CONFIDENTIAL NEW PATIENT QUESTIONNAIRE

PATIENT INFORMATION

REFERRED BY: _____

1. LAST NAME _____ FIRST NAME _____ 3. MI _____

4. ADDRESS _____

5. CITY _____ 6. STATE _____ 7. ZIP_____

8. HOME (_____) _____ 9. WORK (_____)_____ 10. CELL (_____) _____

11. AGE ____ 12. DATE OF BIRTH _____/_____/_____ 13. SEX ☐ M ☐ F 14. SOC. SEC.# _____-_____-_____

15. MARITAL STATUS ☐ S ☐ M ☐ D ☐ W 16. SPOUSE'S NAME _____

18. PRIMARY CARE PHYSICIAN:_____

ADDRESS:_____

TELEPHONE: (_____) _____ FAX: (_____) _____

WORKERS COMPENSATION / SCHEDULED LOSS INFORMATION

2. EMPLOYER & OCCUPATION _____

2. ADDRESS _____

3. CITY _____ 4. STATE _____ 5. ZIP _____

8. BUSINESS PHONE # (_____) _____ 9. FAX # (_____)_____

10. **(SCH. LOSS EXAMS)** DO YOU HAVE: ☐ SURGICAL REPORTS ☐ X-RAY REPORTS ☐ MRI REPORTS

AUTO INJURY / WORK INJURY / PERSONAL INJURY INFORMATION

1. INSURANCE TYPE: ☐ AUTO ☐ WORK ☐ LIEN ☐ _____

2. PATIENT'S RELATIONSHIP TO INSURED: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ _____

3. DATE OF INJURY _____ 4. DESCRIBE HOW INJURY OCCURED? _____

_____

6. WHICH BODY PART(S) WERE INJURED? _____

7. NAME OF INS. CO. _____ 8. INS. PHONE (_____)_____

9. INS. CO. ADDRESS _____

10. POLICY # _____ 11. CLAIM # _____ 12. WCB #_____

13. DID YOU REPORT INJURY? ☐ NO ☐ YES IF YES, TO WHOM?_____

14. HOSPITALIZED? ☐ NO ☐ YES WHERE?_____ 15. X-RAYS TAKEN ☐ NO ☐ YES BY WHOM _____

16. WHERE YOU WORKING AT THE TIME OF THE ACCIDENT? ☐ NO ☐ YES

17. ARE YOU PRESENTLY WORKING? ☐ NO ☐ YES IF NO, DATES LOST FROM WORK _____

18. NAMES OF OTHER DOCTORS SEEN FOR THIS INJURY _____

19. IF AUTO INJURY, WERE YOU? ☐ DRIVER ☐ PASSENGER ☐ PEDESTRIAN ☐_____

20. # OF PEOPLE IN YOUR VEHICLE? _____ 21. WORE SEAT BELT? ☐ NO ☐ YES 22. DID AIRBAG INFLATE ☐ NO ☐YES

23. NAME OF ATTORNEY _____

ATTORNEY ADDRESS:_____

ATTORNEY TELEPHONE: (_____) _____ ATTORNEY FAX: (_____) _____

PRIVATE HEALTH / MEDICARE INSURANCE INFORMATION

1. INSURED'S NAME _____ 2. INSURED'S SS# _____/_____/_____

3. PATIENT'S RELATIONSHIP TO INSURED: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ _____

4. NAME OF INSURANCE CO. _____

5. ADDRESS _____

6. INSURANCE PHONE # (_____)_____ 7. POLICY # _____

SECONDARY INSURANCE 8. INSURED'S NAME _____ 9. SS # _____/_____/_____

10. NAME IS INSURANCE CO. _____

11. ADDRESS _____

12. INSURANCE PHONE # (_____) _____ 8. POLICY # _____

Peninsula Pain and Rehabilitation Center Michael S. Cook D.C.,Dipl.Ac.,Lic.Ac.
11015 Warwick Blvd, Newport News, Va.

CHIROPRACTIC INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays and/or other tests on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named above and/or with other office of clinic personnel the nature and purpose of chiropractic adjustments and procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations, falls, dizziness, headaches, burns with modalities and sprains. 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 judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, and is in my best interests.

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.

(Or Patient Representative) (Indicate relationship if signing for patient)

(Date)

PATIENT SIGNATURE X

Confidential Patient Questionnaire

Name: Date:

Major Complaint(s):

CHECK YOUR PRESENT AND PAST SYMPTOMS

Present	Past		Present	Past	
☐	☐	Neck Pain	☐	☐	Excessive Thirst
☐	☐	Middle Back Pan	☐	☐	Chronic Cough
☐	☐	Low Back Pain	☐	☐	Sinus Problems
☐	☐	Headache	☐	☐	Chronic Fatigue
☐	☐	Dizziness	☐	☐	Painful Urination
☐	☐	Convulsions	☐	☐	Frequent Urination
☐	☐	Fainting, Visual Problems, Nausea	☐	☐	Difficulty with Bladder/Bowels
☐	☐	Shoulder Pain	☐	☐	Stomach Pain
☐	☐	Pain in Shoulder, Arms, Elbows	☐	☐	Difficult Swallowing
☐	☐	Pain in Hands	☐	☐	Depression
☐	☐	Pain in Upper Leg	☐	☐	High Blood Pressure
☐	☐	Pain in lower Leg	☐	☐	Angina
☐	☐	Pain in Ankle/Foot	☐	☐	Heart Attack
☐	☐	Swelling/Stiffness in Joints	☐	☐	Stroke
☐	☐	Jaw Pain	☐	☐	Asthma
☐	☐	Ringing in Ears	☐	☐	Cancer
☐	☐	Rapid Heart Beat	☐	☐	Emphysema
☐	☐	Chest Pain	☐	☐	Arthritis
☐	☐	Loss of Appetite	☐	☐	Diabetes
			☐	☐	Ulcers

Please describe your current pain: __ Sharp __Dull __ Aches __Sore __Weak __ Throbbing
__Shooting __Constricting __Burning __Tingling

Was your problem from a: __Car Accident __Work Related Injury __Started Gradually __Slip and Fall __Other

Describe how the problem began:

What treatment have you received for this condition: __Family Doctor __Chiropractic __ Physical Therapy
__Medical Specialist __Surgery __Injections __X-Ray __MRI Other_____

Have you ever had this problem before? __ Yes __No

What makes the problem better? __Nothing __ Lying Down __Walking __Sitting Other_____

What makes the problem worse? __Nothing __ Lying Down __Walking __Sitting Other_____

Are you currently working? __Yes __No
If yes, do you: ___Sit more then 50% of the day ___Light Manual Labor __Heavy Manual Labor

Does Your Problem Affect Your Daily Activities? __ No __Mild __Moderate __Significant Resretictions
Describe:

Do you Smoke? __No __Yes ___Packs per Day

Do you Drink Alcohol? __No __Socially __Habitually

Patient or Legal Guardian Signature

Confidential Patient Questionairre page 2

Are you Pregnant? __No __Yes Date of Onset of Last Menstrual Period _____

Are you Currently Taking Medication? ___No __Yes Please List all Medicaltions _____

_____

_____

Do you have Any Allergies to Drugs or Other Products? __No __Yes

Describe: _____

FAMILY HISTORY

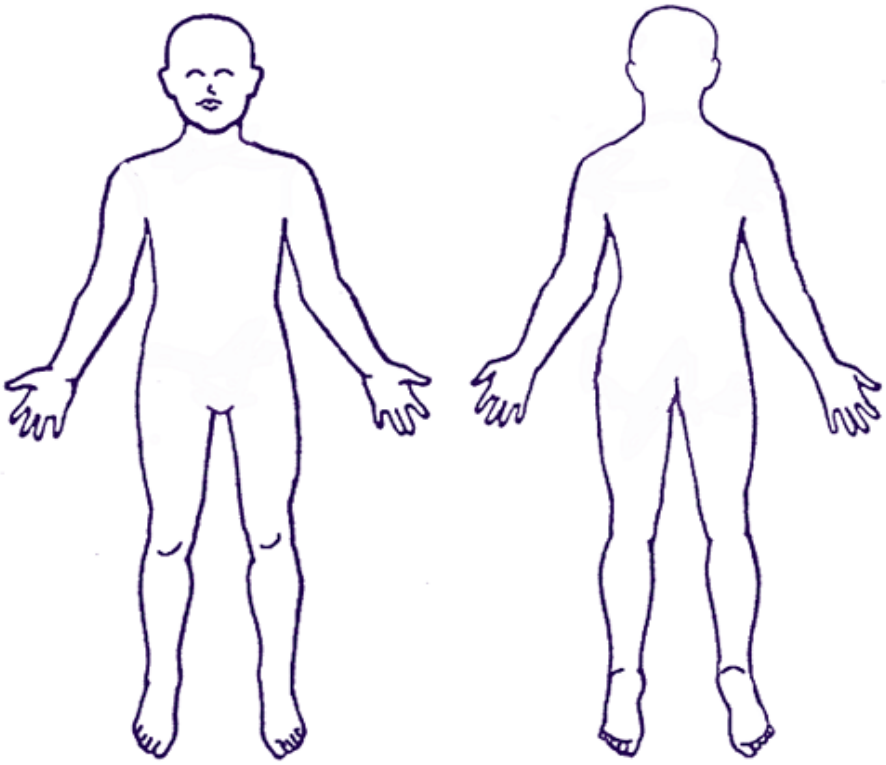
	Diabetes	Heart	Blood Pressure	Kidney	Cancer	Stroke	Other	
Mother	☐	☐	☐	☐	☐	☐	☐	
Father	☐	☐	☐	☐	☐	☐	☐	
Brother	☐	☐	☐	☐	☐	☐	☐	
Sister	☐	☐	☐	☐	☐	☐	☐	
Grandmother	☐	☐	☐	☐	☐	☐	☐	
Grandfather	☐	☐	☐	☐	☐	☐	☐	

Current Work Status:

- ☐ I Have Not Missed Any Days of Work
- ☐ I Have Missed ___ Days of Work
- ☐ I Have Been Put on Light Duty at Work
- ☐ I Have Had to Change my Job as a Result of my Condition

PAIN / SYMPTOM PICTURE

Please mark with an "X" where you have any symptoms



Patient or Legal Guardian Signature _____

Date: _____

ASSIGNMENT OF BENEFITS AND RIGHTS AND FINANCIAL RESPONSIBILITY

This page is intentionally left blank. Every state has specific requirements for assignment of benefits and rights.

Therefore it is imperative that you get specific language from either a health care attorney or your state organization.

You have to ensure that you not only assign the benefits, but the patient has to assign their rights to you to take all necessary steps to collect your fees.

Checklist of required language:

- ☐ **Assign Benefits**
- ☐ **Assign Rights**
- ☐ **The patient is responsible for collection fees**
- ☐ **Authorize the release of information**
- ☐ **Agree to pay your fees in full if insurance does not pay**

_____

Patient's Signature

_____

DATE

Peninsula Pain and Rehabilitation Center
11015 Warwick Blvd
Newport News, Va. 23601
757-591-7291

We may use and disclose your PHI (private health information) in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We may also disclose your PHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute.

We may use or disclose your PHI for workers compensation and similar programs.

We may use a sign-in sheet at the front desk and we may call you in to see the doctor by name.

We may contact you by mail or phone, at your residence, to remind you of appointments or to provide information about treatment alternatives. Unless you instruct us otherwise, we may mail you a postcard reminding you to make an appointment and we may leave a message for you on any answering device or with any person who answers the phone at your residence.

You can make a reasonable request for us to use alternative methods of communicating with you in a confidential manner. These requests must be submitted in writing in a clear and concise fashion. We are not required to agree to your request. However, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies or when information is necessary to treat you.

Rights that you have:
You have the right to request restrictions on some of the uses or disclosures described above. Except as stated, we are not required to agree to such restrictions.

You have the right to inspect and obtain copies of your medical Information. (A fee for the costs of copying, mailing, labor and supplies associated with your request will be charged.)

You have the right to request amendments to your medical information. Such requests must be in writing, and must state the reason for the requested amendment. We will notify you as to whether we agree or disagree with the requested amendment. If we disagree with any requested amendment, we will further notify you of your rights.

You have the right to request an accounting of any disclosure we make of your medical information except for disclosures we make to you, to carry out treatment, payment or healthcare operations, as requested by your written authorization, as permitted or required under 45 CFR 164.502, for emergency or notification purposes, for national security or Intelligence purposes as permitted by law, or to correctional facilities or law enforcement officials as permitted by law.

You have the right to receive a paper copy of this notice. To obtain a paper copy of this notice, please contact our office manager.

You have the right to file a complaint if you believe your privacy rights have been violated. You may file a complaint with our practice or with the Secretary of the Department of Health and

Human Services. All complaints must be submitted in writing and addressed to this office at the above address. You will not be penalized for filing a complaint.

This privacy policy is subject to change as circumstances dictate. Any changes will be effective upon the release of a revised privacy policy, which will be made available to patients upon request.

Please sign and date below, acknowledging that you have read this policy and that you consent to the terms of our privacy policy as stated in this notice.

Signature of Patient or Legal Guardian:_____ Date:_____

Print Name of Patient or Legal Guardian:_____ Date:_____