DYNAMIC
Medical & Rehab

Application for Patient Care

PATIENT INFORMATION

First Name: _____ M.I.: _____ Last Name: _____ Date:_____

Address: _____ City: _____

State: _____ Zip:_____ Email: _____ Phone:_____

SS#:_____-_____-_____ Age:_____ DOB: __ __/__ __/__ __ Male / Female

Primary Care Physician:_____

Do we have permission to contact your doctor regarding your care in our office? ____Yes ____No

Your preferred method of contact for appointment reminders? Email / Text by Cell Phone

Occupation:_____ Employer:_____

Type of Tasks Performed/Common Movements:_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Minor

Spouse's Name:_____ # of Children?_____ Children's Ages:_____

Emergency Contact Name:_____ Relation: _____ Phone #:_____

Smoking Status: Never smoked / Former Smoker / Occasional Smoker / Daily Smoker Preferred Language: _____

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) / Native Hawaiian or Pacific Islander / Other / Decline to Answer **Ethnicity (Circle one):** Hispanic or Latino / Not Hispanic or Latino / Decline to Answer

ACCIDENTS

Have you had an auto accident? (X if applies): ☐ 0-6mo ☐ 6 mo-1 yr ☐ 1-3yrs ☐ 3+yrs ☐ Never

Had a recent fall/other accident? (X if applies) : ☐ 0-6mo ☐ 6 mo-1 yr ☐ 1-3yrs ☐ 3+yrs ☐ Never

Have You Ever Received Physical Therapy ☐ Chiropractic Care ☐ or Pain Management ☐? Last Visit:_____

REFERRALS

How Did You Hear About This Office? ☐ Existing Patient: _____ ☐ Walk-In/Drive-By

☐ Radio: _____ ☐ Internet: _____ ☐ Shapes

☐ Ad:_____ ☐ Community Event: _____ ☐ LifeStyles

☐ Massage-A-Teacher:_____ ☐ Other: _____ ☐ Insurance Comp.

INSURANCE

Do you have health insurance? ☐ Yes ☐ No Name of Carrier: _____

Do you have secondary insurance? ☐ Yes ☐ No Name of Carrier: _____

PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR INSURANCE CARD(S)

Assignment and Release **Method of payment for today's charges: ___Cash ___Check ___Visa / MC**

I certify that I (or my dependent) have insurance coverage with _____ and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PHYSICIAN PRACTICE, Dynamic Medical, Chiropractic & Rehab, INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

I choose to decline receipt of my clinical summary after every visit (These summaries are often blank as a result of the nature and frequency of care.)

SIGNATURE (X) _____ **DATE** _____

Patient Name: _____ Date: _____

PRIMARY COMPLAINTS: Please list in order of most severe (#1) to least severe (#4). *Sample complaints: Low Back, Left Knee, Right Shoulder, Neck, etc.*

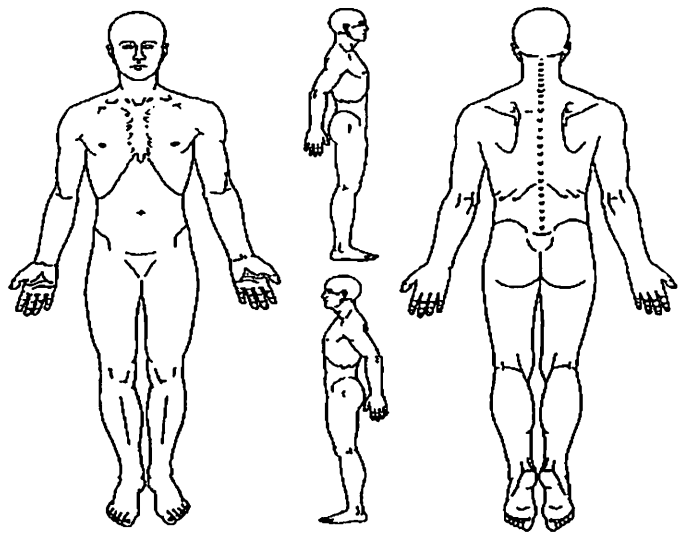
MOST SEVERE ← → LEAST SEVERE

You have the following complaints (WRITE-IN)	1.	2.	3.	4.
Circle the word that best describes this complaint.	Sharp dull achy throbbing numb shooting other	Sharp dull achy throbbing numb shooting other	Sharp dull achy throbbing numb shooting other	Sharp dull achy throbbing numb shooting other
How often do you feel this complaint?	Constant Daily Weekly "Off and On"	Constant Daily Weekly "Off and On"	Constant Daily Weekly "Off and On"	Constant Daily Weekly "Off and On"
How long have you had this complaint?	____ Days / Weeks / Months / Years	____ Days / Weeks / Months / Years	____ Days / Weeks / Months / Years	____ Days / Weeks / Months / Years
Is it getting better, worse, or staying the same?	Better Worse Same	Better Worse Same	Better Worse Same	Better Worse Same
What makes it better, if anything?				
What makes it worse, if anything?				
On a scale of 0 – 10, rate your discomfort. *(0 = no pain, 10 = excruciating)*	**Circle response** 0 1 2 3 4 5 6 7 8 9 10	**Circle response** 0 1 2 3 4 5 6 7 8 9 10	**Circle response** 0 1 2 3 4 5 6 7 8 9 10	**Circle response** 0 1 2 3 4 5 6 7 8 9 10
How have you taken care of this in the past? Has that worked for you?				
Circle the ways this issue is affecting your life. *(all that apply)*	job children sex marriage household hobbies finances sports exercise walking standing bowels urinary fatigue loss of sleep moody poor attitude loss of productivity	job children sex marriage household hobbies finances sports exercise walking standing bowels urinary fatigue loss of sleep moody poor attitude loss of productivity	job children sex marriage household hobbies finances sports exercise walking standing bowels urinary fatigue loss of sleep moody poor attitude loss of productivity	job children sex marriage household hobbies finances sports exercise walking standing bowels urinary fatigue loss of sleep moody poor attitude loss of productivity
Improving this issue in my life would improve my quality of life by: *(Circle best response)*	10-20% 30-40% 50-60% 70-80% 90% 100%	10-20% 30-40% 50-60% 70-80% 90% 100%	10-20% 30-40% 50-60% 70-80% 90% 100%	10-20% 30-40% 50-60% 70-80% 90% 100%

PATIENT HEALTH HISTORY

Please check if you are currently experiencing any of the following conditions and then circle problematic areas on body to right:

- ❑ Neck Pain/Stiffness
- ❑ Back Pain/Stiffness
- ❑ Arm/Hand Pain
- ❑ Leg/Knee Pain
- ❑ Headaches
- ❑ Loss of Taste
- ❑ Nervousness
- ❑ Jaw Problems
- ❑ Loss of Smell
- ❑ Blurred/Double Vision
- ❑ Mood Changes
- ❑ Foot Trouble
- ❑ Pins/Needles in Arms
- ❑ Pins/Needles in Legs
- ❑ Light Bothers Eyes
- ❑ Recent Weigh Change
- ❑ Loss of Memory
- ❑ Cold Extremities
- ❑ Sleeping Difficulties
- ❑ Bowel/Bladder Changes
- ❑ Constipation/Diarrhea
- ❑ Swollen Joints
- ❑ Trouble Concentrating
- ❑ Loss of Balance
- ❑ Nausea
- ❑ Night Pain
- ❑ Fatigue
- ❑ Fever
- ❑ Tension
- ❑ Chest Pain
- ❑ Asthma
- ❑ Cold Sweats
- ❑ Dizziness
- ❑ Fainting



Patient Name: _____ Date: _____

PATIENT HEALTH HISTORY continued.... *Please check if you have ever had any of the following:*

❑ ADD/ADHD	❑ Cancer	❑ Gout	❑ Miscarriage	❑ Scarlet Fever
❑ Aids/HIV	❑ Cataracts	❑ Heartburn	❑ Mononucleosis	❑ Sexual Difficulty
❑ Alcoholism	❑ Chemical	❑ Heart Attack	❑ Mouth Sores or	❑ Stroke
❑ Allergy Shots	Dependency	❑ Heart Problems	Bleeding Gums	❑ Suicide Attempt
❑ Anemia	❑ Chicken Pox	❑ Hemorrhoids	❑ Multiple Sclerosis	❑ Thyroid Problems
❑ Anorexia	❑ Colon Trouble	❑ Hepatitis	❑ Mumps	❑ TMJ Pain
❑ Appendicitis	❑ Contacts/Glasses	❑ Hernia	❑ Nosebleeds	❑ Tonsillitis
❑ Arthritis	❑ Depression	❑ Herniated Disc	❑ Osteoporosis	❑ Tremors
❑ Asthma/Wheezing	❑ Diabetes	❑ Herpes	❑ Pacemaker	❑ Tuberculosis
❑ Anxiety	❑ Dry Skin	❑ High Cholesterol	❑ Parkinson's Disease	❑ Tumors/Growths
❑ Bad Breath/Taste	❑ Ear Infections	❑ Hormone/Gland	❑ Pinched Nerve	❑ Typhoid Fever
❑ Bleeding Disorders	❑ Epilepsy	Problems	❑ Pneumonia	❑ Ulcers
❑ Blood Pressure:	❑ Fibromyalgia	❑ Insomnia	❑ Polio	❑ Vaginal Infections
High or Low (circle)	❑ Fractures	❑ Kidney Problems	❑ Prostate Problems	❑ Venereal Disease
❑ Breast Lump	❑ Gall Bladder	❑ Liver Disease	❑ Prosthesis	❑ Whooping Cough
❑ Broken Bones	❑ Glaucoma	❑ Measles	❑ Psychiatric Care	❑ Other: _____
❑ Bronchitis	❑ Goiter	❑ Menopausal Prob.	❑ Rheumatoid Arthritis	_____
❑ Bulimia	❑ Gonorrhea	❑ Migraines	❑ Rheumatic Fever	_____

Are you currently under drug and/or medical care? ❑ Yes ❑ No If yes, explain _____

Please list any and all medications you are currently taking: _____

_____

Please list any surgeries and/or hospitalizations you have had (type & date): _____

_____

ALLERGIES: (Please place a check mark next to any known allergy that you have.)

___ Milk ___Eggs ___Peanuts ___Almonds ___Cashews ___Walnuts ___ Fish ___ Shellfish ___Soy ___Wheat
___ Gluten ___Penicillin ___Sulfa Drugs ___Tetracycline ___Codeine ___NSAIDS ___Phenytoin ___Carbamazepine
___Mildew ___Mold ___ Dust ___Fungus ___Mites ___Tree Pollen ___Grass Pollen ___Weed Pollen ___Insects ___Dog Dander ___Cat Dander ___Latex ___Other Animal Dander ___ OTHER: _____ *(please fill in)*

Please list any supplements you are currently taking (vitamins/herbs/minerals): _____

Is there a family history of any of the following conditions? *(indicate family member including parents, grandparents & siblings)*

❑ Heart Disease_____ ❑ Diabetes _____
❑ Cancer _____ ❑ Arthritis _____ ❑ Other _____

Do you exercise: ❑ 5-7x/week ❑ 3-4x/week ❑ 1-2x/week ❑ Occasionally ❑ None

Do your work activities mostly involve: ❑ Sitting ❑ Standing ❑ Light Labor ❑ Heavy Labor

Do you sleep on your: ❑ Back ❑ Side ❑ Stomach Do you use a cervical pillow? ❑ Yes ❑ No

What is your daily/weekly intake of the following: Caffeine ____ cups/day Alcohol ____ drinks/week Cigarettes _____ pks/day

I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health. I will give complete & accurate information during my exam.

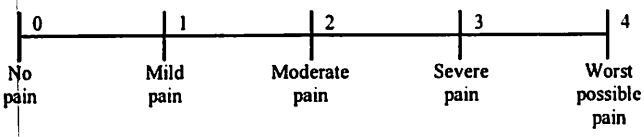
Signature (X) _____ **Date**_____

Functional Rating Index

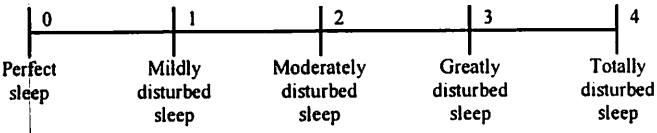
For use with Neck and/or Back Problems only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** has affected your ability to manage everyday activities. For each item below, **please circle the number which most closely describes your condition right now**.

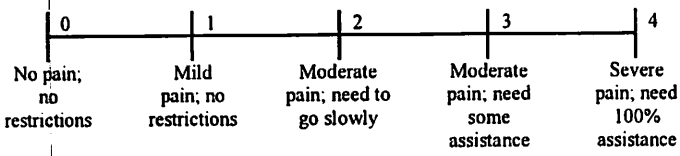
1. Pain Intensity



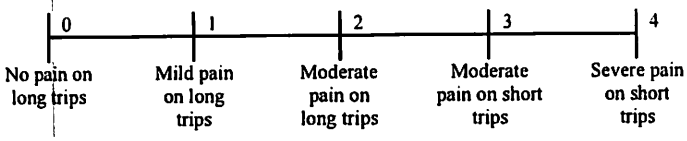
2. Sleeping



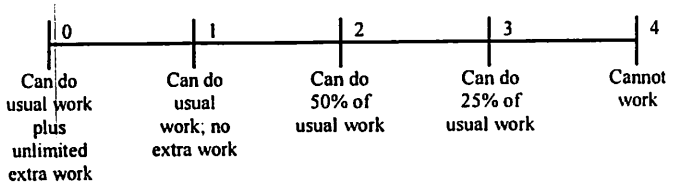
3. Personal Care (washing, dressing, etc.)



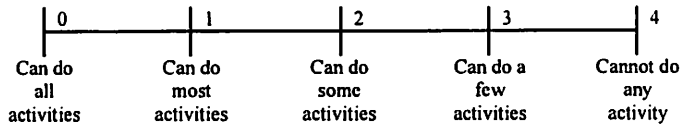
4. Travelling (driving, etc.)



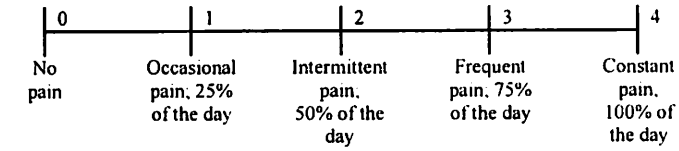
5. Work



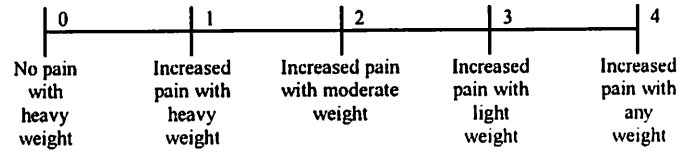
6. Recreation



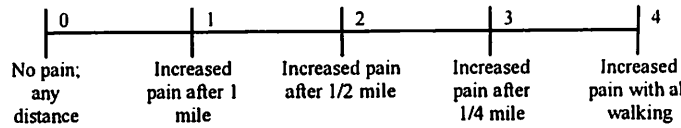
7. Frequency of Pain



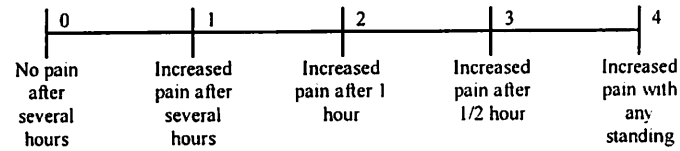
8. Lifting



9. Walking



10. Standing



Patient's Signature _____

Date _____

For Office Use Only:

Practitioner ID#: _____

Total Score _____ / 40

Clinical Diagnosis Codes:

Patient ID#: _____

Informed Consent to Care

A patient coming to the doctor gives him/her permission and authority to care for them in accordance with appropriate test, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare case, underlying physical defects, deformities or pathologies may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the physician. This office does not perform breast, pelvic, prostate, rectal, or full skin evaluations. These examinations should be performed by your family physician, GYN, and dermatologist to exclude cancers, abnormal skin lesions that should undergo biopsy/removal or other treatments. This clinic does not provide care for any condition (such as high blood pressure, diabetes, high cholesterol) other than those addressed in your physical medicine care plan. We also do not prescribe or refill ANY controlled substances. All prescriptions should be refilled by your original prescriber and any new prescriptions should be issued by your primary care provider.

The patient assumes all responsibility/liability if the patient does not report on health forms any past medical history, illnesses, medicines, or allergies.

I agree to settle any claim or dispute I may against or with any of these persons or entities, whether related to the prescribed care or otherwise, will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

Sign here: X_____I have read and understand the above consent form.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have reviewed the Notice of Privacy Practices of _____.
(Please initial one of the following options and sign below.)

_____ I wish to receive a paper copy of Privacy Notice.

_____ I do not request a copy of the Privacy Notice at this time. I acknowledge that I can request a copy at any time and the Privacy Notice is posted in the office. If I should have a problem or question in regard to my rights, I may speak with the Privacy Officer about my concerns.

This serves a notice that as part of our efforts to deliver the most consistent healthcare we can to every patient, we use an electronic healthcare system that enables us to retrieve up to 13 months of prescription history through your insurance carrier.

I acknowledge that it is the policy of this office to leave reminder messages on my answering machine or with another person in my home. I may make a request of an alternative means of communication (within reason) in writing.

X_____ _____
Signature of Patient/Guardian Date

X_____ _____
Witness (Office Staff) Date

ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS
AS WELL AS AN
APPOINTMENT AND/OR DESIGNATION AS AN ERISA/PPACA REPRESENTATIVE AND A BENEFICIARY

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay _____ as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided.

I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, and/or medications that *have been* or *will be* rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under.

I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same.

I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA plan, PPACA plan, or insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our representative, ERISA representative, or PPACA representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals to obtain benefits and/or payments that are due to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan or insurer. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment and/or designation will remain in effect unless revoked in writing. A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

Signed this _____ day of _____ 20 ____.

X_____
(patient signature)

_____
(please print patient name)

X_____
(signature of Guardian if applicable)

X-ray Questionnaire: For women only Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

Name: _____ Date of last menstrual period: _____

There is a possibility that I a may be pregnant at this time Yes, I am definitely pregnant
No, I am definitely not pregnant at this time I request that x-ray films not be taken because: