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

Patient Case History

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

PATIENT DEMOGRAPHICS

First Name | Last Name | Suffix | Nickname

Address | Apt. # | City | State | Zip

Phone # | ***Email**

Birth Date | Gender | Marital Status | Spouse's Name

Employer | Occupation

EMERGENCY CONTACT INFORMATION

Contact Name | Contact Phone#

Contact Address | Apt. # | City | State | Zip

Relationship to Contact

MEDICAL INSURANCE INFORMATION

Policy Holders Name

Policy Holders Address

Policy Holders Employer

How did you hear about us? ☐ **Friend** _____ ☐ **Referral** _____ ☐ **Internet** ☐ **Other**

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MEDICAL HISTORY

Reason for today's visit _____

Do you suffer from any condition other than that for which you are now consulting us?

_____

Primary Care Doctor _____ Phone #_____

Have you had any serious illnesses or surgeries? _____If yes, please describe _____

_____

(Women) Are you pregnant? ☐ Yes ☐ No Due Date: _____ Nursing? ☐ Yes ☐ No

Check (✓) if you or any member of your immediate family have or have had any of the following:

☐ Alcoholism	☐ Fibromyalgia	☐ Measles
☐ Anemia	☐ Goiter	☐ Osteoporosis or Osteopenia
☐ Appendicitis	☐ Heart Disease	☐ Polio
☐ Arthritis	☐ HIV Positive	☐ Pneumonia
☐ Anxiety	☐ High Cholesterol	☐ Pleurisy
☐ Asthma	☐ High Blood Pressure	☐ Reflux (Gerd)
☐ Chicken Pox	☐ Insomnia	☐ Rheumatic Fever
☐ Cancer (Type)_____	☐ IBS	☐ Sprain/Strain Sacroiliac
☐ Crohn's Disease	☐ Influenza	☐ Scoliosis
☐ Diabetes	☐ Low Back Pain	☐ Thyroid Condition
☐ Depression	☐ Low testosterone	☐ Ulcers
☐ Epilepsy	☐ Mental Disorder	☐ Ulcerative Colitis
☐ Eczema	☐ Mumps	☐ Whiplash

☐ Other - specify: _____

MEDICATIONS

Medication	Dose	Frequency

ALLERGIES

☐ Seasonal (hay fever) ☐ Latex ☐ Iodine
☐ Shellfish ☐ Bee Stings ☐ Cats ☐ Dogs
☐ Penicillin ☐ Sulfa ☐ Adhesive Tape
☐ Food (specify) _____
☐ Other (specify) _____

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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:

Patients Name_____
Please Print

Patients Signature _____

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

Patients Name_____
Please Print

Legal Guardians Name_____
Please Print

Legal Guardians Signature_____

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ACKNOWLEDGEMENT OF PRIVACY PRACTICE NOTICE & 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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PATIENT'S RESPONSIBILTIES 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

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OFFICE FINANCIAL 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 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.

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!!!

Patients Name_____

Please Print

Patients Signature_____

Date _____