# SPINALWORKS Medical Group

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As a multi-disciplined health care facility, we focus on natural therapies including medical rehab, physical medicine, corrective chiropractic, massage, weight loss, and natural trigger point and joint injections to best treat our patients.

Please fill out the following intake paperwork so they we may get started with your appointment.

File #:_____

**Patient Information**

Patient Name _____ Date _____ Email _____

SS # _____ DOB _____ ❑ M ❑ F Phone # _____

Check appropriate box: ❑ Minor ❑ Single ❑ Married ❑ Widowed

Patient's Address _____ City _____ State _____ Zip _____

Employer's Name _____

Spouse or Patient's Guardian name _____ Spouse's Employer _____

Whom may we thank for referring you? _____

Person to contact in case of an emergency _____ Phone _____

In case of a medical emergency, if the patient is of school age 15+, is ok to treat in my absence.

_____ _____

Parent or Guardian Date

**Responsible Party** ❑ Same as above

Name of the Person responsible for this account _____ Relationship to Patient _____

Address _____ Home Phone _____

Email _____ Cell Phone _____

Driver's License # _____ Date of Birth _____

Is this person currently a patient at our office? ❑ Yes ❑ No If yes, complete the following:

**Do you have any Medical Insurance?** ❑ No, I will be self-pay ❑ I have already provided this information

Name of the insured _____ Relationship to patient _____

Date of Birth _____ SS# _____ Name of employer _____ Work phone _____

Address of employer _____ State _____ Zip _____

Insurance Company _____ Member ID _____ Group # _____

# Health History

**Chief Complaint** _____

**History of Present Illness**

**Location** _____
(Where is the pain/problem?)

**Quality** _____
(Example: normal vs abnormal color, activity, etc..)

**Severity** _____
(How severe is the pain/problem on a scale of 1-10 with 10 being the most severe?)

**Duration** _____
(How long have you had this pain/problem? When did it start?

**Timing** _____
(Does the pain/problem occur at a specific time?)

**Context** _____
(Where were you at the onset of this pain/problem?)

**Associated Signs/Symptoms** _____
(What other associated problems have you been having?)

**Modifying Factors** _____
(What makes the pain/problem worse or better? Have you had previous episodes?)

**Past Medical History**

Have you ever had the following: (Leave blank if you are uncertain.)

Measles ❑No ❑Yes
Mumps ❑No ❑Yes
Chicken Pox ❑No ❑Yes
Whooping Cough ❑No ❑Yes
Scarlet Fever ❑No ❑Yes
Pneumonia ❑No ❑Yes
Rheumatic Fever ❑No ❑Yes
Arthritis ❑No ❑Yes
Venereal Disease ❑No ❑Yes
Anemia ❑No ❑Yes

Bladder Infection ❑No ❑ Yes
Epilepsy ❑No ❑ Yes
Migraines ❑No ❑ Yes
Tuberculosis ❑No ❑ Yes
Diabetes ❑No ❑ Yes
Cancer ❑No ❑ Yes
Polio ❑No ❑ Yes
Glaucoma ❑No ❑ Yes
Hernia ❑No ❑ Yes
Blood or Plasma ❑No ❑ Yes Transfusion

Back Trouble ❑ No ❑ Yes
High Blood Pressure ❑ No ❑ Yes
Low Blood Pressure ❑ No ❑ Yes
Hemorrhoids ❑ No ❑ Yes
Date of Last Chest X-ray ❑ No ❑ Yes
Asthma ❑ No ❑ Yes
Hives or Eczema ❑ No ❑ Yes
AIDS or HIV ❑ No ❑ Yes
Infectious Mono ❑ No ❑ Yes
Bronchitis ❑ No ❑ Yes

Mitral Valve Prolapses ❑No ❑ Yes
Stroke ❑No ❑ Yes
Hepatitis ❑No ❑ Yes
Ulcer ❑No ❑ Yes
Kidney Disease ❑No ❑ Yes
Thyroid Disease ❑No ❑ Yes
Bleeding Tendency ❑No ❑ Yes
Any other disease (List)

| Previous Hospitalizations/Surgeries/Serious Illnesses | When? | Hospital, City, State |
|---|---|---|
| | | |
| | | |

**Medication: (Include nonprescription)**

Have you ever taken Fen-Phen/Redux? ❑No ❑Yes

Are you taking any medications (prescription or over the counter) for acid indigestion?
❑No ❑Yes If Yes, what type? _____

**Do you have a sulfa allergy?** ❑ Yes ❑ No

**Allergies/Medication Allergies??**

# Patient Social History

Use of Alcohol ❑Never ❑Rarely ❑Moderate ❑Daily
Use of Tobacco ❑Never ❑Rarely ❑Moderate ❑Daily
Use of Drugs ❑Never Type/Frequency _____
Excessive Exposure at home or work to: ❑Fumes ❑Dust ❑Solvents ❑Airborne Particles ❑Noise

# Family Medical History

| | Age | Disease | If Deceased, Cause of Death |
|---|---|---|---|
| Father | | | |
| Mother | | | |
| Siblings | | | |
| | | | |
| Spouse | | | |
| Children | | | |
| | | | |

**Indicated which of the below you have experienced in the last 1-2 months**
**1- Never 2- Rarely 3-Occasionally 4-Frequently 5-Constantly**

**Muscular/Skeletal**

| | |
|---|---|
| Muscle Aches | 1 2 3 4 5 |
| Fibromyalgia | 1 2 3 4 5 |
| Arthritis | 1 2 3 4 5 |
| Joint Pain | 1 2 3 4 5 |
| Low Back Pain | 1 2 3 4 5 |
| Neck Pain | 1 2 3 4 5 |
| Wrist/Hand Pain | 1 2 3 4 5 |
| Elbow Pain | 1 2 3 4 5 |
| Shoulder Pain | 1 2 3 4 5 |
| Hip Pain | 1 2 3 4 5 |
| Knee Pain | 1 2 3 4 5 |
| Ankle/Foot Pain | 1 2 3 4 5 |
| Pain b/t shoulder blades | 1 2 3 4 5 |

**Neurological**

| | |
|---|---|
| Headaches | 1 2 3 4 5 |
| Migraines | 1 2 3 4 5 |
| Dizziness | 1 2 3 4 5 |
| Numbness | 1 2 3 4 5 |
| Tingling | 1 2 3 4 5 |
| Pins/needles in hands or feet | 1 2 3 4 5 |
| Burning in hands or feet | 1 2 3 4 5 |
| Hyper Sensitivity | 1 2 3 4 5 |
| Difficulty with Balance | 1 2 3 4 5 |

**General**

| | |
|---|---|
| Fatigue | 1 2 3 4 5 |
| Malaise | 1 2 3 4 5 |
| Weakness, tiredness | 1 2 3 4 5 |
| Lightheadedness | 1 2 3 4 5 |
| Irritability | 1 2 3 4 5 |
| Constipation | 1 2 3 4 5 |
| Diarrhea | 1 2 3 4 5 |
| Feeling Foggy | 1 2 3 4 5 |
| Forgetfulness | 1 2 3 4 5 |

**Do you have a living will?** ❑ Yes ❑ No **Do you have a DNR (Do not Resuscitate)?** ❑ Yes ❑ No

**IF YES, PLEASE PROVIDE THE OFFICE WITH A COPY FOR YOUR FILE**

**To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.**

_____ _____

**Signature of the Patient, Parent or Guardian** **Date**

_____ _____

**Doctor's Signature** **Date**

## Patient Consent for Communication

We have the ability to call or text you, reminding you of your appointments  If you would like to receive this feature in the future, please read the consent below and sign.  Patients in our practice may be contacted via phone/text message to be reminded of an appointment, to obtain feedback on an experience within our office, and to provide general health reminders/ information

1. I consent to receiving appointment reminders and other healthcare communications via telephone from Spinalworks Medical Group _____ **(Initials)**

2. I consent to receive text messages from Spinalworks Medical Group on my cell phone and any number forwarded or transferred to that number.  I authorize Spinalworks Medical Group to text my phone for appointment reminders and information._____ **(Initials)**

3. I consent to emails, to receive communications as stated above._____ **(Initials)**

4. I understand that this request to receive emails an/or text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing. _____ **(Initials)**

**Signature:** _____ **Date**:_____

## Patient Consent to Treat

I hereby authorize the Doctor's/Nurse Practitioners' of Spinalworks Medical Group to treat my case as they deem appropriate through the use of lab testing, trigger point injections, durable medical equipment, rehabilitation, manual therapy, chiropractic manipulation of the spine, nutritional support, and diagnostic testing.  I realize the goal of holistic health care is to strengthen the patient's body in order to health themselves.

It is understood and agreed the amount paid to the clinic for x-rays for interpretation. The patient also agrees that he/she is responsible for all bills incurred at this office.

**Signature:** _____ **Date:**_____

## Acknowledgment of Receipt of Notice of Privacy Practices for Protected Health Information

I acknowledge that I have received Spinalworks Medical Group's notice of Privacy Practice for Protected Health Information

Name of Patient:_____ Date:_____

**Signature of Patient or representative: of Patient:** _____

FOR OFFICE USE ONLY:

I made a good faith effort to obtain the patient's written acknowledgment of our Notice of Privacy Practices for Protect Health Information by (check all that apply)

- ❍ Showing the patient the Notice of Privacy Practices posted in our office.
- ❍ Giving the patient a copy of our Notice of Privacy Practices to read prior to receiving any treatment or service
- ❍ Giving the patient all necessary information to obtain our Notice of Privacy Practices on our website
- ❍ Asking the patient to sign this Acknowledgment form
- ❍ Other (Explain in detail)_____

I was unable to obtain the patient's written Acknowledgment because (check all that apply)

- ❍ The patient refused to sign this form
- ❍ The patient would not sign the form because the patient said he/she did not understand the Notice
- ❍ Other (Explain in detail)_____