MADISON MEDICAL & SPORTS rehabilitation center
AN INTEGRATIVE MEDICAL SERVICES CO.

HIPAA PROTECTED HEALTH INFORMATION AUTHORIZED ACCESS ONLY
Today's Date:
Case #:
Patient/Clinic ID #:

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:**	
Sex: ☐ Male ☐ Female	☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced		
Occupation:		**Shift 1 2 3**	**Description:**
Employer:		**Work Phone #:**	**Ext.**
Work Address:		**Years Worked:**	
Spouse:		**List Children:**	
Spouse SSN#:		**Spouse's Occupation:**	
Spouse's Employer:		**Spouse's Work #:**	**Ext.**
Spouse's Insurance:		**Spouse's Ins. Phone #:**	
Last Doctor's Name:		**List Surgeries:**	
Care Received:			
Results:			

Are your present problems due to an injury? ☐ Yes ☐ No ☐ On the job ☐ Auto Collision ☐ Personal Injury ☐ Other

Have you made a report of your accident? ☐ Yes ☐ No ☐ To Employer ☐ Auto Carrier ☐ 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 _____

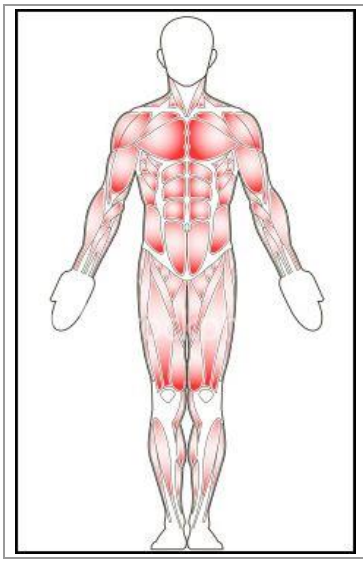
Have you retained an attorney? ☐ Yes ☐ No Name & Address _____

Have you had any of the following diseases?

☐ 303.9 Alcoholism	☐ 345. Epilepsy	☐ 072. Mumps
☐ 280. Anemia	☐ 240. Goiter	☐ 511. Pleurisy
☐ 541. Appendicitis	☐ 429.9 Heart Disease	☐ 480. Pneumonia
☐ 716. Arthritis	☐ 042. HIV Positive	☐ 045. Polio
☐ 239. Cancer	☐ 487. Influenza	☐ 390. Rheumatic Fever
☐ 052. Chicken Pox	☐ 724.2 Low Back Pain	☐ 737.30 Scoliosis

☐ 250. Diabetes	☐ 055. Measles	☐ 846. Sprain/Strain Sacroiliac
☐ 690. Eczema	☐ 319. Mental Disorder	☐ 847.0 Whiplash

CHIEF COMPLAINT / REGION OF PAIN	HABITS	EXERCISE
1) _____	☐ Smoking Packs/day _____	☐ None
2) _____	☐ Alcohol Cups/day _____	☐ Moderate
3) _____	☐ Coffee Cups/day _____	☐ Daily
4) _____	☐ Soda Cups/day _____	Type _____



SEVERITY OF PAIN

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

MARK PAIN REGION

Burning – Stabbing Sharp – Constant

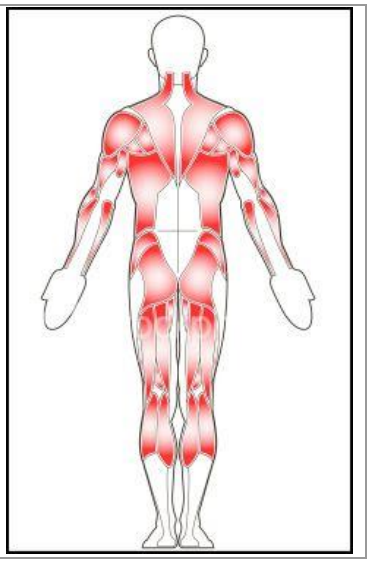
Mark Pain Area

+++	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.



FAMILY HISTORY					
Mother - Living: ☐ Yes ☐ No	☐ Diabetes	☐ Heart	☐ Kidney	☐ Cancer	☐ Back
Father - Living: ☐ Yes ☐ No	☐ Diabetes	☐ Heart	☐ Kidney	☐ Cancer	☐ Back
Brother(s) - Living: # of	☐ Diabetes	☐ Heart	☐ Kidney	☐ Cancer	☐ Back
Sister(s) - Living: # of	☐ Diabetes	☐ Heart	☐ Kidney	☐ Cancer	☐ Back
Adoption History	☐ Diabetes	☐ Heart	☐ Kidney	☐ Cancer	☐ Back

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:	

Please enter: "2" (Previously), "3" (Presently), in front of all of the following signs and symptoms. Leave blank if not applicable.
A complete history and understanding of your health will facilitate care.

GENERAL SYMPTOMS

_____ 784.0 Headache
_____ 780.6 Fever
_____ 780.99 Chills
_____ 780.8 Night Sweats
_____ 780.2 Fainting
_____ 780.4 Dizziness
_____ 780.3 Convulsions
_____ 780.52 Loss of Sleep
_____ 780.7 Fatigue
_____ 799.2 Nervousness
_____ 783. Loss of Weight
_____ 782. Numbness or pain in arms/legs/hands
_____ 995.3 Allergy (What)
_____ 786.07 Wheezing
_____ 729.2 Neuralgia

MUSCLES & JOINTS

_____ 728.9 Weakness
_____ 781.0 Twitches
_____ 723.5 Stiff Neck
_____ 724.5 Backache
_____ 719.0 Swollen Joints
_____ 781. Tremors
_____ 729.5 Foot Trouble
_____ 724.79 Painful Tail Bone
_____ 724.5 Pain between Shoulder
_____ 737.3 Spinal Curvature

GASTRO-INTESTINAL

_____ 783. Poor Appetite
_____ 536.8 Poor Digestion
_____ 994.2 Starvation
_____ 787.3 Belching or Gas
_____ 787.0 Nausea
_____ 787.0 Vomiting
_____ 578.0 Vomiting Blood
_____ 536.8 Pain over Stomach
_____ 564.0 Constipation
_____ 787.91 Diarrhea
_____ 562.1 Colon Trouble
_____ 455.6 Hemorrhoids (Piles)
_____ 776.7 Fluid Retention
_____ 873.9 Liver Trouble
_____ 274. Gout
_____ 782.4 Jaundice
_____ 575.9 Gall Bladder Trouble

CARDIO-VASCULAR

_____ 785.0 Rapid Heart
_____ 427.89 Slow Heart
_____ 401.9 High Blood Pressure
_____ 458.9 Low Blood Pressure
_____ 786.51 Pain Over Heart
_____ 429.9 Heart Trouble
_____ 719.07 Swelling Ankles
_____ 459.9 Poor Circulation
_____ 454.9 Varicose Veins
_____ 436. Strokes
_____ 454.9 Varicose Veins
_____ 785.1 Palpitations

EYE/EAR/NOSE/THROAT

_____ 368.9 Poor Vision
_____ 378.0 Crossed Eyes
_____ 379.91 Pain in Eyes
_____ 389.9 Deafness
_____ 388.70 Earache
_____ 388.3 Ear Noises
_____ 388.6 Ear Discharges
_____ 478.1 Nasal Obstruction
_____ 784.7 Nose Bleeds
_____ 462. Sore Throats
_____ 784.49 Hoarseness
_____ 477.9 Hay Fever
_____ 493.9 Asthma
_____ 460. Frequent Colds
_____ 240.9 Enlarged Thyroid
_____ 463. Tonsillitis
_____ 473. Sinus Trouble

SKIN OR ALLERGIES

_____ 680. Skin Eruptions – No
_____ 698.9 Itching
_____ 924.9 Bruising Easily
_____ 701.1 Dryness
_____ 680.9 Boils
_____ 782. Sensitive Skin
_____ 708.9 Hives or Allergy
_____ 692.9 Eczema

RESPIRATORY

_____ 786.2 Chronic Cough
_____ 786.3 Spitting Blood
_____ 786.4 Spitting Phlegm
_____ 786.50 Chest Pain
_____ 386.09 Difficulty Breathing

GENITO-URINARY

_____ 788.4 Frequent Urination
_____ 788.1 Painful Urination
_____ 599.7 Blood in Urine
_____ 590. Kidney Infection
_____ 788.3 Bed Wetting
_____ 788.3 Inability to control urine
_____ 601.9 Prostate Trouble

FOR WOMEN ONLY

_____ 625.3 Painful Periods
_____ 626.2 Excessive Flow
_____ 626.4 Irregular Cycle
_____ 627.2 Hot Flashes
_____ 625.3 Cramps or Backaches
_____ 623.5 Vaginal Discharge
_____ Pregnant at this time
_____ Last Pap

By Whom _____

Other _____

IN PATIENT / OUT PATIENT OPERATIONS AND PROCEDURES - HOSPITALIZATION			
DATE	**DATE**	**DATE**	**DATE**
_____ Vaccinations	_____ Other	_____ Rectal Surgery	_____ Thyroid
_____ Tonsillectomy	_____ Tubes in Ears	_____ Other	_____ Stomach
_____ Gall Bladder	_____ Appendectomy	_____ Sinus	_____ Other
_____ Back Operations	_____ Female Organs	_____ Hernia	
Hospital Stays:			
Other Surgeries:			
List any accidents or falls and list dates:	☐ Car _____ ☐ School _____	☐ Sports _____ ☐ Other _____	☐ Recreational Vehicle _____
List any broken bones (fractures) or dislocations:			
Have you ever been on crutches?	☐ Yes ☐ No Why?		
Have you ever had a lapse of memory?	☐ Yes ☐ No	Have you ever been unconscious?	☐ Yes ☐ No
Have you ever had X-rays?	☐ Yes ☐ No Why?	By Whom?	
For what ailments were these X-rays made?			
Do you suffer from any condition other than that for which you are now consulting us?			
Are you presently taking any medication – prescription or over-the-counter? ☐ Yes ☐ No List: medication – frequency – dosage			

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 _____

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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/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 chiropractic, medical 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 Name: _____
Please Print

Patient Signature: _____

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 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: _____
Please Print

Office Use Only:

Date: _____
Received By: _____

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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 completed 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

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Patients' Responsibilities for Follow-up Care Pledge

I, _____, hereby acknowledge and understand that even with the best training, skill and experience, a medical professional is not always able to effectively treat and cure my medical problems if I do not follow that medical professional's recommendations and cooperate in my care. Therefore, I understand it is important that any and all recommendations by providers at this office are timely and completely followed by me in order to increase the likelihood of a positive and healthy treatment/outcome. I acknowledge and understand that if any provider in this office prescribes medicine to me, that the proper taking of any such medicine shall be my sole responsibility (or my guardian who has attended this consultation). I agree to properly follow the prescribed dosage and frequency amounts of these medicines as recommended by my physician.

I understand that a physician in this office may determine that he/she requires the assistance of other specialty-trained medical professionals or requires medical testing of me that may or may not be provided by this office. In these situations, the physician may refer me to see another physician or other healthcare provider, or to receive medical tests at another practice or facility including, but not limited to, blood work, X-ray, MRI, CT scan, diagnostic ultrasound, EKG or PFT. I understand that my timely and complete cooperation with this recommendation and referral is important and essential to the ultimate success of my treatment/outcome.

I understand that it is not possible for any person in this office to constantly monitor me to ensure that I have followed these recommendations and referrals. Therefore, I understand that if I immediately fail to see that specialist, or obtain the test, which was referred, then this can risk my current treatment, a full recovery from my current health problems, my current health, or increase future health risks.

I further understand that the medical staff in this office may recommend/advise follow-up visits, care and treatment by the staff in this office, as important and essential to the ultimate success of my treatment/outcome; that I must timely and fully cooperate with this recommended follow-up care; and that my failure to do so may risk my current treatment, a full recovery from my current health problems, and may increase my current and future health risks.

I understand that it is solely my responsibility to follow any of the medical recommendations/advice given by any medical staff in this office and any bad health outcome from my failure to follow these recommendations/advice of the staff is not at all the fault of the staff or the office.

_____	_____
Patient Name	Date of Birth
_____	_____
Patient Signature	Date