

GULF COAST SPORT & SPINE, LLC

New Patient Intake Form

Title: (Check one) Mr. Mrs. Ms. Miss Dr.

First Name _____ **Middle Initial** ____ **Last Name** _____

Address _____

City _____ **State** _____ **Zip Code** _____

Home Phone (____) _____ - _____ **Work Phone** (____) _____ - _____

Cell Phone (____) _____ - _____ **Email** _____

Date of Birth ____/____/____ **Sex:** Male Female

Social Security Number: _____ - _____ - _____ **Marital Status:** Single Married Other

Employment Status: Employed Full-Time Student Part-Time Student Other _____

Employer Data

Employer _____

Your Occupation _____

Spouse Data

Is your spouse a patient in this clinic? Yes No

First Name _____ **Middle Initial** ____ **Last Name** _____

Home Phone (____) _____ - _____ **Work Phone** (____) _____ - _____

Spouse Date of Birth ____/____/____

Emergency Contact

Contact Name _____ **Relationship to Patient** _____

Contact Home Phone (____) _____ - _____ **Cell Phone** (____) _____ - _____

How did you hear about our office? _____

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Surgeries: (Check all that apply to you)

- | | | | |
|--|---|---|---------------------------------------|
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Cardiovascular procedure | <input type="checkbox"/> Cervical spine | <input type="checkbox"/> Hysterectomy |
| <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> Prostate | <input type="checkbox"/> Lumbar spine | <input type="checkbox"/> Gall Bladder |
| <input type="checkbox"/> Brain | <input type="checkbox"/> Shoulder | <input type="checkbox"/> Thoracic spine | <input type="checkbox"/> Knee |
| <input type="checkbox"/> Carpal Tunnel | <input type="checkbox"/> Gastro-intestinal | <input type="checkbox"/> Uro-genital | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Breast Augmentation | <input type="checkbox"/> Other _____ | | |

***Please provide date and specific procedure if applicable: _____

Allergies: (Check all that apply to you)

- | | | | |
|-------------------------------|---|---|--------------------------------------|
| <input type="checkbox"/> Mold | <input type="checkbox"/> Seasonal | <input type="checkbox"/> Milk/Lactose | <input type="checkbox"/> Animal |
| <input type="checkbox"/> Egg | <input type="checkbox"/> Sulfites | <input type="checkbox"/> Wheat/Glutens | <input type="checkbox"/> Peanut |
| <input type="checkbox"/> Soy | <input type="checkbox"/> Fish/Shellfish | <input type="checkbox"/> Chemical _____ | <input type="checkbox"/> Other _____ |

Social History: (Check all that apply to you)

- | | | | |
|----------------|---|--|-----------------------------------|
| Caffeine use: | <input type="checkbox"/> occasional | <input type="checkbox"/> often | <input type="checkbox"/> never |
| Drink Alcohol: | <input type="checkbox"/> occasional | <input type="checkbox"/> often | <input type="checkbox"/> never |
| Exercise: | <input type="checkbox"/> occasional | <input type="checkbox"/> often | <input type="checkbox"/> never |
| Drink Water: | <input type="checkbox"/> <64 oz/day | <input type="checkbox"/> >64 oz/day | <input type="checkbox"/> never |
| Cigarettes: | <input type="checkbox"/> <1 pack/day | <input type="checkbox"/> >1 pack/day | <input type="checkbox"/> never |
| Sleep: | <input type="checkbox"/> <8 hours/night | <input type="checkbox"/> >=8 hours/night | <input type="checkbox"/> Insomnia |
| Other | _____ | | |

Family History: (Check all that apply)

- | | | |
|---------------|---------------------------------|----------------------------------|
| Arthritis: | <input type="checkbox"/> Parent | <input type="checkbox"/> Sibling |
| Cancer: | <input type="checkbox"/> Parent | <input type="checkbox"/> Sibling |
| Diabetes: | <input type="checkbox"/> Parent | <input type="checkbox"/> Sibling |
| Heart Disease | <input type="checkbox"/> Parent | <input type="checkbox"/> Sibling |
| Hypertension | <input type="checkbox"/> Parent | <input type="checkbox"/> Sibling |
| Stroke | <input type="checkbox"/> Parent | <input type="checkbox"/> Sibling |
| Thyroid | <input type="checkbox"/> Parent | <input type="checkbox"/> Sibling |
| Other | _____ | |

Occupational Activities: (Check all that apply)

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Administration | <input type="checkbox"/> Business owner | <input type="checkbox"/> Clerical/secretarial | <input type="checkbox"/> Computer user |
| <input type="checkbox"/> Construction | <input type="checkbox"/> Daycare/childcare | <input type="checkbox"/> Executive/legal | <input type="checkbox"/> Food service industry |
| <input type="checkbox"/> Health care | <input type="checkbox"/> Heavy equipment operator | <input type="checkbox"/> Heavy manual labor | <input type="checkbox"/> Home services |
| <input type="checkbox"/> Household | <input type="checkbox"/> Light manual labor | <input type="checkbox"/> Manufacturing | <input type="checkbox"/> Medium manual labor |

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Review of Systems – (Check box if you have had trouble with any of the following)

Cardiovascular	Past	Present	No	Respiratory	Past	Present	No	Allergic/Immunologic	Past	Present	No
Poor Circulation				Asthma				Hives			
Hypertension				Tuberculosis				Immune Disorder			
Aortic Aneurism				Short Breath				HIV/AIDS			
Heart Disease				Emphysema				Allergy Shots			
Heart Attack				Cold/Flu		X		Cortisone Use			
Chest Pain				Cough		X					
High Cholesterol				Wheezing							
Pace Maker								Ear, Nose and Throat			No
Jaw Pain				Eyes			No	Difficulty Swallowing	Past	Present	
Irregular Heartbeat					Past	Present		Dizziness			
Swelling of legs				Glaucoma				Hearing Loss			
				Double Vision				Sore Throat		X	
Genitourinary			No	Blurred Vision				Nosebleeds			
Kidney Disease	Past	Present						Bleeding Gums			
Burning Urination				Psychiatric			No	Sinus Infections			
Frequent Urination				Depression							
Blood in Urine				Anxiety				Gastrointestinal			No
Kidney Stones				Stress					Past	Present	
Lower Side Pain								Gall Bladder Problems			
				Endocrine			No	Bowel Problems			
Neurologic			No		Past	Present		Constipation		X	
	Past	Present		Thyroid				Liver Problems			
Stroke				Diabetes				Ulcers			
Seizures				Hair Loss				Diarrhea		X	
Head Injury				Menopausal				Nausea/Vomiting		X	
Brain Aneurysm				PMS				Bloody Stools			
Numbness								Poor Appetite			
Severe Headaches				Hematologic			No				
Pinched Nerves								Musculoskeletal			No
Parkinson's				Hepatitis					Past	Present	
Carpal Tunnel				Blood Clots				Gout			
Vertigo				Cancer				Arthritis			
				Bruising		X		Joint Stiffness			
Constitutional			No	Bleeding				Muscle Weakness			
	Past	Present		Fever, Chills		X		Osteoporosis			
				Sweating		X		Broken Bones			
Weight Loss/Gain				Varicose Vein				Joints Replaced			
Low Energy Level								Neck Pain			
Difficulty Sleeping								Low Back Pain			
								Upper Back Pain			

Additional Medical Conditions: (Check all that apply to you)

Fibromyalgia Other _____

Please list all current medications being taken _____

Do you take daily vitamins/supplements? Yes No

Are you satisfied with the quality of the vitamins/supplements you take? Yes No N/A

Are You Pregnant? (Circle) **Yes** **No** - **If yes, how many weeks pregnant are you?** _____

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By Using the key below, indicate on the body diagram where you are experiencing the following symptoms:

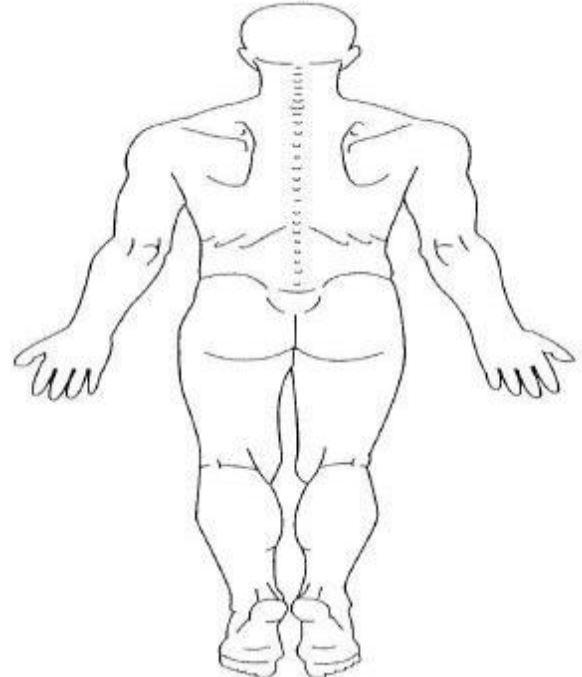
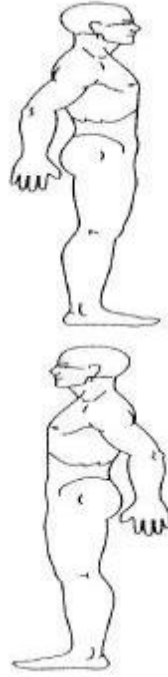
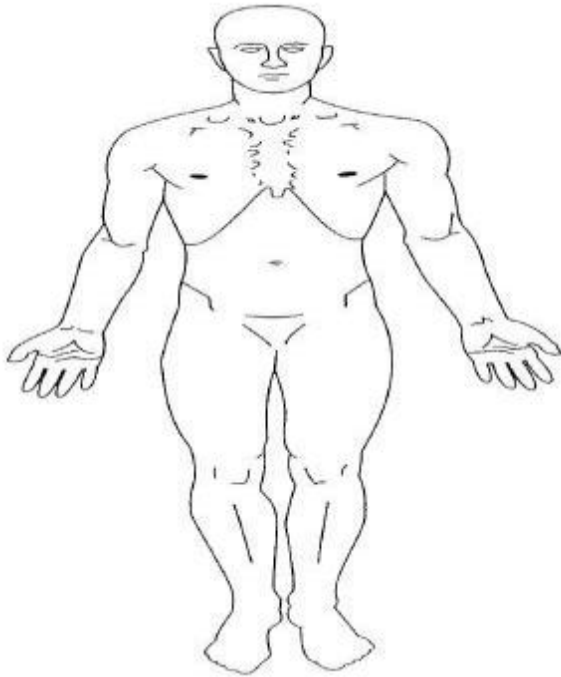
N=Numbness

B=Burning

S=Sharp

T=Tingling

A=Dull Ache



Average Pain Intensity:

Last 24 hours: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain
 Past week: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

Please list anything that relieves the pain: _____

Please list anything that worsens the pain: _____

When did your symptoms begin? _____

How did your symptoms begin? _____

How often do you experience your symptoms?

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Constantly
(76-100% of the day) | <input type="checkbox"/> Frequently
(51-75% of the day) | <input type="checkbox"/> Occasionally
(26-50% of the day) | <input type="checkbox"/> Intermittently
(0-25% of the day) |
|---|--|--|---|

What describes the nature of your symptoms?

- | | | | |
|----------------------------------|-----------------------------------|------------------------------------|-------------------------------------|
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Ache | <input type="checkbox"/> Numb | <input type="checkbox"/> Shooting |
| <input type="checkbox"/> Burning | <input type="checkbox"/> Tingling | <input type="checkbox"/> Throbbing | <input type="checkbox"/> Other_____ |

How are your symptoms changing? Getting better Not changing Getting worse

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During the past 4 weeks, how much has pain interfered with your normal work (including both work outside the home and housework):

- Not at all A little bit Moderately Quite a bit Extremely

During the past 4 weeks, how much of the time has your condition interfered with your social activities?

- All of the time Most of the time Some of the time A little of the time
 None of the time

In general, would you say your overall health right now is....

- Excellent Very good Good Fair Poor

Who have you seen for your symptoms:

- No one Other Chiropractor Medical Doctor Physical Therapist
 Other _____

What treatment did you receive for your symptoms?

- Adjustments Physical Therapy Medication Surgery
 Other _____

When did you receive this treatment?

- In the last month 2 – 3 months ago 3 – 6 months ago 6 months to 1 year ago
 1 – 2 years ago 2 – 5 years ago 5 – 10 years ago

What tests have you had for your symptoms?

- X-rays MRI CT Scan EMG/NCV Other

When were these tests done?

- In the last month 2 – 3 months ago 3 – 6 months ago 6 months to 1 year ago
 1 - 2 years ago 2 – 5 years ago 5 – 10 years ago

Have you had similar symptoms in the past?

- Yes No

If you have seen treatment in the past for the same or similar symptoms, who did you see?

- This Office Other Chiropractor Medical Doctor Physical Therapist
 Other _____

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PAYMENT POLICY

Thank you for choosing Gulf Coast Sport & Spine, LLC as your Chiropractic provider. We are committed to providing you with quality and affordable health care. Due to some of the questions our patients have regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask any questions you may have, and sign in the space provided below. A copy will be provided to you upon request.

1. **INSURANCE.** We participate in most insurance plans, including Medicare. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan we do participate with, but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility, please contact your insurance company with any questions you may have regarding your coverage. If your insurance company requires a referral it is your responsibility to provide us with a referral dated the day of your first visit from your primary care physician prior to your first visit. We are only able to provide a summary of your chiropractic benefits.
2. **CO-PAYMENT AND DEDUCTIBLES.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.
3. **PROOF OF INSURANCE.** All patients must complete our patient information form before seeing the provider. We must obtain a copy of your most current insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
4. **CLAIM SUBMISSION.** We will submit your claims and assist you in any way we reasonably can to help get your claim paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance pays your claim. Your insurance benefits are a contract between you and your insurance company; we are not party to that contract.
5. **COVERAGE CHANGES.** If your insurance coverage changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 90 days, the balance will automatically be billed to you.
6. **MISSED APPOINTMENT.** Our policy is to charge \$20.00 after **two (2)** missed appointment not cancelled at least 6 hours in advance. The charges will be your responsibility and billed directly to you.
Please help us to serve you better by keeping your regular scheduled appointment.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

I have read and understood the payment policy and agree to abide by its guidelines.

Signature of patient or responsible party

Date

GULF COAST SPORT & SPINE, LLC

PATIENT'S AFFIRMATION OF RECEIPT OF PATIENT'S STATEMENT OF PRIVACY RIGHTS

I hereby acknowledge receipt of this office's Statement of Privacy Rights, provided on my behalf and in accordance with law and have read and understand my rights to privacy and security of Personal Health Information, as a patient of this practice.

Patient's Signature _____ **Date** _____

ASSIGNMENT OF BENEFITS AND POWER OF ATTORNEY TO CASH CHECKS

I, the undersigned, do hereby authorize payment directly to the office below, the benefits of my coverage, if any, otherwise payable to me for services but not to exceed the customary charge for those services. If these payments are made out to me I grant unto the office below as attorney the full power and authority in my name and stead to endorse any and all checks and drafts or money orders. I hereby authorize the doctor to release all information necessary to secure payment of benefits. A photocopy of this assignment shall be valid.

Patient's Signature _____ **Date** _____

INFORMED CONSENT FOR CHIROPRACTIC CARE

A patient, in coming to the Chiropractic Physician, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustments or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor of course, will not give any treatment or health care if he is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through health care procedures whatever he is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the Chiropractic Physician. The Chiropractic Physician provides a specialized, non-duplicating health care service. You Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime. I understand that if I am accepted as a patient by a physician at Gulf Coast Sport and Spine, LLC, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Patient Signature _____ **Date:** _____

PLEASE TURN INTO FRONT DESK