NEXUS
Spine & Sport

Patient Name: _____ **Birthdate:** _____ **Height:** _____

Social Security Number: _____ **Male** **Female** **Weight:** _____

Home Address: _____

Home Phone: _____ **Cell Phone:** _____

Email Address: _____

Who Referred You to Our Office? _____

Emergency Contact: _____ **Relation:** _____ **Phone:** _____

What are You Seeing the Doctor For? _____ Headache _____ Neck Pain _____ Back Pain _____ Other

Primary Care Physician: _____

May We Send Health Updates to this Physician? _____ Yes _____ No

	PRIMARY INSURANCE	SECONDARY INSURANCE
Insurance Company		
Group #		
Subscriber ID:		
Address:		
Insured's Name:		
Insured's Employer:		
Insured's SS#		
Relation / DOB:		

Martial Status: _____ Single _____ Married _____ Divorced _____ Widowed

Current Work Status: _____ Employed _____ Retired _____ Not Working _____ Light Duty

Occupation: _____

Handed: _____ Right _____ Left _____ Both

Have You Seen a Doctor in the Past for These Injuries/Conditions?

Doctor: _____ **Date:** _____ **Treatment:** _____

Doctor: _____ **Date:** _____ **Treatment:** _____

MEDICATIONS

MEDICATIONS	DOSE

ALLERGIES

ALLERGY	SEVERITY (MILD, MODERATE, SEVERE)

PAST SURGERIES

SURGERY	DATE

BACK PAIN

Location:

_____ No back pain
_____ Centrally located low back pain
_____ Right sided low back pain
_____ Left sided low back pain
_____ Both sides into the hips
_____ Between the shoulder blades

Describe Your Pain:

_____ Deep dull
_____ Sharp
_____ Burning
_____ Electric
_____ Hot/tingling
_____ Stiff and sore

When did your back pain begin?

_____ After my accident
_____ Years ago (Date) _____
_____ A few days/weeks/months ago
_____ Always had some pain/stiffness

Intensity:

_____ Mild (1-3)
_____ Moderate (4-7)
_____ Severe (8-10)

Duration:

_____ Constant
_____ Intermittent

Have you had this pain in the past?

_____ Yes _____ No

Previous treatment for low back pain?

_____ Yes _____ No

Does your pain radiate?

_____ Does not radiate to legs/feet/toes
_____ Radiates into the right leg
_____ Radiates into the left leg
_____ Radiates into the right foot/toes
_____ Radiates into the left foot/toes

How well do you function with your pain?

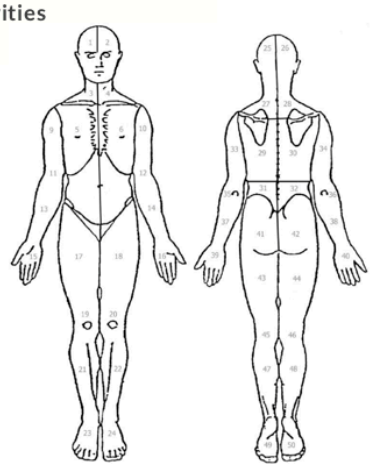
_____ I have 100% function with usual activities
_____ I have 75% function with usual activities
_____ I have 50% function with usual activities
_____ I have 25% function with usual activities
_____ I cannot function

What makes your pain worse?

_____ Flexion
_____ Extension
_____ Rotating left / right
_____ Laying on back
_____ Coughing / sneezing
_____ Laying on side
_____ Motion

What makes your pain better?

_____ Cold/ice
_____ Heat
_____ Massage
_____ Exercise and stretching
_____ Rest
_____ Laying on side
_____ Laying on back



NECK PAIN

Location:

_____ No neck pain
_____ Centrally located low neck pain
_____ Right sided low neck pain
_____ Left sided low neck pain
_____ Both sides into the shoulders
_____ At the base of the skull

Describe Your Pain:

_____ Deep dull
_____ Sharp
_____ Burning
_____ Electric
_____ Hot/tingling
_____ Stiff and sore

When did your neck pain begin?

_____ After my accident
_____ Years ago (Date) _____
_____ A few days/weeks/months ago
_____ Always had some pain/stiffness

Intensity:

_____ Mild (1-3)
_____ Moderate (4-7)
_____ Severe (8-10)

Duration:

_____ Constant
_____ Intermittent

Have you had this pain in the past?

_____ Yes _____ No

Previous treatment for low back pain?

_____ Yes _____ No

Does your pain radiate?

_____ Does not radiate to arms/hands/fingers
_____ Radiates into the right arm
_____ Radiates into the left arm
_____ Radiates into the right fingers
_____ Radiates into the left fingers

How well do you function with your pain?

_____ I have 100% function with usual activities
_____ I have 75% function with usual activities
_____ I have 50% function with usual activities
_____ I have 25% function with usual activities
_____ I cannot function

What makes your pain worse?

_____ Moving head up
_____ Moving head down
_____ Rotating left / right
_____ Motion
_____ Coughing / sneezing

What makes your pain better?

_____ Cold/ice
_____ Heat
_____ Massage
_____ Rest
_____ Medication

HEADACHES

Location:

_____ No headaches
_____ Forehead
_____ Right side of head
_____ Left side of head
_____ Behind the eyes
_____ Back of head

Describe Your Pain:

_____ Deep pressure
_____ Dull ache
_____ Burning
_____ Throbbing
_____ Hot/tingling
_____ Stiff and sore

When did your headaches begin?

_____ After my accident
_____ Years ago (Date) _____
_____ A few days/weeks/months ago
_____ Always had some pain/stiffness

Intensity:

_____ Mild (1-3)
_____ Moderate (4-7)
_____ Severe (8-10)

Frequency:

_____ per week

History:

_____ History of headaches?
_____ Ever suffered a concussion?
_____ Prior epilepsy treatment?
_____ Prior history of seizures?

What makes your pain worse?

_____ Noise
_____ Light
_____ Food
_____ Motion
_____ Coughing / sneezing

What makes your pain better?

_____ Cold/ice
_____ Heat
_____ Massage
_____ Rest
_____ Medication

OTHER PAIN

Location:

_____

Describe Your Pain:

_____

Intensity:

_____ Mild (1-3)
_____ Moderate (4-7)
_____ Severe (8-10)

Duration:

_____ Constant
_____ Intermittent

When did your pain begin?

_____ After my accident
_____ Years ago (Date) _____
_____ A few days/weeks/months ago
_____ Always had some pain/stiffness

Have you had this pain in the past?

_____ Yes _____ No

Previous treatment for low back pain?

_____ Yes _____ No

Does your pain radiate?

_____

How well do you function with your pain?

_____

What makes your pain worse?

_____

What makes your pain better?

_____

REVIEW OF SYSTEMS

Have you noticed any of the following?

_____ Unexpected weight loss or gain
_____ Blurred / double vision
_____ Headache
_____ Chest pain
_____ Shortness of breath
_____ Nausea
_____ Painful urination
_____ Joint pains
_____ Skin rash
_____ Dizziness
_____ Depression
_____ Easy bruising
_____ Excessive thirst or urination
_____ Reaction to foods / environment

PAST MEDICAL HISTORY

Have you had any of the following?

_____ Hypertension
_____ Coronary Artery Disease
_____ Arthritis
_____ Cancer
_____ Overweight
_____ Osteoporosis
_____ Immune Disorder
_____ Other: _____

Do you consume alcohol?

_____ I do not drink _____ I am a recovering alcoholic _____ I drink occasionally

Do you smoke?

_____ Yes _____ No _____ I used to smoke

Do you use recreational drugs?

_____ No _____ I have previously used _____ I currently use

FAMILY HISTORY

Has anyone in your immediate family ever had the following?

_____ Cancer
_____ Stroke
_____ Hypertension
_____ Alcoholism
_____ Bleeding tendency
_____ Other: _____

REVIEW OF SYSTEMS

PLEASE INDICATE IF YOU HAVE ANY OF THE FOLLOWING BY CHECKING THE BOX:

CONSTITUTIONAL	□ NONE □ DAYTIME DROWSINESS □ FEVER □NIGHT SWEATS □ CHILLS □ FATIGUE □ LOSS OF APPETITE □ WEIGHT GAIN/LOSS
EYES/VISION	□ NONE □ CATARACTS □ ITCHING □ WEARS CONTACTS/GLASSES □ BLINDNESS □ DOUBLE VISION □ PHOTOPHOBIA □ BLIND SPOTS □ EYE PROBLEMS □ TEARING
EARS, NOSE & THROAT	□ NONE □ FAINTING □ HISTORY OF HEAD INJURY □ RUNNY NOSE □ DIZZINESS □ FREQUENT SORE THROATS □ LOSS OF SENSE OF SMELL □ SINUS INFECTION □ EAR DISCHARGE □ HEADACHES □ NOSEBLEEDS □ EAR PAIN □ HEARING LOSS □ NASAL CONGESTION
RESPIRATION	□ NONE □ COUGH □ SHORTNESS OF BREATH □ WHEEZING □ ASTHMA □ COUGHING UP BLOOD □ SPUTUM PRODUCTION
CARDIOVASCULAR	□ NONE □ HIGH BLOOD PRESSURE □ PAROXYSMAL NOCTURNAL DYSPNEA □ VERICOSE VEINS □ CLAUDICATION □ LOW BLOOD PRESSURE □ ULCERS □ SHORTNESS OF BREATH WITH EXERTION □ ORTHOPNEA HEART PROBLEM □ HEART MURMUR □ PALPITATIONS
GASTROINTESTINAL	□ NONE □ BELCHING □ DIFFICULTY SWALLOWING □ JAUNDICE □ ABDOMINAL PAIN □ BLACK/TARRY STOOL □ HEARTBURN □ ULCERS □ ABNORMAL STOOL □ CONSTIPATION □ HEMMERHOIDS □ RECTAL BLEEDING □ DIARRHEA □ INDIGESTION
FEMALE	□ NONE □ BIRTH CONTROL □ FREQUENT URINATION □ VAGINAL DISCHARGE □ BREAST LUMP/PAIN □ HORMONE THERAPY □ ABNORMAL VAGINAL BLEEDING □ BURNING URINATION □ IRREGULAR MENSTRUATION □ CRAMPS □ URINE RETENTION **DO YOU HAVE ANY CONCERNS ABOUT YOUR SEXUAL HEALTH?** □ YES □ NO **ARE YOU/HAVE YOU BEEN A VICTIM OF DOMESTIC OR SEXUAL ABUSE?** □ YES □ NO
MALE	□ NONE □ BURNING URINATION □ FREQUENT URINATION □PROSTATE PROBLEMS □ ERECTILE DYSFUNCTION □ HESITANCY/DRIBBLING □ URINE RETENTION DO YOU HAVE ANY CONCERNS ABOUT YOUR SEXUAL HEALTH? □ YES □ NO ARE YOU/HAVE YOU BEEN A VICTIM OF DOMESTIC OR SEXUAL ABUSE? □ YES □ NO
ENDOCRINE	□ NONE □ EXCSESSIVE APPETITE □ GOITER □ UNUSUAL HAIR GROWTH □ COLD INTOLERANCE □ EXCESSIVE HUNGER □ HAIR LOSS □ VOICE CHANGES □ DIABETES □ EXCESSIVE THIRST □ HEAT INTOLERANCE
SKIN	□ NONE □ CHANGE IN SKIN COLOR □ HISTORY OF SKIN DISORDERS □ RASH □ CHANGE IN NAIL TEXTURE □ HAIR LOSS □ ITCHING □ SKIN LESIONS/ULCERS □ HIVES □ NUMBNESS □ VARICOSITIES
NERVOUS SYSTEM	□ NONE □ DIZZINESS □ LIMB WEAKNESS □ SEIZURES □ STROKE □ LOSS OF CONSCIOUSNESS □ SLEEP DISTURBANCE □ UNSTEADINESS OF GAIT/LOSS □ FACIAL WEAKNESS □ LOSS OF MEMORY □ SLURRED SPEECH □ HEADACHE □ NUMBNESS □ STRESS
PSYCHOLOGICAL	□ NONE □ BI-POLAR DISORDER □ DEPRESSION □ MEMORY LOSS □ ANXIETY □ CONFUSION □ INSOMNIA □ MOOD CHANGE □ BEHAVIORAL CHANGE □ CONVULSIONS □ LOSS OR CHANGE OF APPETITE
HEMATOLOGIC	□ NONE □ BLEEDING □ BLOOD TRANSFUSION □ FATIGUE □ ANEMIA □ BLOOD CLOTTING □ BRUISING EASILY □ LYMPH NODES SWELLING

Everything I have answered is true and correct to the best of my knowledge.

Signature: _____ Date: _____

HEALTH REVIEW:

HOW MANY HOURS OF SLEEP ARE YOU GETTING PER NIGHT? □ LESS THAN 5 □ 6-8 □ 8-10 □ 10 OR MORE

HOW MANY DAYS/ WEEK DO YOU EXERCISE FOR 30 MINUTES OR MORE? □ 0 □ 1-2 □ 3-4 □ 5-6 □ 7

LIST MAJOR STRESSORS: _____

***IN ADDITION, TALK WITH YOUR DOCTOR ABOUT OTHER AREAS WHICH MAY BE AFFECTING YOUR HEALTH, SUCH AS WORRIES ABOUT FINANCES, SOCIAL SUPPORT, ALCHOHOL, TOBACCO AND DRUG USE.**

AUTHORIZATION AND RELEASE

I authorize payment of insurance benefits directly to the doctor or Nexus Spine & Sport PLC. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. I understand that I am responsible for all costs of care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. The following person(s) have my permission to receive my personal health information:

WHILE WE WORK CLOSELY WITH YOU TO RESOLVE YOUR CHIEF COMPLAINT, AS HEALTH PROFESSIONALS, WE ARE ALSO CONCERNED ANOUT YOUR OVERALL WELLNESS. ON FUTURE VISITS WE WILL DISCUSS ISSUES WITH YOU THAT MAY IMPACT YOUR OVERALL HEALTH.

ALL ANSWERS I HAVE GIVEN ARE CORRECT TO THE BEST OF MY KNOWLEDGE, AND I AGREE TO CONTINUE WITH MY EVALUATION AT Nexus Spine & Sport PLC AT THIS TIME.

PATIENT'S SIGNATURE_____ **DATE:**_____

GUARDIAN'S SIGNATURE AUTHORIZING CARE:_____ **DATE:**_____

NEXUS
Spine & Sport

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Informed Consent to Treatment

The nature of treatment: The doctor(DC) will use his/her hands, mechanical device, or gentle non-force techniques in order to perform spinal and extremity manipulations & treatment that involves moving your joints, muscles, and other soft tissues. You may feel & hear an audible "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. This mechanism is known as tribonucleation and is a very safe treatment. Bones are not popping or cracking during an adjustment. Various ancillary procedures, such as hot or cold packs, mechanical traction, cold laser electric muscle stimulation, therapeutic ultrasound or dry manual therapy, or therapeutic exercises may also be used.
Possible Risks: As with any health care procedure, complications are possible, although very rare, following a spinal manipulation. Complications could include muscle soreness, fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke is extremely rare, but could occur upon treatment just as with other professional treatments. Severe injuries to arteries of the neck are possible, but exceedingly rare. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications. These should dissipate within those few days.
Probability of risks occurring: The risks of complications due to treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".
Other treatment options, which could be considered, may include the following: *Over-the-counter analgesics.* The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases. *Medical care,* typically anti-inflammatory drugs, steroid injections, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases. *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases. *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.
Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation longer and more difficult.

I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise proper judgment during the course of the procedure(s) by which the doctor feels at that time, based on the facts then known, are in my best interest. I understand that results are not guaranteed. I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. 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 the explanation above of chiropractic treatment and the associated risks. I have fully evaluated the risks and benefits of undergoing treatment. I hereby consent to the performance of conservative non-surgical treatment including but not limited to spinal manipulations, physical examination, physical therapy, or any clinic services they deem necessary in my case, (or on the patient named below, for whom I am legally responsible for) by the doctor or intern, affiliated with Nexus Spine & Sport. I have read, or have had this read to me, the above consent. By signing below, I agree to the above and allow the doctor or intern, affiliated with Nexus Spine & Sport to perform such. I intend this consent form to cover the entire course of treatment for my present condition and for my future condition and for any future condition(s) for which I seek treatment. I have freely decided to undergo chiropractic care and herby give my full consent to treatment.

Consent to Treat a Minor (17 years & Under)

Being the parent or legal guardian of this child, I hereby authorize this office and its doctors to examine and administer care to my son/daughter named _____ as the examining/treating doctor deems necessary.

Patient Name (Print)_____**Date**_____
Patient/Guardian Signature_____

Nexus Spine & Sport's

Financial Policy

Thank you for choosing our office to serve your needs. Please sign and date the bottom of this form. Please let us know if you have any questions before signing and agreeing to our policies.

- ✓ Payment of your co-pay, co-insurance, deductible, and/or full payment is due at the time of service.
- ✓ Your insurance benefits are an agreement between you and your insurance company, not between your insurance company and our office. We cannot be 100% certain if your insurance covers Chiropractic, although most policies do provide coverage. As a courtesy to you, our office will complete any necessary insurance forms at no additional charge, and file them with your insurance company. Insurance balances which are not paid within 60 days will become your responsibility and will be billed to you.
- ✓ If your treatment is not covered by your insurance company, the cost for such charges will be your responsibility and be due immediately.
- ✓ Patients' accounts that go unpaid for 45 days or more will accrue a 20% interest charge on the TOTAL account balance.
- ✓ Patients' accounts that go unpaid for 90 days or more may be sent to collections. If you are sent to collections, you will also be charged a 33% collection fee in addition to your delinquent balance.
- ✓ If you agree to a payment plan and suspend or terminate your schedule of care before your payment plan has been completed, you are still responsible for the ENTIRE amount you originally agreed to pay. All payment plans are NONREFUNDABLE.
- ✓ It is the policy of Nexus Spine & Sport to assess a **$45 missed visit fee** to patients who cancel appointments with <u>less than a 24-hour notice</u>. One missed visit will not result in the assessment of a fee, but you will be charged for any additional missed visits. This clinic provides care for many individuals and missed visits result in time lost that could have been used to provide care for others.

By signing below, I certify that I have read, understood, and accepted ALL the above policies

_____ _____

Signature of patient/legal guardian Date