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Patient Registration

Name (First, MI, Last):____ **Gender**: ☐ Male ☐ Female

Date of Birth: _____/_____ /________ **Marital Status:** ☐ Single ☐ Married **Social Security #**: _______ **-** _____ - _________

Mailing Address:________________________________ **City/State:** _________________________**Zip Code:** __________

Street Address:_________________________________ **City/State:** _________________________**Zip Code:** __________

Phone (Home):_____________________ **Phone** (Cell):_____________________ **Phone** (Work):______________________

Email: _____________________ **Primary Care Provider:**____________________ **Referring Provider:**_______________

Emergency Contact: ____

Relationship: ___________________________ Phone:___________________________________

If you would like to give us permission to release/discuss personal information in your medical record with someone other than yourself, please fill out the **Authorization Form: PHI Release Authorization**.

We may need to communicate upcoming appointment information, and/or other information regarding your medical care. What is the best phone number for contact where we may also leave messages?

☐ Home ☐ Cell ☐ Work

Race
- ☐ White
- ☐ Black or African American
- ☐ Asian
- ☐ Other: _______________
- ☐ American Indian or Alaska Native
- ☐ Native Hawaiian or Other Pacific Islander

Preferred Language
- ☐ English
- ☐ Other:______________

Ethnicity
- ☐ Non-Hispanic or Latino
- ☐ Hispanic or Latino
- ☐ Other

The above information is thorough and accurate to the best of my knowledge.
For any changes to the above information, I will notify the office.

PATIENT/Authorized Person SIGNATURE: ________________________________ **Date:** ___________________

Authorized Person NAME (print): ______________________________________ **Relationship:** ______________

CPS Update/Staff Initial ☐

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Consents and Terms

Name (First, MI, Last):_______________________________________ **Date of Birth:** _____/_____ /_______

Insurance Information* *(fill out completely)*

Primary Insurance: ______________________	*Secondary Insurance*: ______________________
Insurer ID#:______________________	Insurer ID#:______________________
Group #:______________________	Group #:______________________
Claims Address: ______________________	Claims Address: ______________________
Subscriber: ______________________	Subscriber: ______________________
Subscriber's Date of Birth:____________	Subscriber's Date of Birth:____________
Relationship to patient:	Relationship to patient:
☐ Self ☐ Spouse ☐ Other	☐ Self ☐ Spouse ☐ Other

Workers Compensation

Company ______________________ Address ______________________

Claim # ______________________ Date of Injury ____________ Body Part Covered ____________

Case Manager ______________________ Phone Number ______________ Ext____________

Employer at time of injury______________________ Contact Name/Phone____________

Attorney Name______________________ Phone____________

Please let us know if you have any questions.

Payment Policy: Payment is due at time of service: Co-pays are due; Full payment is due for self-pay patients. Cash or credit cards (Visa, MasterCard and Discover) are accepted. On a limited basis checks may be accepted. There is a service charge on any returned check; full payment required within 10 days of notice.

Insurance: The office will kindly bill your insurance company. We participate with a number of medical insurance plans that we will contact to verify eligibility and benefits. You have the **ultimate responsibility of verifying the coverage with your insurance.** You acknowledge that we may be an out of network provider with your insurance. If your insurer sends payment directly to you, you agree to endorse the insurance check and forward funds to the appropriate entity above within 30 days of receipt. Patients who do not supply accurate and/or updated insurance information are Self-Pay.

Insurance Referrals: If your plan requires a referral from your Primary Care provider, it is your responsibility to obtain it before seeking treatment from us. If a claim is denied due to a lack of referral you are responsible for charges.

Missed Appointments: If you are unable to keep an appointment you must notify the office at least 24 hours prior to your scheduled appointment. If you "no-show" or cancel without sufficient notice, you may be subject to a 'no show' cash fee, payable by you, not your insurance company.

The above information is thorough and accurate to the best of my knowledge. I will notify the office of any changes within 30 days. If I do not notify the office of insurance changes, I am fully financially responsible.

I understand that rude or disrespectful treatment of staff is not tolerated and may result in my discharge. (e.g. using profanity, raising my voice, making vulgar or inappropriate comments).

I understand that my health is my own, not my families' or spouse's. Therefore, I need to be the person to communicate with the provider and his/her staff if at all possible

I consent to evaluation and treatment by any Mosenthal Spine & Sport provider. I authorize my Provider to communicate with other providers regarding my treatment and care.

I acknowledge that I have a copy and/or access to the Notice of Privacy Practices.

I authorize release of records and information for treatment, payment and healthcare operations.

I authorize my insurance carrier to pay benefits for services rendered, directly to PMC Medical Group, LLC or any of its affiliates. I am financially responsible for claims denied or not covered by my insurance carrier.

I have read and agree to the terms of the above information. CPS Update/Staff Initial ☐

PATIENT/Authorized Person SIGNATURE: ______________________ **Date:** ____________

Authorized Person NAME (print): ______________________ **Relationship:** ____________

Mosenthal Spine & Sport

Receipt of Documents

Patient Name; ________________________________ DOB _____ / _____ / _____

I have received and understand the information contained in the following documents:

1. Notice of Privacy Policies
2. Patient Bill of Rights
3. Patient Responsibilities
4. Patient Complaint Procedure
5. Advance Directives Information

PATIENT/Authorized Person

SIGNATURE: ____________________________________

Authorized Person NAME (print): __________________________________

Relationship: _____________

Date: _____ / _____ / _____

Health History Form

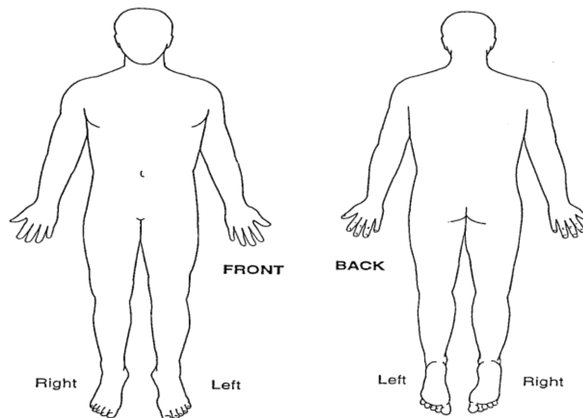
Name: ________________________________ **Date of Birth**:____/____/___ **Today's Date**:____/____/____

1. Occupation: _______________________________ Employer: _________________________________
2. The symptom(s) that have prompted me to seek care today include:__________________________________

   ____
3. Have you consulted a chiropractor before? ☐ Yes ☐ No If yes, 'Activator Chiropractic? ☐ Yes ☐ No
4. **Onset:** When did you first notice your current symptoms?____
5. What event/situation do you feel caused your symptom? ____
6. Are your symptoms due to an auto or work-related injury? (circle) Yes No
7. **Intensity:** How extreme are your current symptoms? ***0*** ☐☐☐☐☐☐☐☐☐☐ ***10***
   Absent Uncomfortable Agonizing
8. **Duration and Timing:** When did it start and how often do you feel it?
   a. ☐ Constant ☐ Comes & Goes, How often:______________________________________
9. **Quality of Symptoms:** What does it feel like?

☐ Numbness	☐ Aching	☐ Burning	☐ Other:______
☐ Tingling	☐ Cramps	☐ Shooting	____________
☐ Stiffness	☐ Nagging	☐ Throbbing	____________
☐ Dull	☐ Sharp	☐ Stabbing	

10. **Location** of Symptoms: (Circle) Include **R**=right or **L**=left Jaw___; Headache___; Neck___; Shoulder___;
    Elbow___; Wrist___; Mid-Back___; Low-Back___; 'Sciatica'___; Hip___; Knee___; Ankle___
11. **Location:** Draw location of hurt? (*"O" for current condition, "X" for conditions experienced in past*)



12. **Radiation:** Does it affect other areas of your body? To what areas does the pain radiate?

    ____
13. **Aggravating or Relieving Factors:** What makes it better or worse, such as time of day, movements, activities?

    Circle: Problem **worsens** with: Standing Walking Sitting Bending Sleeping Arching backwards AM PM

    Describe: ____

    Circle: Problem **lessens** with: Ice Heat Walking Sitting

    Describe what lessens the problem?____

14. **Other Relieving factors:** What makes it better?

- ☐ Prescription drugs
- ☐ Over the counter drugs
- ☐ Homeopathic remedies
- ☐ Physical Therapy
- ☐ Surgery
- ☐ Acupuncture
- ☐ Chiropractor
- ☐ Massage
- ☐ Ice
- ☐ Heat
- ☐ Other:______________

____

15. **Activities:** How does your current condition interfere with your life and ability to function?

	No Effect	*Mild Effect*	*Moderate Effect*	*Severe Effect*
Sitting	☐	☐	☐	☐
Rising out of chair	☐	☐	☐	☐
Standing	☐	☐	☐	☐
Walking	☐	☐	☐	☐
Lying down	☐	☐	☐	☐
Bending over	☐	☐	☐	☐
Climbing stairs	☐	☐	☐	☐
Using a computer	☐	☐	☐	☐
Getting in/out of car	☐	☐	☐	☐
Driving a car	☐	☐	☐	☐
Looking over shoulder	☐	☐	☐	☐
Caring for family	☐	☐	☐	☐
Grocery shopping	☐	☐	☐	☐
Household chores	☐	☐	☐	☐
Lifting objects	☐	☐	☐	☐
Reaching overhead	☐	☐	☐	☐
Showering/Bathing	☐	☐	☐	☐
Dressing myself	☐	☐	☐	☐
Love life	☐	☐	☐	☐
Getting to sleep	☐	☐	☐	☐
Staying asleep	☐	☐	☐	☐
Concentrating	☐	☐	☐	☐
Exercising	☐	☐	☐	☐
Yard Work	☐	☐	☐	☐

16. Recent Fever / Infection? Yes No   Unexplained Weight Loss? Yes No

    Muscle Weakness? Yes No   Pain with unration or bowel movements? Yes No

17. Any recent changes in your life that you think is contributing to today's symptom? (circle)

    Increased Stress   Increased Computer Work   New Diet   Change in exercise/activity   Medication   Surgery

18. Do you feel that today's symptom is due to: (circle)   Muscle strain   Nerve pinch   Disc   Old mattress

    Stress   Repetitive strain   Poor posture   Too much sitting   Recent cold/virus   Menstruation

    Urinary tract infection   Trauma / Injury   Diet   Telephone use   Other: __________________

19. How are your symptoms changing: (circle)   Getting worse   Staying the Same   Getting Better

20. What else should we know about your current condition: ____

    ____

21. Is this the first occurrence of this symptom for you? (circle) Yes No

22. Since your symptoms started, who have you seen for evaluation / treatment:

    PCP   PT/OT   DC   Massage Therapist   Orthopedist   No One/Self Treat   Other: __________________

23. Describe any recent diagnosis from your PCP: ____

24. For today's symptoms, have you had an (circle)   X-Ray   MRI   Bloodwork   Other: ____________________

25. **Work Environment:** (circle)   Sit   Stand   Desktop computer   Laptop

    Do you use a sit/stand work station? (circle) Yes No   Frequent telephone use ? (circle) Yes No

    If you sit for your work, recent ergonomic assessment? (circle) Yes No

26. **Medical History:** Please mark any of the following that you have or have had in the past

- ☐ Acid Reflux/GERD
- ☐ ADHD
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Bowel Problems
- ☐ Cancer
- ☐ Chronic Cough
- ☐ Chronic Pain
- ☐ COPD/Emphysema
- ☐ Dementia
- ☐ Depression
- ☐ Diabetes
- ☐ Eating Disorder
- ☐ Glaucoma/Cataracts
- ☐ Headaches
- ☐ Hearing Loss
- ☐ Heart Disease
- ☐ Heart Palpitations
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV/AIDS
- ☐ Immune disorders
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Osteoporosis
- ☐ Seizure Disorder
- ☐ Sexually Transmitted Disease
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Other:____________________

27. **Current Medications**: Include Herbals and Supplements

Name of Medication	**Strength** (ex. 500 mg)	**Dosing Instructions** (ex. Twice a day)

28. **Operations:** Please list any surgical interventions/operations

Type of Operation	**Date**	**Type of Operation**	**Date**

29. **Treatments:** Check the one's that you have received in the past or currently receiving

Past	*Current*		*Past*	*Current*		*Past*	*Current*	
☐	☐	Acupuncture	☐	☐	Dialysis	☐	☐	Hormone Replacement
☐	☐	Antibiotics	☐	☐	Dry Needling	☐	☐	Ice
☐	☐	Birth Control Pills	☐	☐	Exercise Program	☐	☐	Inhaler
☐	☐	Blood Transfusions	☐	☐	Heat	☐	☐	Massage Therapy
☐	☐	Chemotherapy	☐	☐	Herbs	☐	☐	Physical Therapy
☐	☐	Chiropractic Care	☐	☐	Homeopathy	☐	☐	Nutrition Supplements

30. **Family History:** Please tell us about the health of your immediate family

	Father	Mother	Siblings	Children	Other
Age at Death					
Cause of Death					
Heart Disease/ Stroke					
High Blood Pressure					
Diabetes					
Cancer (type)					
Epilepsy/Seizures					
Asthma					
Blood Disease					
Other:					

31. **Social History:** Tell us about your **health habits**

Marital Status	Single Significant Other Married Divorced Widowed	
Living Situation	Alone Spouse/Significant other Children/Family Other	
Are you pregnant?	Yes / No Hysterectomy Menopause Tubal ligation	
If Pregnant,	When is your due date?	
Do you have children?	Yes / No	If yes, how many?
Education (highest level)	9 10 11 12 GED Some college Associates Bachelors Masters PhD	
Are you working?	Yes / No	If yes, occupation?
Are you disabled?	Yes / No	If yes, reason?
Legal actions related to symptom?	Yes / No	Explain:

			If applicable, amount?
Tobacco Use? *If no, have you ever?*	Yes / No Yes / No	Cigarettes / Cigars / Chew Cigarettes / Cigars / Chew	Per day: Per day: How Many Years:
Do you drink alcohol?	Yes / No	Beer / Wine / Liquor	Per day:
Do you drink caffeine?	Yes / No	Coffee / Tea / Soda / Energy Drink	Per day:
Any present illicit drug use?	Yes / No	Marijuana / Cocaine / Heroin / Illicit Rx. / Other	
Any past illicit drug use?	Yes / No	Marijuana / Cocaine / Heroin / Illicit Rx. / Other	
Do you exercise?	Yes / No	Type?	Per week:
Do you wear your seatbelt?	Yes / No	If yes, percent of time:	
Mattress & Pillow: Age and Type			
Hours of sleep per night?			
Preferred sleeping position		Back Side Stomach	
Use a supportive neck pillow ?	Yes / No		
Wear shoes with good support?	Yes / No		
Wear a heel lift	Yes / No	If yes, (circle) Right or Left	
Do you carry a heavy purse?	Yes / No		
Rate your current daily posture:		Excellent Good Average Poor	
Satisfied with your weight ?	Yes / No		
Rate your diet:		Excellent Good Average Poor	
Rate your stress level		(minimal) 1 2 3 4 5 6 7 8 9 10 (severe)	
Daily meditate / pray / truly relax?	Yes / No	5-10 min	

32. Any other information you think we should know regarding your current symptom: Please describe.

____

Signature: ______________________________ Date: _____ / _____ / _____

Payment Policies

Modality Charges:

Dry Needle/AC: $20 per session with chiropractic adjustment (treatment waiver needs to be signed with each session)

K-Laser: $20 per session with chiropractic adjustment

H-Wave: $20 per session with chiropractic adjustment

Notice of Cancellation

Due to the volume of patients that would like to be seen, we **REQUIRE** (and appreciate) a 24 hour notice of cancellation.

If you NO SHOW there will be a $25 fee due payable before your next booking. (phone call/email)

We appreciate your understanding and thank you for choosing Mosenthal Spine & Sport as your "get well" clinic.

PATIENT SIGNATURE: ______________________________ **DATE:** ____________