*
- ☐ *Chest pain/angina w/ exertion*
- ☐ *Heart disease*
- ☐ *Swelling in feet or ankles*
- ☐ *Shortness of breath*
- ☐ *Bleeding disorders*
- ☐ *Blood clots*
- ☐ *High blood pressure*
- ☐ *Asthma*

Constitutional

- ☐ *Recent change in weight*
- ☐ *Fatigue*
- ☐ *Weakness of arm/leg*
- ☐ *Numbness of arm/leg*
- ☐ *Headaches/Migraines*
- ☐ *Loss of consciousness*
- ☐ *Sinus problems*
- ☐ *Hay fever allergies*
- ☐ *Difficulty hearing*
- ☐ *Difficulty swallowing*

Endocrine

- ☐ *Diabetes*
- ☐ *Thyroid conditions*
- ☐ *Goiter*
- ☐ *Steroid use*

Gastrointestinal

- ☐ *Kidney stones*
- ☐ *Kidney disease*
- ☐ *Difficulty with bowel function*
- ☐ *Difficulty with bladder function*

Integumentary/Dermatologic

- ☐ *Skin rash or sores*

Illness / Disease

- ☐ *Chicken pox*
- ☐ *Gout*

Lymphatic

- ☐ *Swollen glands or masses*
- ☐ *Breast lump*
- ☐ *Lymphedema*

Musculoskeletal

- ☐ *Arthritis*
- ☐ *Osteoporosis*
- ☐ *Rheumatoid arthritis*
- ☐ *Herniated disc*
- ☐ *Pinched nerve*

Neurologic

- ☐ *Seizures or convulsions*
- ☐ *Stroke*
- ☐ *Brain aneurysm / hemorrhage*
- ☐ *Multiple sclerosis*
- ☐ *Parkinson's disease*
- ☐ *Muscular dystrophy*

Psychiatric

- ☐ *Depression*
- ☐ *Anxiety or panic attacks*
- ☐ *Psychiatric care*
- ☐ *Suicide attempt*

Other

- ☐ *Alcoholism*
- ☐ *Appendicitis*
- ☐ *Cancer*
- ☐ *Chemical dependency*
- ☐ *Chemotherapy*
- ☐ *Tumor or growth*
- ☐ *Venereal disease*
- ☐ *Other (please explain)*

For Women Only

- ☐ *Currently pregnant*
- ☐ *Irregular menstral cycles*

Date of last menstruation:

For Men Only

- ☐ *Testicular pain*
- ☐ *Prostate condition*

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PATIENT REGISTRATION FORM

Patient Information

First Name	MI	Last Name	Social Security Number

Date of Birth	Age	Gender	Marital Status ☐ *Single* ☐ *Married* ☐ *Widowed* ☐ *Divorced* ☐ *Separated*	Name of Spouse

Primary Phone ☐ *H* ☐ *W* ☐ *C*	Secondary Phone ☐ *H* ☐ *W* ☐ *C*	Email Address

Whom may we thank for referring you?

MAILING ADDRESS

Number and Street or Box Number		
City	State	Zip Code

PHYSICAL ADDRESS ☐ *Same as my mailing address*

Number and Street		
City	State	Zip Code

EMPLOYMENT INFORMATION

Occupation	Employer	Phone Number

EMERGENCY CONTACT

Name	Relationship	Phone Number

Responsible Party ☐ *Self (skip if checked)* ☐ *Parent* ☐ *Legal Guardian*

First Name	MI	Last Name	Social Security Number

Date of Birth	Mailing Address	City	State	Zip Code

Primary Phone ☐ *H* ☐ *W* ☐ *C*	Secondary Phone ☐ *H* ☐ *W* ☐ *C*	Email Address

IF PATIENT IS A MINOR, NAME OF ADULT ACCOMPANYING & AUTHORIZING TREATMENT OF PATIENT

Name	Relationship	Name of Primary Custodial Parent

Are You Elligible for Medicare? ☐ Yes ☐ No

Primary Insurance ☐ None (skip if checked) ☐ Private Insurance ☐ Worker's Comp. ☐ Auto

Name of Insured		Insured's Employer		Injury Date (if applicable)
Insurance Company		Group Number		ID Number
Insured's Date of Birth	Insured's Phone Number	Insured's SSN	Relationship to Patient ☐ Self ☐ Spouse ☐ Parent ☐ Other (explain)	
How much is your deductible?	Is your deductible based upon... ☐ Calendar Year ☐ Fiscal Year (Which Month?)			

Secondary Insurance ☐ None (skip if checked) ☐ Private Insurance ☐ Worker's Comp. ☐ Auto

Name of Insured		Insured's Employer		Injury Date (if applicable)
Insurance Company		Group Number		ID Number
Insured's Date of Birth	Insured's Phone Number	Insured's SSN	Relationship to Patient ☐ Self ☐ Spouse ☐ Parent ☐ Other (explain)	
How much is your deductible?	Is your deductible based upon... ☐ Calendar Year ☐ Fiscal Year (Which Month?)			

Assignment & Release

I acknowledge that the above information is correct and accurate to the best of my knowledge. I hereby assign payment for all medical benefits to which I am entitled from private insurance and any other health plans to: Back In Action Physical Therapy; Spine & Sports Injury Center, LLC. ***I understand that I am financially responsible for all charges whether or not paid by insurance****. I also hereby authorize Back In Action Physical Therapy, Spine & Sports Injury Center, LLC and/or their agents to release all information necessary to process my claims and secure payment from the insurance company(ies) listed above.*

Signature of Patient, Parent, Guardian or Personal Representative	*Date*	*Relationship to Patient*

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FINANCIAL POLICY

Private Insurance

Billing insurance is a courtesy that we provide you, the undersigned Patient, or the undersigned person responsible for consenting on Patient's behalf. We will accept assignment of insurance benefits if you provide our office with all current billing information needed for your insurance(s). Your insurance policy is a contract between you and your insurance company. This office is not a party to that contract. Please be aware that your insurance will not pay for all your healthcare costs, specifically as it relates to treatment in a chiropractic office. It will only cover services that it deems "Medically Necessary" per their specific guidelines. Maintenance/wellness chiropractic care, nutritional supplements, therapeutic modalities used for maintenance beyond your benefit plan visit limitations or services are often excluded from benefit plans.

Please read and initial each paragraph below. *If you choose not to initial or sign this form, it will be your responsibility to bill your insurance and payment will be due, in full, at the time of service.*

1	*I understand it is ultimately my responsibility to know my chiropractic/physical therapy benefits and coverage, as our office is not responsible for verification of benefits.*
2	*I agree and understand that the patient portion is due at the time of service. This includes copay, coinsurance, and deductible.*
3	*I understand that Larson Chiropractic and Back in Action Physical Therapy will make all reasonable attempts to collect unpaid amounts from my insurance carrier(s) within 90 days of billing. After attempts to collect are exhausted, the bill will be my responsibility regardless of where the insurance claim(s) is in process.*

Non-Insured Policy

We offer a Prompt Pay discount for chiropractic adjustments to patients who pay at the time of service. If not paid at the time of service, regular prices will be charged to your account.

Minor Patients

For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved payment plan. We are not a party to divorce details; therefore, the parent or responsible party who accompanies a minor will be responsible for covering all deductibles & copays, regardless of the divorce decree.

Massages – Missed or Late Policy

Due to the scheduling demands of our massage therapists, if you are late by 5 minutes or more, you may need to be rescheduled as well as incur a $35 fee. We require 12-hour notice to cancel a massage appointment or you may incur a $35 charge per half hour scheduled. These charges are not billable to insurance and you will be responsible for them. If you miss more than two massage appointments without notice, we will require prepayment for any future massages.

Returned Checks

A $25 fee will be charged to the patient's account for any checks returned for non-sufficient funds. We reserve the right to change a patient's status to "Pay in full at the time of service" once they have had their check returned for non-sufficient funds.

I have read, understand, and agree to the financial policy of Larson Chiropractic and Back in Action Physical Therapy. I understand that this account it is ultimately my financial responsibility, regardless of whether my insurance pays or not.

Patient Name (Printed) _____ *Relationship to Patient* _____

Signature of Patient or Responsible Party _____ *Date* _____

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Consent to Treatment of a Minor

I hereby authorize licensed healthcare providers and their assistants to administer chiropractic care, physiotherapy, physical therapy and/or rehabilitation as deemed necessary to my: (circle one)

Son ***Daughter*** ***Other (explain)*** _____

Minor's Name	*Contact Phone*
Mother's Name	*Contact Phone*
Father's Name	*Contact Phone*
Legal Guardian	*Contact Phone*

I, as parent or legal guardian, remain financially responsible for any charges incurred, regardless of insurance coverage, or lack thereof. I understand that by signing this Consent to Treat Form, I agree to be the party responsible for payment, unless otherwise granted in writing. This applies even if the minor child is covered under another parent or guardian's insurance, as in the case of divorce/separation.

Dated at _____ , Alaska

on the _____ day of _____ , 20 _____

Signed: _____

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Privacy Policy

Here is a link to our privacy policy.

Acknowledgement of Receipt of Notice of Privacy Practices

The Privacy of your protected information is important to us. We have provided you with a copy of our Notice of Privacy Practices. It describes how your health information will be handled in various situations. Please ask for your own copy, should you wish to retain it for your records.

We ask that you sign this form to acknowledge that you received our Notice of Privacy Practices.

I have received Larson Chiropractic / Back in Action Physical Therapy's Notice of Privacy Practices.

Printed Name	*Relationship to Patient*
Signature of Patient or Responsible Party	*Date*

Clinic Staff Only (if Acknowledgement is not Signed):

Was the patient shown a copy of the Notice of Privacy Practices? ☐ *Yes* ☐ *No*

If you answered "No" above, please explain why the patient did not sign the acknowledgement form, and describe the staff's efforts in trying to obtain their signature.

☐ *Patient Unable to Comprehend*
☐ *Patient Communication Barrier*
☐ *Legal Rep. Not Available*
☐ *Other:*
☐ *Patient left before signature obtained*
☐ *Emergency admission / patient not present*
☐ *Patient bypassed registration / not available*

Completed by:

Staff Member Signature	*Title*	*Date*

Revised 8/31/16