MADISON MEDICAL & SPORTS rehabilitation center

AN INTEGRATIVE MEDICAL SERVICES CO.

HIPAA PROTECTED HEALTH INFORMATION AUTHORIZED ACCESS ONLY
Today's Date:

PATIENT CASE HISTORY

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Patient Name:			**DOB:**
Driver's License #:		**SSN #:**	
Address:			
City:		**State:**	**Zip:**
Home Phone #:	**Cell Phone #:**		**Email:**
Insurance Co :		**Effective Date of Coverage:**	
Insurance ID:			
Sex: ☐ **Male** ☐ **Female**			
Employer:		**Work Phone #:**	**Ext.**
Work Address:		**Years Worked:**	
Spouse's Name:			
Spouse SSN#:		**Spouse's Occupation:**	
Spouse's Employer:		**Spouse's Work #:**	
Spouse's Insurance:		**Spouse's Ins. Phone #:**	
Last Doctor's Name:			
Care Received:			
Results:			

Are your present problems due to an injury? ☐ Yes ☐ No

☐ On the job ☐ Auto Collision ☐ Personal Injury ☐ Other

_____

Has the accident been reported? ☐ Yes ☐ No

☐ Workers' Comp ☐ Auto Carrier ☐ Other

_____

Are you now or have you been disabled/impaired? (Service or work) ☐ Yes ☐ No

When:_____

Have you retained an attorney? ☐ Yes ☐ No

Name & Address:

_____

_____

Allergies:

□ Seasonal (hay fever) □ Latex □ Iodine □ Shellfish □ Bee Stings □ Cats □ Dogs □ Penicillin □ Sulfa

□ Adhesive Tape □ Food - specify:_____

□ Other-specify:_____

Current Medications:

Name of Medication:	Dose:	Frequency:

Current Vitamins/Supplements:

Name:	Dose (if known):	Frequency:

Specialists seen (ex: cardiology, allergist, orthopedic, etc.):

Name:	Specialty:	Phone Number:

Medical Conditions:

□ High Blood Pressure □ High Cholesterol □Heart Disease □ Diabetes □ Thyroid Condition □ Asthma

□ Reflux (GERD) □ Ulcers □ Ulcerative Colitis or Crohn's Disease □ IBS □ Osteoporosis or Osteopenia

□ Arthritis □ Fibromyalgia □ Anxiety □ Depression □ Insomnia □ Low testosterone

□ History of cancer - specify: _____ □ Other - specify: _____

Past Injuries or Hospitalizations (ex. Pneumonia, Asthma attack, Injuries, etc.):

Incident:	Approximate Date:

Past Surgeries:

□ Tonsils/Adenoids □ Appendix □ Hernia □ Gallbladder □ Colon □ C-Section □ Spine Surgery

□ Heart Surgery □ Lung Surgery

□ Orthopedic Surgery (ex. Hip replacement, fractures) specify:_____

□ Plastic surgery: _____

□ Other: _____

Social:

Caffeine intake: □ None □ ___ cups per (day/week/month) *please circle*

Alcohol intake: □ None □ ___ drinks per (day/week/month/year)

Cigarette/Cigar smoking: □ None □ ___ #of packs or cigars per (day/week/month/year)

Recreational Drug Use: □ None □ Other: _____

Marital Status: □ Single □ Engaged □ Married □ Separated □ Divorced □Widowed/er

□ Domestic partnership □ Civil Union

Occupation: _____ Children: Number:_____ Ages: _____

Family History:

Mother: □ Alive □ Deceased

Age:___

□ High Blood Pressure □ High Cholesterol
□ Diabetes □ Thyroid Condition
□ Lung condition:_____
□ Heart Condition: _____
□ Cancer: _____
□ Neurologic (Alzheimer's, Parkinson's, MS, etc.)
□ Other: _____
_____

Father: □ Alive □ Deceased

Age:____

□ High Blood Pressure □ High Cholesterol
□ Diabetes □ Thyroid Condition
□ Lung condition:_____
□ Heart Condition: _____
□ Cancer: _____
□ Neurologic (Alzheimer's, Parkinson's, MS, etc.)
□ Other: _____
_____

Brother(s): □ Alive □ Deceased

Age(s): _____

□ High Blood Pressure □ High Cholesterol
□ Diabetes □ Thyroid Condition
□ Lung condition:_____
□ Heart Condition: _____
□ Neurologic (Alzheimer's, Parkinson's, MS, etc.)
□ Cancer: _____
□ Other: _____
_____

Sister(s): □ Alive □ Deceased

Age(s): _____

□ High Blood Pressure □ High Cholesterol
□ Diabetes □ Thyroid Condition
□ Lung condition:_____
□ Heart Condition: _____
□ Neurologic (Alzheimer's, Parkinson's, MS, etc.)
□ Cancer: _____
□ Other: _____
_____

Extended Family:

(Grandparents, Aunts, Uncles, Cousins, etc.)

□ High Blood Pressure □ High Cholesterol
□ Diabetes □ Thyroid Condition
□ Lung condition:_____
□ Heart Condition: _____
□ Neurologic (Alzheimer's, Parkinson's, MS, etc.)
□ Cancer: _____
□ Other: _____
_____

Routine Screenings/Preventative Care:

When was your last…

	Date:	Result:
Mammogram		
PAP		
Colonoscopy		
Bone Density		
Bloodwork		
Influenza Vaccine		
Tdap Vaccine (Tetanus/Whopping Cough)		
Shingles Vaccine or illness		
Pneumonia		
Other (Hepatitis, Gardasil, etc.)		

Do you have any history of a BCG vaccine or positive PPD? □ Yes □ No

VISION	**Yes**	**No**
Do you wear glasses or contact lenses?		
Have you ever had Lasik (vision correction procedure)		
Do you or have you had cataracts?		
Last Eye Doctor visit?	Date: ___ / ___ / _____	
Do you feel your vision is worsening over the last few months?		
Do you ever experience double vision?		
EARS/HEARING		
Do you have frequent ringing in your ears?		
Are you noticing your hearing has been decreasing over time?		
Do you have trouble hearing with background noise? (ex. At a restaurant)		
Are you experiencing ear pain?		
WELLNESS		
Have you experienced any recent fluctuations in weight?		
If so, how much? _____ lbs. in _____ (months, years)		
At what weight do you feel most comfortable?	_____ lbs.	
Do you have a history of an eating disorder?		
Do you have trouble falling asleep or staying asleep?		
Do you feel exceptionally fatigued during the day?		

What is your typical exercise routine? _____

_____

Do you follow any particular diet? (ex. Atkins, Gluten Free, etc.) _____

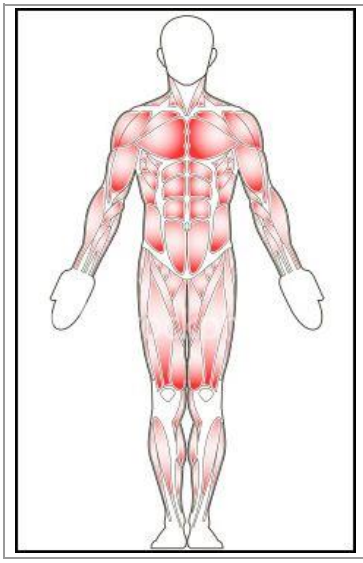
	YES	NO
HEART		
Have you been experiencing any chest pain?		
Do you experience palpitations? (a sensation of heart racing or skipping a beat?)		
Do you have a history of heart murmur?		
Have you ever had an abnormal EKG?		
When was your last Echocardiogram? (Ultrasound of your heart)	Date: ___/___/____	
Result: _____		
When was your last stress test?	Date: ___/___/____	
Result: _____		
LUNGS		
Have you been experiencing a cough?		
Do you ever have shortness of breath?		
Have you ever had a chest x-ray? Date: __/__/__		
Was it normal?		
ABDOMEN		
Do you experience frequent abdominal pain?		
Frequent Constipation?		
Frequent Diarrhea?		
Frequent Reflux?		
Frequent Bloating?		
Excess flatulence or belching?		
Frequent nausea or vomiting?		
Trouble swallowing?		
Blood in the stool?		
Do you have any history of hemorrhoids?		
SKIN		
Do you have any rashes, lesions, or skin conditions you are concerned with?		
Please specify:		

	YES	NO	
URINARY			
Do you experience pain or burning with urination?			
Do you ever notice blood in your urine?			
Do you wake up frequently at night to urinate?			
Do you feel your bladder is not quite empty after urinating?			
Do you experience a weak urinary stream?			
Do you ever leak urine unexpectedly? (ex.coughing, sneezing, exercising)			
Have you ever had a kidney stone?			
Do you have any known issue with your prostate?			N/A
Do you experience inadequate erections?			N/A
Do you have a low libido or desire for sexual relations?			
Would you like to be tested for STDs (Sexually Transmitted Diseases)			
GYNECOLOGICAL *(females only)*			
Last Menstrual Period	Date: ____/____/_____		
Have you ever had an abnormal PAP?			
Are your periods fairly regular?			
Is there any possibility you may be pregnant?			
Do you experience heavy bleeding during periods?			

Are periods exceptionally painful?		
Do you experience bleeding between periods?		
Do you have any abnormal vaginal discharge?		
MUSCULOSKELETAL		
Have you experienced any recent trauma or injury?		
Specify:		
Do you experience back pain?		
Do you experience neck pain?		
Do you have pain in any joint?		
Specify:		
Do you feel that your muscles are abnormally weak?		
Do you experience numbness or a sensation of pins and needles in your limbs frequently?		
Do you wear orthotics?		
What is your shoe size?		
Do you experience pain in your feet when you first get up in the morning?		
Do you experience pain in your feet/legs/arches?		
Do you have a difficulty with balance?		
Do you experience difficulty or pain with walking?		

CHIEF COMPLAINT / REGION OF PAIN		**EXERCISE**
1) _____		☐ Daily
2) _____		☐ Weekly _____ times per week
3) _____		☐ Occasionally ____ times per month
4) _____		Type_____

How long has this been going on? _____



SEVERITY OF PAIN

List region of pain and circle severity number. (1 = least, 10 = greatest)

MARK PAIN REGION

Burning – Stabbing Sharp – Constant

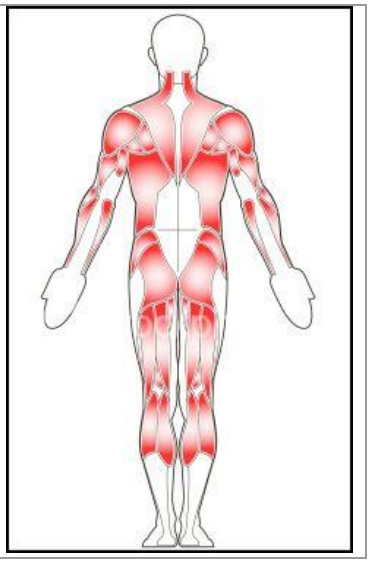
Mark Pain Area

+++	Burning
000	Stabbing
---	Sharp
!!!	Constant
xxx	Other

Regions

Neck	1	2	3	4	5	6	7	8	9	10
Mid Back	1	2	3	4	5	6	7	8	9	10
Lower Back	1	2	3	4	5	6	7	8	9	10
Hips	1	2	3	4	5	6	7	8	9	10
Arms	1	2	3	4	5	6	7	8	9	10
Legs	1	2	3	4	5	6	7	8	9	10

Please mark the area of pain on the drawing using the code listed above.



If there are any questions or concerns you would like to discuss during your appointment, please list them below so that we don't forget to address them…

1)

2)

3)

4)

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to examine and treat my condition as he/she deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed the amount paid the Doctor for x-rays is for examination only and the x-ray negatives will remain the property of this office, being on file where they may be seen at any time while I am active patient in this office. The patient also agrees that he/she is responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. Patients may obtain copies of their file and x-rays upon request. Copying fees may apply.

Patient Signature _____	Date _____
Guardian Signature _____	Date _____
Doctor Signature _____	Date _____

OFFICE USE ONLY	
Patient's Last Physical:	**Patient's Last Spinal Exam:**
Patient's Last Lab:	**Patient's Last Spinal X-ray:**
Patient's X-ray:	**Patient's Last EMG:**
Patient's Prostate Exam:	**Patient's Last Infrared Thermography:**
Patient's Last Pap Smear:	**Patient's Last Disc Exam:**
Patient's Last Breast Exam:	**Patient's Last MRI:** **CT Scan:**
Notes:	

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INFORMED CONSENT FOR PROCEDURE

I hereby consent to the performance of medical procedures, including diagnostic x-rays and various forms of physical therapy on me (or on the patient named below, for whom I am legally responsible for). I agree to one or more of the doctors/physical therapists, and/or other licensed doctors/professionals who now, or in the future, may perform recommended medical/chiropractic/podiatric/therapeutic procedures on me while working at Madison Medical & Sports Rehabilitation Center, or while serving as back up for one of the doctors/physical therapists contracted on staff.

I have had the opportunity to discuss the nature and purpose of future procedures with the doctor/physical therapist, and/or with another office or clinic personnel.

I understand and have been informed that, in the practice of medicine, there are some risks to treatment including, but not limited to, sprains, fractures, strokes, disk injuries and dislocation. I do not expect the doctor/physical therapists to explain all risks and complications. However, I wish to rely on the doctor/physical therapist to exercise proper judgment during the course of the procedure, which the doctor/physical therapist feels at the time is in my best interest based on the facts that are known.

I have read, or have had read to me the above consent. I have also have had the opportunity to ask questions about this consent. By signing below, I agree to the recommended medical/therapeutic procedure by any of the contracted doctors/therapists and other staff members I encounter during the course of my treatment. This consent will cover the entire course of medical, chiropractic, podiatric or physical therapy treatments for my present condition and any other future condition(s) for which I seek treatment at Madison Medical & Sports Rehabilitation Center.

TO BE COMPLETED BY PATIENT ***Date:*** _____

Patient's Signature: _____

Patient's Name: (please print) _____

TO BE COMPLETED BY PATIENT'S REPRESENTATIVE IF PATIENT IS A MINOR OR LEGALLY OR PHYSICALLY INCAPABLE.

Patient's Name: (please print) _____

Legal Guardian's Name: (please print) _____

Legal Guardian's Signature: _____

Office Use Only:

Date: _____

Received By: _____

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OFFICE FINANCIAL/CANCELLATION POLICY

- Patients are required to complete ALL necessary paperwork.
- Changes in appointments require advance notice. Please notify the office as soon as possible to reschedule your appointment. This will insure you get the treatment results you deserve.
- Patients must cancel 24 hours in advance to ensure there is no penalty for a missed appointment. Three consecutive cancelled appointments on the date of service will result in a cancellation fee of $30.00 for the missed visit.
- Patients without insurance coverage are expected to pay (in form of cash, check or credit card) the same day that services are rendered.
- For our patients with assignable insurance coverage, we have made an effort to remove the financial burden of your health care providers that will accept assignment of benefits. Our center will render treatment and wait to be reimbursed by your insurance company.
- We will assist you in any way we can with your insurance carrier, but any insurance or financial obligations are the full responsibility of the patient.
- HMO/PPO's --- PLEASE be sure that we are participating in your insurance plan, and any pre-certifications/referrals are the patient's responsibility.
- This office is unique in its ability to offer Medical, Chiropractic, Physical Therapy, and Podiatry services. Please understand that if any treatment prescribed, it is done on the basis of medical necessity, in order to resolve your condition and prevent reoccurrence.
- Please feel free to ask any questions that remain unanswered. We wish to be of assistance in any way we can.

THANK YOU FOR CHOOSING MADISON MEDICAL & SPORTS REHABILITATION CENTER FOR YOUR HEALTHCARE NEEDS!!!

Date: _____

Patient's Name: _____

Office Use Only:

Date: _____
Received By: _____

MADISON MEDICAL & SPORTS rehabilitation center
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ACKNOWLEDGMENT OF PRIVACY PRACTICE NOTICE AND DESIGNATION OF DISCLOSURE

I. Acknowledgement of Privacy Practice Notice

I have reviewed a copy of Madison Medical and Sports Rehab Center's Notice of Privacy Practices.

II. Designation of Certain Relatives, Close Friends and Other Caregivers

Madison Medical and Sports Rehab Center cannot release information regarding your treatment or test results to anyone that is not specifically authorized by you as per the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Persons under the age of 10 may have their information shared with the parent of legal guardian without written consent with the exception of information pertaining to sexually transmitted diseases. Certain medical emergencies may necessitate release of your medical information to someone not listed in this release; information requested in the course of a criminal investigation is not bound to this release.

Madison Medical and Sports Rehab Center may disclose my health information to the person(s) listed below. I understand that I am not required to list anyone. I also understand that I may change this at any time in writing.

Print Name: _____ Relationship to Patient: _____

Print Name: _____ Relationship to Patient: _____

Print Name: _____ Relationship to Patient: _____

☐ Do not release my information to anyone.

III. Attention

By completing below I agree to items I and II above.

_____
Print Patient's Name

_____
Print name of Parent or Guardian

_____ _____
Signature of Patient or Guardian Date