Southern States Spine & Muscle Rehabilitation Center

New Patient Health History Form

Date: ____-____-____

Personal History

DOB:____-____-____ Age:_____ SS# ____-____-_____ Driver's License #:_____

Gender: Male / Female [ ] Single [ ] Married [ ] Divorced [ ] Widowed
Race: [ ] Caucasian [ ] African American [ ] Hispanic [ ] Asian [ ] Other

First Name:_____ Middle:_____ Last:_____
Address:_____ City:_____ State:_____ Zip:_____
Phone (H):____-____-_____ Cell: ____-____-____ Wk: ____-____-____
Email Address:_____

Emergency Contact Info

Name: _____ Relationship:_____ Phone # ____-____-____

How did you hear about us:_____

Employer

Business Name: _____ Job Title:_____ Type of Work:_____
Business # ____-____-_____

Payment Information

Person Responsible for Payment_____ Date of Birth____/____/____ Phone ____-____-_____
Do you have Health Insurance [ ] Yes [ ] No Are you the Policy Holder [ ] Yes [ ] No

Insurance Information

[ ] Self [ ] Workers Comp [ ] Auto [ ] Medicare [ ] Medicaid [ ] VA [ ] Attorney [ ] Other_____

*** PATIENTS WITH NO INSURANCE (SELF PAY) Payment will be collected in full at each visit**

***CO-PAYMENTS DEDUCTIBLES CO-INSURANCE ARE DUE AT EACH VISIT**

PRIMARY INSURANCE	SECONDARY INSURANCE
Insurance Company	Insurance Company
Policy ID #	Policy ID #
Group #	Group #
Policy Holder's Name:	Policy Holder's Name:
Policy Holder's DOB:	Policy Holder's DOB:
Relationship to Patient	Relationship to Patient

Patient/Guardian Signature_____ Date_____

Do you have any problems with the following (Please Circle)
Cardiovascular Respiratory Diabetic Arthritis Gastrointestinal Female Issues Male Issues

List Current Medications:_____

_____

_____

Please list any PAST Health Surgeries, Injuries, etc:_____

_____

_____

Family Health History

Father [ ] Living [ ] Deceased List Health/Disease _____
Mother [ ] Living [ ] Deceased List Health/Disease _____
Grand Parents [ ] Living [ ] Deceased List Health/Disease _____

Do you Smoke [ ] Yes [ ] No How often:_____day/week/month Do you Chew Tobacco [ ] Yes [ ] No
Do you Drink [ ] Yes [ ] No How often:_____day/week/month Do you use Drugs [ ] Yes [ ] No

Current Complaint

Reason for today's Visit: _____

_____

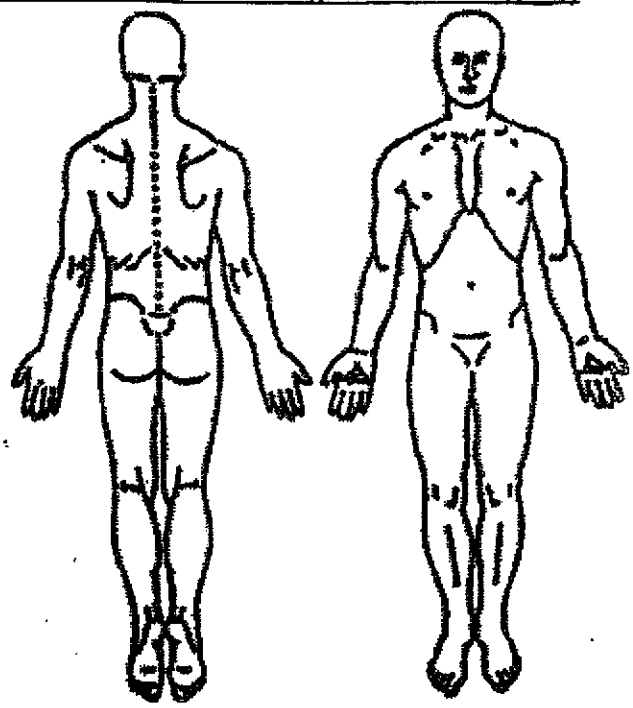
_____

_____

_____

_____

AREA OF DISCOMFORT (please mark diagram)



Have you ever been under Chiropractic Care:
[ ] Yes [ ] No
If yes, please describe_____

_____

Have you seen Physical Therapy for this condition:
[ ] Yes [ ] No
If yes, please describe_____

_____

When did this condition begin: ____-____-____

Has it ever occurred before: [ ] Yes [ ] No
If Yes when:_____
Is the condition: [ ] Work Related [ ] Auto
[ ] No Injury [ ] Other

Explain:_____

_____

_____

If Accident
Date: ____-____-____ Time:_____ State:_____

Have you seen other doctors for this condition? [ ] Yes [ ] No
If Yes, Physician Name:_____ Office Location:_____
Type of Treatment:_____

Brief explanation of Job duties:_____

_____

_____

How does your current condition effect your Job Performance:
[ ] Mild Pain (no limits) [ ] Moderate Pain (some limits) [ ] Mod/Severe Pain (limited) [ ] Severe (unable to work)

On a scale of one to ten how intense are your symptoms:
(Not intense) 0 1 2 3 4 5 6 7 8 9 10 (unbearable)

Daily Activities: Check all that apply to current condition

Sitting	___ No Effect	___ Mild(painful/can do)	___ Moderate Pain (Painful/limited)	___ Severe (Unable to perform)
Standing	___ No Effect	___ Mild(painful/can do)	___ Moderate Pain (Painful/limited)	___ Severe (Unable to perform)
Getting up / down	___ No Effect	___ Mild(painful/can do)	___ Moderate Pain (Painful/limited)	___ Severe (Unable to perform)
Walking	___ No Effect	___ Mild(painful/can do)	___ Moderate Pain (Painful/limited)	___ Severe (Unable to perform)
Climbing Stairs	___ No Effect	___ Mild(painful/can do)	___ Moderate Pain (Painful/limited)	___ Severe (Unable to perform)
Driving	___ No Effect	___ Mild(painful/can do)	___ Moderate Pain (Painful/limited)	___ Severe (Unable to perform)
Household Chores	___ No Effect	___ Mild(painful/can do)	___ Moderate Pain (Painful/limited)	___ Severe (Unable to perform)
Yard Work	___ No Effect	___ Mild(painful/can do)	___ Moderate Pain (Painful/limited)	___ Severe (Unable to perform)
Lifting	___ No Effect	___ Mild(painful/can do)	___ Moderate Pain (Painful/limited)	___ Severe (Unable to perform)
Carrying Items	___ No Effect	___ Mild(painful/can do)	___ Moderate Pain (Painful/limited)	___ Severe (Unable to perform)
Compute Use	___ No Effect	___ Mild(painful/can do)	___ Moderate Pain (Painful/limited)	___ Severe (Unable to perform)
Bathing	___ No Effect	___ Mild(painful/can do)	___ Moderate Pain (Painful/limited)	___ Severe (Unable to perform)
Dressing	___ No Effect	___ Mild(painful/can do)	___ Moderate Pain (Painful/limited)	___ Severe (Unable to perform)
Sleep	___ No Effect	___ Mild(painful/can do)	___ Moderate Pain (Painful/limited)	___ Severe (Unable to perform)
Sexual Activities	___ No Effect	___ Mild(painful/can do)	___ Moderate Pain (Painful/limited)	___ Severe (Unable to perform)

List Recreational Activities (indicate limitations)

_____ [ ]No Effect [ ]Mild(painful/can do) [ ]Moderate Pain (Painful/limited) [ ]Severe (Unable to perform
_____ [ ]No Effect [ ]Mild(painful/can do) [ ]Moderate Pain (Painful/limited) [ ]Severe (Unable to perform
_____ [ ]No Effect [ ]Mild(painful/can do) [ ]Moderate Pain (Painful/limited) [ ]Severe (Unable to perform
_____ [ ]No Effect [ ]Mild(painful/can do) [ ]Moderate Pain (Painful/limited) [ ]Severe (Unable to perform

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Consent for Treatment

By signing below, I give my consent for examination ,x-ray ,neurological and orthopedic testing,rehabilitative procedures and laboratory test.
I understand by signing below, I am giving written consent for the use and disclosure of protected health information for treatment and payment.

Patient/Guardian Signature_____ Date_____

Authorization to Release Medical Information

I authorize Southern States Spine & Muscle Rehabilitation Center to release any medical information necessary to process my insurance claims and I hereby release Southern States Spine & Muscle Rehabilitation Center of any consequence thereof. I certify that all insurance information given to this clinic is correct.

Patient/Guardian Signature_____ Date_____

Request for Payment of Benefits to Provider of Care

I authorize _____Insurance Company to pay by check or electronic payment to be made directly to Southern States Spine & Muscle Rehabilitation Center located at 106-A Woodland Dr , Lancaster SC 29720 toward the total charges for professional services rendered. I have agreed to pay any balance of charges remaining after insurance has paid.

Patient/Guardian Signature_____ Date_____

Attorney Representation

I understand my Attorney_____will pay directly to Southern States Spine & Muscle Rehabilitation Center out of my settlement. I fully understand that I am directly responsible for all medical bills and that this agreement is made solely for Southern States Spine & Muscle Rehabilitation Center additionally protection and consideration awaiting payment. I understand that such payment is not contingent on any settlement judgment or verdict by which I may eventually recover said fee. I understand Third Party Auto Insurance will not be billed by Southern States Spine & Muscle Rehabilitation Center.

Patient/Guardian Signature_____ Date_____

$ 30.00 NO SHOW FEE
LATE CANCELLATIONS

Appointments must be canceled or rescheduled at least 8 hours prior to appointment time to avoid late charges.

ALL NO SHOW APPOINTMENTS WILL BE CHARGED A $30.00 FEE

Patient/Guardian Signature_____ Date_____

Notice of Privacy Practice
Required pursuant to Health Insurance Portability and Accountability Act (HIPAA)

In order to protect the privacy of our patients and to comply with the standards of HIPAA please list below any Person or Medical Provider that you wish to have information pertaining to your care below.

Family / Friend

_____ _____ Circle information allowed: Clinical / Financial
Name of Person Relationship

_____ _____ Circle information allowed: Clinical / Financial
Name of Person Relationship

Medical Provider

_____ _____ Circle information allowed: Clinical / Financial
Name of Person Relationship

_____ _____ Circle information allowed: Clinical / Financial
Name of Person Relationship

In order to protect the privacy of our patients and to comply with the standards of HIPAA please list below any Person or Medical Provider that you <u>DO NOT</u> wish to have information pertaining to your care below.

Family / Friend

_____ _____ Circle information allowed: Clinical / Financial
Name of Person Relationship

_____ _____ Circle information allowed: Clinical / Financial
Name of Person Relationship

Medical Provider

_____ _____ Circle information allowed: Clinical / Financial
Name of Person Relationship

_____ _____ Circle information allowed: Clinical / Financial
Name of Person Relationship