Spinal Rehabilitation and Wellness Center

Specializing in Advanced Pain Relief

Last Name: ______________________ First Name: ______________________ Sex: M F

Address: ______________________

City: ______________ State: ______________ Zip Code: ______________

SS#: ______________ DOB: ______________ Age: ______________

Phone: (Home) ______________ (Work) ______________ (Cell) ______________

E-mail Address: ______________________

Do we have permission to contact you at: home# Y/N work# Y/N cell# Y/N e-mail: Y/N text msg: Y/N

Marital Status: M S D W Number of Children: ______________

Spouse's Name (Parent if minor): ______________________

Employer (name & address): ______________________

Occupation: ______________________ Years at current position: ______________

How were you referred to our office? Dr. ______________ Advertisement: ______________

Friend/Co-Worker: ______________________ Other: ______________

Chief Complaint of Visit: ______________________

Primary Physician: ______________________ Chiropractor: ______________

Insurance Information: (please bring card up to front desk)

Primary Cardholder Name: ______________________ DOB: ____/____/____

Employer: ______________________ SS#: ______________

Secondary Insurance Co. Name: ______________________

Secondary Cardholder SS#: ______________________ DOB: ____/____/____

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the above named agency to release any treatment information requested by attorneys, physicians, insurance companies, employers or any other entity which may be concerned with the payment of charges incurred for the treatment services of the physician.

X ______________________ Date ____/____/____

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize payment directly to the physician. I am responsible for payment of all non-covered services rendered by the physician.

X ______________________ Date ____/____/____

Patient Name: ______________________________ **Date:** ____________

Chief Complaint:
Primary:

____

____

Secondary:

____

____

Do You Presently Suffer From Any Of The Following:

☐ Neck Pain	☐ Shoulder Pain	☐ Mid Back Pain	☐ Low Back Pain	☐ Hip Pain
☐ Elbow Pain	☐ Wrist Pain	☐ Knee Pain	☐ Ankle Pain	☐ Foot Pain
☐ Numbness	☐ Tingling	☐ Headaches	☐ Jaw Clicking	☐ Clenching of Teeth
☐ Ringing in Ears		☐ Facial Pain	☐ Chewing Pain	☐ Inbalance

Doctors Seen For Your Complaints (Current or Previous Condition):

Discipline	Name:	Date:	Results:
☐ Primary Care Physician	________	____	________
☐ Chiropractor	________	____	________
☐ Orthopedist	________	____	________
☐ Physiatrist	________	____	________
☐ Neurologist	________	____	________
☐ Pain Management	________	____	________
☐ Podiatrist	________	____	________
☐ Acupuncturist	________	____	________
☐ Dentist	________	____	________

Diagnostic Imaging Studies Performed For Your Chief Complaint

	Facility:	Dates:
☐ X-Ray	________	________
☐ MRI	________	________
☐ CT	________	________
☐ Bone Scan	________	________
☐ EMG/NCV	________	________

Current Medications

Name | Dosage | Time Used

____

____

____

____

____

Surgical History/Hospitalizations

Date: | Surgery

____

____

____

____

____

____

____

Onset/Mechanism of Injury (How your pain occured):

____

____

____

Nature of Pain:

☐ Sharp ☐ Dull ☐ Burning ☐ Stabbing ☐ Throbbing ☐ Numb ☐ Tingling

Radiating Pain

☐ Head ☐ Shoulder ☐ Shoulder Blade ☐ Elbow ☐ Forearm ☐ Wrist ☐ Hand

☐ Hip ☐ Thigh ☐ Knee ☐ Calf ☐ Ankle ☐ Foot

What Makes Your Pain Better?

____

____

____

What Makes Your Pain Worse?

____

____

____

Frequency

☐ Constantly (76-100% of the day) ☐ Frequently (51-75% of the day)

☐ Occasionally (26-50% of the day) ☐ Intermittently (0-25% of the day)

Pregnancy Release:

This is to certify that to the best of my knowledge I am not pregnant and the doctor and his associates have my permission to perform x-rays (if needed). I have been advised that an x-ray can be harmful to an unborn child.

Date of last menstrual cycle: ____/____/____ Initials: ________

Patient Name: ______________________ Signature: ______________________

Health History

Name: **Chart #:** **Today's Date:** **Date of Onset:**

Please select all choices that apply to the patient.

☐ Abdominal Pain	☐ Colitis	☐ Headaches	☐ Irritable Colon	☐ Osteoporosis	☐ Sinus Trouble
☐ Allergies	☐ colon cancer	☐ Heart Attacks	☐ Kidney Disease	☐ Painful Urination	☐ Spinal Disc Disorder
☐ Angina	☐ Convulsions	☐ Heart Disease	☐ Kidney Stones	☐ peptic ulcer	☐ STDs
☐ Anorexia	☐ Diabetes	☐ hepatitis A	☐ kyphosis	☐ PMS	☐ stomach cancer
☐ Aortic Aneurysm	☐ juvinile diabetes	☐ hepatitis B	☐ leg pain	☐ Polio	☐ stomach ulcer
☐ Arthritis	☐ adult diabetes	☐ hepatitis C	☐ Liver Disease	☐ Profuse Menstrual	☐ Stroke
☐ Asthma	☐ Dislocated Joints	☐ High Blood Pressure	☐ lordosis	☐ prostate cancer	☐ Thyroid Disorder
☐ Blood Disorder	☐ Dizziness	☐ hip pain	☐ Low Blood Pressure	☐ Prostate Problems	☐ traumatic arthritis
☐ Bone Cancer	☐ duodenum ulcer	☐ HIV/AIDS	☐ lower back pain	☐ Rapid Heart Rate	☐ Tuberculosis
☐ brain cancer	☐ Emphysema	☐ hypertension	☐ lung cancer	☐ rectum cancer	☐ Ulcer
☐ Breast Soreness	☐ Epilepsy	☐ hyperthyroidism	☐ Lung Disease	☐ rheumatoid arthritis	☐ upper back pain
☐ breast cancer	☐ esophageal cancer	☐ hypotension	☐ migrane	☐ Rheumatic Fever	☐ Vaginal Discharge
☐ Bulemia	☐ Fainting	☐ hypothyroidism	☐ Multiple Sclerosis	☐ Scoliosis	☐ ______
☐ Cancer	☐ gouty arthritis	☐ Irregular Bowel Habits	☐ neck pain	☐ shoulder pain	☐ ______
☐ chest pain	☐ Hay Fever	☐ Irregular Menstrual	☐ osteo arthritis	☐ Sickle Cell Anemia	☐ ______

Select all choices that apply to the patient's family (please do not include relations by marriage).

☐ Abdominal Pain	☐ Colitis	☐ Headaches	☐ Irritable Colon	☐ Osteoporosis	☐ Sinus Trouble
☐ Allergies	☐ colon cancer	☐ Heart Attacks	☐ Kidney Disease	☐ Painful Urination	☐ Spinal Disc Disorder
☐ Angina	☐ Convulsions	☐ Heart Disease	☐ Kidney Stones	☐ peptic ulcer	☐ STDs
☐ Anorexia	☐ Diabetes	☐ hepatitis A	☐ kyphosis	☐ PMS	☐ stomach cancer
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☐ Cancer	☐ gouty arthritis	☐ Irregular Bowel Habits	☐ neck pain	☐ shoulder pain	☐ ______
☐ chest pain	☐ Hay Fever	☐ Irregular Menstrual	☐ osteo arthritis	☐ Sickle Cell Anemia	☐ ______

Patient exercises:	☐ Moderately	☐ Occasionally	☐ Rarely	☐ Regularly	☐ Never
Patient smokes:	☐ 2 packs per day	☐ ½+ pack per day	☐ Never	☐ ______	☐ ______
☐ 2+ packs per day	☐ 1 pack per day	☐ ½ pack a day or less	☐	☐	☐
Patient uses alcohol:	☐ Excessively	☐ Moderately	☐ Occasionally	☐ Rarely	☐ Never
Medication the patient is currently taking:		☐ Muscle Relaxants	☐ No prescription medications	☐ Psychotropic medication	☐ ______
☐ Analgesics	☐ Birth Control	☐ No non-prescription medication			☐ ______
☐ Anti-Inflamatory	☐ Hypertension		☐ Tranquilizers	☐ Vitamin supplements	☐

Activities Discomfort Scale

For each of the following activities, please place a check in the one column that best describes how much pain the activity presently causes, on the average (does not include unusual or prolonged activity).

Activity	Doesn't Hurt At All	Hurts A Little	Hurts Very Much	Almost Unbearable	Unbearable Pain Prevents Activity
1. Walking					
2. Sitting					
3. Bending					
4. Standing					
5. Sleeping					
6. Lifting					
7. Running or jogging					
8. Climbing Stairs					
9. Carrying					
10. Pushing or Pulling					
11. Driving					
12. Dressing					
13. Reading					
14. Watching TV					
15. Household Chores					
16. Gardening					
17. Sports					
18. Employment					

ADDITIONAL COMMENTS:

PATIENT NAME ______________________ PATIENT SIGNATURE ______________________

EXAMINER ______________________ DATE ____________ Score ____________ [72]

Turner JA, Robinson J, McCreary CP. Chronic low back pain: Predicting response to nonsurgical treatment. *Arch Phys Med Rehabilitation* 1983; 64: 560-563

PATIENT AUTHORIZATION FOR CONTACT REGARDING HEALTH RELATED SERVICES THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN HAVE ACCESS TO OBTAIN THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

In the course of your care as a patient at Spinal Rehabilitation and Wellness Center, we may use or disclose personal and health related information about you in the following ways:

- Your personal health information, including clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you further testing, assessment, or treatment
- Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer

If you are not at home to receive an appointment reminder, a message may be left on your answering machine or one may be sent to your e-mail address. Furthermore, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office regarding those matters. Should you decide to not provide us such authorization, your care will not be affected in this office.
Under federal law, we are also permitted or require using or disclosing your health information without consent or authorization under the following circumstances:

- Should we provide health care services to you based on the orders of another health care provider
- Should we provide health care services to you as an emergency
- Should we be required by law to provide care to you and are unable to obtain your consent after attempting to do so
- Should there be substantial communication barriers between you and our office and our office's professional judgment believes you intend for our office to provide care
- Should we be ordered by the courts or another appropriate agency

Any use or disclosure of your protected health information, other than as described in the examples outlined above will only be made upon your written authorization. We normally provide information about your health care to you in person at the time you receive care. You have the right to inspect and/or copy your health information for seven years from the date the record was created or for as long as the information remains in our files. In addition, you have the right to request an amendment to your health information. Requests to inspect, copy, or amend your health related information should be provided to us in writing.
We are required by the state and federal law to maintain the privacy of our patient files and the health protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information. We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. Should changes be made to our privacy notice, we will notify you in writing as soon as possible. Should you have any concern regarding: the information that we use or disclose based on this privacy notice, our privacy practices, or any aspect of our privacy activities, please direct your concerns to Maria Fernandez. If you would like further information about our privacy practices, please contact Maria Fernandez at the office.
This notice is effective as of January 1st, 2012 and will expire seven years after the date it was created.

Patient Name	**Patient Signature**	**Date**

Spinal Rehabilitation and Wellness Center
Specializing in Advanced Pain Relief

ASSIGNMENT OF BENEFITS

Patient Name: ______________________________

Patient Address: ______________________________

Date of Loss: ______________________________

Insurance Company: ______________________________

Name of Policyholder: ______________________________

Policy Number: ____________________

Claim Number: ____________________

1. **I, the undersigned, hereafter referred to a "the patient" do hereby assign all of my rights and interests to SPINAL REHAB. & WELLNESS CENTER, LLC, hereafter referred to as "the medical provider" to pursue and obtain payment from the above-mentioned insurance carrier. This assignment shall include but it is not limited to, all rights available to me pursuant to the Personal Injury Protection Statutes of the State of New Jersey.**
2. **I, irrevocably assign, to the medical provider, all my rights and benefits under the insurance contract for payment for services rendered to me.**
3. **I, the patient, do hereby understand and acknowledge that if I willfully refuse to comply with reasonable requests of the insurance carrier, payment of my medical bills may be denied and I will be held responsible for same.**
4. **I, the patient, authorized my bodily injury attorney and/or insurance carrier to pay directly to the medical provider any monies due on my account, or, the same to be deducted from any settlement made on my behalf.**
5. **I, the patient, do hereby acknowledge that I will not file suit and/or arbitration for the payment of the above provider's medical bills. I understand that the above referenced medical provider has an attorney and will collect payment on my behalf from the insurance carrier.**
6. **The provider will comply with the decision point review request as required by the plan.**
7. **The provider shall submit disputes to personal injury protection dispute arbitration if the decision point review plan requires same.**
8. **In the event it is determined by an Arbitrator and/or Court of Law that the imposition of a copayment penalty was a result of the medical providers failure to precertify treatment or comply with other decision point review requirements the provider will hold the patient harmless for such copayment penalty.**
9. **In the event that the insurance carrier and/or the vendor designated by the insurance carrier does not accept my assignment, or my assignment is challenged for being invalid, I execute this limited/special power of attorney and appoint and authorize the medical provider and counsel on behalf of the medical provider to file suit and/or arbitration directly against the carrier in my name and/or allow the medical provider to amend the law suit and/or arbitration to include my name.**
10. **I, the patient, do hereby direct the health insurance carrier to issue payment on my behalf directly to the medical provider.**
11. **A photocopy of this assignment shall be valid as the original. This assignment of benefits has been explained to my full satisfaction, and I understand its nature and effect.**

Signed: ______________________________

Patient Name: ______________________________ **Dated:** ____________