Fire Mountain Spine & Rehabilitation Center
Initial Patient Intake

Welcome! We specialize in assisting our patients to achieve their highest level of health through our spinal and postural corrective programs. Our approach is very unique and advanced from other rehabilitative programs. This allows our patients to achieve far superior results compared to most other systems. We look forward to serving you.

General Information **Today's Date:** _____

Name: _____ Birth Date: _____

Email:_____ Social Security #:_____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Who may we thank for referring you? _____

Marital Status: _____ Occupation: _____

Name(s) and Age(s) of Children: _____

Do you notice poor posture habits in your children? ❑ Yes ❑ No

In case of Emergency, please call: _____ Phone:_____

Purpose of this Visit

Reason for Visit: _____

Is this purpose related to an auto accident/work injury? ❑ Yes *(explain below)* ❑ No

Describe: _____

When did this condition begin/when did you first notice it? _____

Describe:_____

What activities aggravate your symptom? _____

Is there anything which has relieved your symptoms? ❑ Yes *(explain below)* ❑ No

Describe: _____

Have you experienced this condition before? ❑ Yes ❑ No

Who have you seen for this? _____ What did they do? _____

How did you respond? _____

Have you ever experienced pain in your neck, spine, or body due to:

Automobile ❑ Yes ❑ No _____

Motorcycle ❑ Yes ❑ No _____

Bicycle ❑ Yes ❑ No _____

Sports ❑ Yes ❑ No _____

Other: _____

Have you ever had surgery or been hospitalized? ❑ Yes ❑ No

If yes, please explain: _____

Age of mattress: _____ Is it comfortable? ❑ Yes ❑ No

Position of Sleep: ❑ Back ❑ Stomach ❑ Side ❑ Other: _____

For women: Are you pregnant? ❑ Yes ❑ No Date of last menstrual period: _____

Health Care Information

Have you ever received chiropractic care? ❑ Yes ❑ No If yes, with whom? _____

Date of last visit: _____ For how long were you receiving care? _____

How frequent were your visits? _____ Reason for ending care: _____

Please describe, to the best of your ability, what type of adjustment and/or other services were utilized.

_____

Were you pleased with his/her service? ❑ Yes ❑ No

Are you aware that posture is an important determinant of one's overall health *and* conveys valuable health information? ❑ Yes ❑ No

Do you ever feel that it takes effort and awareness to maintain an aligned posture? ❑ Yes *(explain below)* ❑ No

Describe: _____

Note: The most common postural weakness is the *Forward Head Syndrome* (Head and neck start to bend forward and progressively move downward, compromising the brain stem, spinal cord, and nerves.) Even mild forms of this posture can affect our overall health.

Health Lifestyle

Do you exercise? ❑ Yes ❑ No If yes, what type? _____ How often? _____

Do you consume: ❑ Alcohol ❑ Coffee/caffeine ❑ Tobacco

Are you currently taking any prescription or over-the-counter medications? ❑ Yes ❑ No

If yes, please list: _____

Have you at other times taken prescription drugs over an extended period? ❑ Yes ❑ No

If yes, please list: _____

Do you take any supplements? ❑ Yes ❑ No

If yes, please list: _____

Health Conditions

Cervical Spine (Neck):
Posture distortions/subluxations of the skull and neck will affect the nerves into the arms, hands, and head. Do you experience any of the following:

- ❑ Neck pain
- ❑ Sinusitis
- ❑ Pain into shoulders/arms/hands
- ❑ Numbness in shoulders/arms/hands
- ❑ Recurrent Colds/flus
- ❑ Weakness of grip
- ❑ TMJ/pain/clicking
- ❑ Headaches
- ❑ Allergies/Hay Fever
- ❑ Dizziness
- ❑ Visual Disturbances
- ❑ Hearing Disturbances
- ❑ Fatigue
- ❑ Thyroid Conditions
- ❑ Insomnia/difficulty sleeping
- ❑ Depression/mood swings
- ❑ Poor Immune Response

Thoracic Spine (Upper Back):
Postural distortions/subluxations in the upper back will affect the nerves to the heart and lungs. Do you experience any of the following:

- ❑ Heart Palpitations
- ❑ Tachycardia
- ❑ Recurrent Lung Infections/Bronchitis
- ❑ Asthma/wheezing
- ❑ Shortness of breath
- ❑ Pain on deep inspiration/expiration

Lumbar Spine (Low Back):
Postural distortions/subluxations in the upper back will affect the nerves into the pelvic organs and legs/feet. Do you experience any of the following:

- ❑ Low back pain
- ❑ Pain into buttock/hips/legs/feet
- ❑ Numbness/tingling in buttock/hips/legs/feet
- ❑ Muscle cramps in legs/feet
- ❑ Weakness in hips/knees/ankles
- ❑ Recurrent bladder infections
- ❑ Frequent, difficult urination
- ❑ Constipation/diarrhea
- ❑ Menstrual irregularities/cramping
- ❑ Sexual dysfunction

Informed Consent for Chiropractic Treatment and Care
I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor or intern, affiliated with Fire Mountain Spine & Rehabilitation Center.

I understand that, as in the practice of medicine, in the practice of chiropractic care there are some risks to treatment, including but not limited to: fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgment during the course of the procedure, which the doctor feels at the time, based on the facts then known, is in my best interests.

I have read, or have had read to me, the above consent. By signing below I agree to the above, and allow the doctor or intern, affiliated with Fire Mountain Spine & Rehabilitation Center, to perform such. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

I have read and understand the above policy listed: **Initial** _____

Our Privacy Pledge
We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information. There are several circumstances in which we may need to disclose your health care information:

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services
- We may need to use your health information within our practice for quality control or other operational purposes.

I have read and understand the above policy listed: **Initial** _____

Specific Health Care Authorizations

The patient identified above authorizes Fire Mountain Spine & Rehabilitation center to use and/or disclose protected health information in accordance with the following:

- I give permission to Fire Mountain Spine & Rehabilitation Center to use my name, address, phone number, and clinical records to contact me with appointment reminds, missed appointment notifications, birthday cards, holiday related cards, information about treatment alternatives, newsletters, or other health related information.
- I give permission to Fire Mountain Spine & Rehabilitation Center to display my name on an internal referral board and/or patient sign–in sheet.
- If Fire Mountain Spine & Rehabilitation Center contacts me by phone, I give them permission to leave a phone message on my answering machine or voice mail.
- I give Fire Mountain Spine & Rehabilitation Center permission to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information in the course of care. Should I need to speak with a doctor at any time in private, the doctor will provide a room for these conversations.
- I give Fire Mountain Spine & Rehabilitation Center permission to report my findings and review my x-rays with family and/or friends present in the room.

This authorization is requested by Fire Mountain Spine & Rehabilitation Center for its own use/disclosure of PHI. Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the information and may no longer be protected by the federal privacy rules.

You have the right to refuse to sign this authorization. If you refuse to sign this authorization, Fire Mountain Spine & Rehabilitation Center will not refuse to provide treatment. This notice is effective as of today. This authorization will expire seven years after the date on which you last received services from us. By initialing below, I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I may have access to a copy of this authorization.

I have read and understand the above policy listed: **Initial** _____

Cancellation policy

We require **24 hour notice** in the event of a cancellation. There is a **$50.00** charge for a cancellation without proper notice. This charge will not be covered by insurance, but will have to be paid by you personally. For Worker's Compensation and Personal Injury patients documentation of any missed appointments is forwarded to your Case Manager and Primary Physician and this could jeopardize your claim.

I have read and understand the above policy listed: **Initial** _____

By signing below, I agree that I have provided information to the best of my knowledge and have read and understand all of the above listed policies and notifications; I have had the opportunity to ask any questions or address any concerns before signing.

_____ _____

Patient or Guardian's Signature **Date**

Fire Mountain Spine & Rehabilitation Center
Professional Fee Schedule

Our experience has shown that it is wise to have an understanding with our patients as to our center policies and fees. Therefore, this form has been prepared for your convenience and information. We offer several methods of payment for your care at our center, and you may choose the plan which best fits your needs. Please read carefully and choose the plan you prefer. This information will enable us to better serve you and help to avoid misunderstandings in the future. If special arrangements are necessary, please consult with the Doctor. Our main concern is your health and well-being, and we will do our best to help you.

I understand that I am responsible for all fees incurred for the services provided, and agree to ensure full payment of all charges. **I understand I am responsible for all Durable Medical Equipment such as foam rollers, head weights, etc, not covered by insurance.** I also clearly understand that if I do not follow the Doctors specific recommendations at this clinic that I will not receive the full benefit from these programs, and that if I terminate my care prematurely, that all fees incurred will be due and payable at that time. I authorize the assignment of all insurance benefits be directed to the Doctor for all services rendered.

Plan #1: Insurance: If you have insurance that covers chiropractic care and/or physical therapy, we will bill your insurance company directly. You will be required to pay for your care, until we have verified your insurance coverage. In the event the insurance check should come to you, you are expected to bring the check to us. If you have a deductible or co-insurance, we will bill you your portion of responsibility upon receipt of payment from your insurance carrier. Co-payments will be collected each visit. Remember, insurance companies will not cover "maintenance" and wellness care. Most "health" policies are designed and intended to only take care of acute problems. Therefore, you will likely have to choose another method of payment once your insurance company will no longer pay for your chiropractic care and/or physical therapy.

I clearly understand that all insurance coverage, whether accident, work related, or general coverage is an arrangement between my insurance carrier and myself. If this office chooses to bill any services to my insurance carrier, they are performing these services strictly as a convenience for me. The Doctors office will provide any necessary reports or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny my claims and that I am ultimately held responsible for any unpaid balances. Any monies received will be credited to my account.

Plan #2: Cash: Fees are to be paid at the time of services rendered, unless special arrangements have been made in advance.

Plan #3: Cash Pre-Pay: Ask doctor for details.

Plan #4: Industrial: You need to report your accident to your employer, bring in necessary insurance information, and sign industrial forms for billing by your second visit. We will bill your insurance directly.

Plan #5: Auto Injury: You need to supply us with the accident report, your car insurance, health insurance, liable parties' insurance, and attorney information if applicable. Until necessary insurance information is gathered and verified for chiropractic care, you will be required to pay for your care. We will bill your insurance directly after verification of coverage. In the event the check should come to you, you are required to bring the check to us.

I qualify for and understand plan # _____ requirements.

Signature _____ **Date** _____