



# Application for Patient Care

**PATIENT INFORMATION**

First Name: \_\_\_\_\_ M.I.: \_\_\_\_\_ Last Name: \_\_\_\_\_ Date: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_  
 State: \_\_\_\_\_ Zip: \_\_\_\_\_ Email: \_\_\_\_\_  
 Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_ Work #: \_\_\_\_\_  
 SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Male / Female  
 Primary Care Physician: \_\_\_\_\_  
 Do we have permission to contact your doctor regarding your care in our office? \_\_\_ Yes \_\_\_ No  
 Your preferred method of contact for appointment reminders? Email / Text by Cell Phone  
 Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_  
 Type of Tasks Performed/Common Movements: \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Widowed  Separated  Minor  
 Spouse's Name: \_\_\_\_\_ # of Children? \_\_\_\_\_ Children's Ages: \_\_\_\_\_  
 Emergency Contact Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone #: \_\_\_\_\_  
 Smoking Status: Never smoked / Former Smoker / Occasional Smoker / Daily Smoker Preferred Language: \_\_\_\_\_  
**Race (Circle one):** American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) / Native Hawaiian or Pacific Islander / Other / Decline to Answer **Ethnicity (Circle one):** Hispanic or Latino / Not Hispanic or Latino / Decline to Answer

**ACCIDENTS**

Have you had an auto accident? (X if applies):  0-6mo  6 mo-1 yr  1-3yrs  3+yrs  Never  
 Had a recent fall/other accident? (X if applies) :  0-6mo  6 mo-1 yr  1-3yrs  3+yrs  Never  
 Have You Ever Received Physical Therapy  Chiropractic Care  or Pain Management ? Last Visit: \_\_\_\_\_

**REFERRALS**

How Did You Hear About This Office?  Existing Patient: \_\_\_\_\_  Walk-In/Drive-By  
 Radio: \_\_\_\_\_  Internet: \_\_\_\_\_  Shapes  
 Ad: \_\_\_\_\_  Community Event: \_\_\_\_\_  LifeStyles  
 Massage-A-Teacher: \_\_\_\_\_  Other: \_\_\_\_\_  Insurance Comp.

**INSURANCE**

Do you have health insurance?  Yes  No Name of Carrier: \_\_\_\_\_  
 Do you have secondary insurance?  Yes  No Name of Carrier: \_\_\_\_\_

**PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR INSURANCE CARD(S)**

### ***Assignment and Release – For Insured Patients Only***

I certify that I (or my dependent) have insurance coverage with \_\_\_\_\_ and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE GROUP PRACTICE, **PM Health Alliance LLC**, INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

SIGNATURE (X) \_\_\_\_\_ DATE \_\_\_\_\_

**PRIMARY COMPLAINTS: Please list in order of most severe (#1) to least severe (#4).** *Sample complaints: Low Back, Left Knee, Right Shoulder, Neck, etc.*

**MOST SEVERE** ← → **LEAST SEVERE**

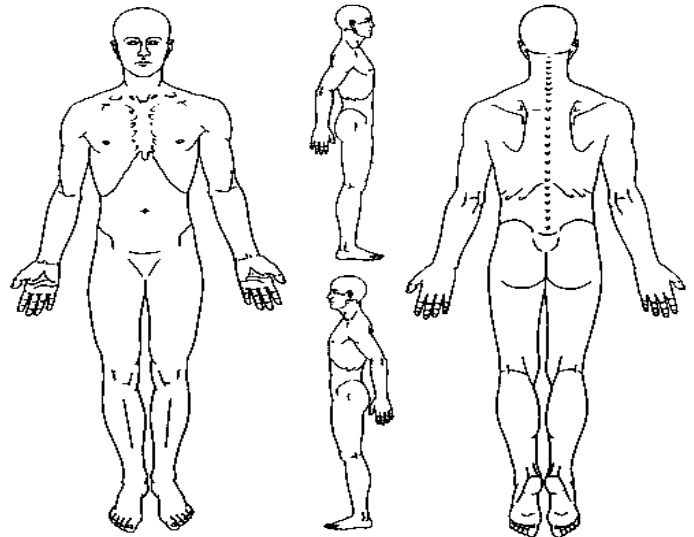
You have the following complaints (WRITE-IN)	1.	2.	3.	4.
<b>Circle the word that best describes this complaint.</b>	Sharp dull achy throbbing numb shooting other	Sharp dull achy throbbing numb shooting other	Sharp dull achy throbbing numb shooting other	Sharp dull achy throbbing numb shooting other
<b>How often do you feel this complaint?</b>	Constant Daily Weekly "Off and On"	Constant Daily Weekly "Off and On"	Constant Daily Weekly "Off and On"	Constant Daily Weekly "Off and On"
<b>How long have you had this complaint?</b>	___ Days / Weeks / Months / Years	___ Days / Weeks / Months / Years	___ Days / Weeks / Months / Years	___ Days / Weeks / Months / Years
<b>Is it getting better, worse, or staying the same?</b>	Better Worse Same	Better Worse Same	Better Worse Same	Better Worse Same
<b>What makes it better, if anything?</b>				
<b>What makes it worse, if anything?</b>				
<b>On a scale of 0 – 10, rate your discomfort. (0 = no pain, 10 = excruciating)</b>	<b>Circle response</b> 0 1 2 3 4 5 6 7 8 9 10	<b>Circle response</b> 0 1 2 3 4 5 6 7 8 9 10	<b>Circle response</b> 0 1 2 3 4 5 6 7 8 9 10	<b>Circle response</b> 0 1 2 3 4 5 6 7 8 9 10
<b>How have you taken care of this in the past? Has that worked for you?</b>				
<b>Circle the ways this issue is affecting your life. (all that apply)</b>	job children sex marriage household hobbies finances sports exercise walking standing bowels urinary fatigue loss of sleep moody poor attitude loss of productivity	job children sex marriage household hobbies finances sports exercise walking standing bowels urinary fatigue loss of sleep moody poor attitude loss of productivity	job children sex marriage household hobbies finances sports exercise walking standing bowels urinary fatigue loss of sleep moody poor attitude loss of productivity	job children sex marriage household hobbies finances sports exercise walking standing bowels urinary fatigue loss of sleep moody poor attitude loss of productivity
<b>Improving this issue in my life would improve my quality of life by: (Circle best response)</b>	10-20% 30-40% 50-60% 70-80% 90% 100%	10-20% 30-40% 50-60% 70-80% 90% 100%	10-20% 30-40% 50-60% 70-80% 90% 100%	10-20% 30-40% 50-60% 70-80% 90% 100%

Have you taken any of the following for the above complaints in the last 6 months?  Tylenol  Ibuprofen/NSAIDs  Aspirin  
 Have you tried any of the following?  Physical Therapy/Rehab  Occupational Therapy  Chiropractic  Pain Mngt  Ice/Heat  
 How long ago, or how often did you attempt the selected therapies? \_\_\_\_\_

### PATIENT HEALTH HISTORY

**Please check if you are currently experiencing any of the following conditions and then circle problematic areas on body to right:**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Neck Pain/Stiffness   | <input type="checkbox"/> Pins/Needles in Arms  | <input type="checkbox"/> Nausea         |
| <input type="checkbox"/> Back Pain/Stiffness   | <input type="checkbox"/> Pins/Needles in Legs  | <input type="checkbox"/> Night Pain     |
| <input type="checkbox"/> Arm/Hand Pain         | <input type="checkbox"/> Light Bothers Eyes    | <input type="checkbox"/> Fatigue        |
| <input type="checkbox"/> Leg/Knee Pain         | <input type="checkbox"/> Recent Weigh Change   | <input type="checkbox"/> Fever          |
| <input type="checkbox"/> Headaches             | <input type="checkbox"/> Loss of Memory        | <input type="checkbox"/> Tension        |
| <input type="checkbox"/> Loss of Taste         | <input type="checkbox"/> Cold Extremities      | <input type="checkbox"/> Chest Pain     |
| <input type="checkbox"/> Nervousness           | <input type="checkbox"/> Sleeping Difficulties | <input type="checkbox"/> Asthma         |
| <input type="checkbox"/> Jaw Problems          | <input type="checkbox"/> Bowel/Bladder Changes | <input type="checkbox"/> Cold Sweats    |
| <input type="checkbox"/> Dizziness/Fainting    | <input type="checkbox"/> Constipation/Diarrhea | <input type="checkbox"/> Loss of Smell  |
| <input type="checkbox"/> Blurred/Double Vision | <input type="checkbox"/> Loss of Balance       | <input type="checkbox"/> Swollen Joints |
| <input type="checkbox"/> Mood Changes          | <input type="checkbox"/> Trouble Concentrating | <input type="checkbox"/> Foot Trouble   |



**PATIENT HEALTH HISTORY continued....** *Please check if you have ever had any of the following:*

- |   |  |   |   |   |
|---|--|---|---|---|
| <input type="checkbox"/> ADD/ADHD                             | <input type="checkbox"/> Cataracts           | <input type="checkbox"/> Heartburn              | <input type="checkbox"/> Mononucleosis                | <input type="checkbox"/> Sexual Difficulty  |
| <input type="checkbox"/> Aids/HIV                             | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Heart Attack           | <input type="checkbox"/> Mouth Sores or Bleeding Gums | <input type="checkbox"/> Stroke             |
| <input type="checkbox"/> Alcoholism                           | <input type="checkbox"/> Chicken Pox         | <input type="checkbox"/> Heart Problems         | <input type="checkbox"/> Multiple Sclerosis           | <input type="checkbox"/> Suicide Attempt    |
| <input type="checkbox"/> Allergy Shots                        | <input type="checkbox"/> Colon Trouble       | <input type="checkbox"/> Hemorrhoids            | <input type="checkbox"/> Mumps                        | <input type="checkbox"/> Thyroid Problems   |
| <input type="checkbox"/> Anemia                               | <input type="checkbox"/> Contacts/Glasses    | <input type="checkbox"/> Hepatitis              | <input type="checkbox"/> Nosebleeds                   | <input type="checkbox"/> TMJ Pain           |
| <input type="checkbox"/> Anorexia                             | <input type="checkbox"/> Depression          | <input type="checkbox"/> Hernia                 | <input type="checkbox"/> Osteoporosis                 | <input type="checkbox"/> Tonsillitis        |
| <input type="checkbox"/> Appendicitis                         | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Herniated Disc         | <input type="checkbox"/> Pacemaker                    | <input type="checkbox"/> Tremors            |
| <input type="checkbox"/> Arthritis                            | <input type="checkbox"/> Dry Skin            | <input type="checkbox"/> Herpes                 | <input type="checkbox"/> Parkinson's Disease          | <input type="checkbox"/> Tuberculosis       |
| <input type="checkbox"/> Asthma/Wheezing                      | <input type="checkbox"/> Ear Infections      | <input type="checkbox"/> High Cholesterol       | <input type="checkbox"/> Pinched Nerve                | <input type="checkbox"/> Tumors/Growths     |
| <input type="checkbox"/> Bad Breath/Taste                     | <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Hormone/Gland Problems | <input type="checkbox"/> Pneumonia                    | <input type="checkbox"/> Typhoid Fever      |
| <input type="checkbox"/> Bleeding Disorders                   | <input type="checkbox"/> Fibromyalgia        | <input type="checkbox"/> Insomnia               | <input type="checkbox"/> Polio                        | <input type="checkbox"/> Ulcers             |
| <input type="checkbox"/> Blood Pressure: High or Low (circle) | <input type="checkbox"/> Fractures           | <input type="checkbox"/> Kidney Problems        | <input type="checkbox"/> Prostate Problems            | <input type="checkbox"/> Vaginal Infections |
| <input type="checkbox"/> Breast Lump                          | <input type="checkbox"/> Gall Bladder        | <input type="checkbox"/> Liver Disease          | <input type="checkbox"/> Prosthesis                   | <input type="checkbox"/> Venereal Disease   |
| <input type="checkbox"/> Broken Bones                         | <input type="checkbox"/> Glaucoma            | <input type="checkbox"/> Measles                | <input type="checkbox"/> Psychiatric Care             | <input type="checkbox"/> Whooping Cough     |
| <input type="checkbox"/> Bronchitis                           | <input type="checkbox"/> Goiter              | <input type="checkbox"/> Menopausal Prob.       | <input type="checkbox"/> Rheumatoid Arthritis         | <input type="checkbox"/> Other: _____       |
| <input type="checkbox"/> Bulimia                              | <input type="checkbox"/> Gonorrhea           | <input type="checkbox"/> Migraines              | <input type="checkbox"/> Rheumatic Fever              | _____                                       |
| <input type="checkbox"/> Cancer                               | <input type="checkbox"/> Gout                | <input type="checkbox"/> Miscarriage            | <input type="checkbox"/> Scarlet Fever                | _____                                       |

Are you currently under drug and/or medical care?  Yes  No If yes, explain \_\_\_\_\_

Please list any and all medications, supplements/vitamins, herbs etc. you are currently taking:

<u>Name</u>	<u>Strength/Dosage</u>	<u>Frequency</u>	<u>What are you taking it for?</u>

Please list any surgeries and/or hospitalizations you have had (type & date): \_\_\_\_\_

**ALLERGIES (food/drug/etc.):** \_\_\_\_\_

Is there a family history of any of the following conditions? (*indicate family member including parents, grandparents & siblings*)

- Heart Disease \_\_\_\_\_     Diabetes \_\_\_\_\_  
 Cancer \_\_\_\_\_     Arthritis \_\_\_\_\_     Other \_\_\_\_\_

Do you exercise:                       5-7x/week       3-4x/week       1-2x/week       Occasionally     None

Do your work activities mostly involve:                       Sitting       Standing       Light Labor       Heavy Labor

Do you sleep on your:     Back     Side     Stomach      Do you use a cervical pillow?  Yes     No

What is your daily/weekly intake of the following: Caffeine \_\_\_\_ cups/day    Alcohol \_\_\_\_ drinks/week    Cigarettes \_\_\_\_ pks/day

**I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health. I will give complete & accurate information during my exam.**

**Signature (X)** \_\_\_\_\_

**Date** \_\_\_\_\_



Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

### TERMS OF ACCEPTANCE AND CONSENT FOR CARE

The clinic will attempt to identify and diagnose any ailments you may have that may be corrected through physical medicine, massage therapy, chiropractic care, and/or active/passive rehabilitation. If any condition or disease appears to be present out of our scope of practice, we will refer you to an appropriate physician to diagnose and/or treat that condition. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases underlying physical defects, deformities or pathologies, may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known these things which otherwise might not come to the attention of the physician (deformities, illnesses, etc).

I agree to settle any claim or dispute I may have against or with any of these persons or entities, whether related to the prescribed care or not, by binding arbitration under the current malpractice terms which can be obtained by written request.

I also understand that the fee paid for treatment x-rays is for analysis only. The file itself is the property of this office. Once films are taken, they cannot be released, but may be copied. There is a fee for copying of the xrays.

Also, for your protection, portions of our office where patients do not disrobe are under video surveillance, specifically, but not limited to, the lobby and front desk check-out stations.

I have read and I accept the terms above and understand them fully. I hereby give consent to the clinic to evaluate me to determine my condition and treat me for such conditions. I also understand that I may at any time discontinue with the exam and/or x-rays or any treatment if I so choose.

*I also understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered to me will be immediately due and payable. I agree that I will be responsible for all attorney and legal fees if legal action becomes necessary to collect this amount.*

I, \_\_\_\_\_ have read and fully understand the above statements.  
(PRINT NAME)

\_\_\_\_\_  
(SIGNATURE)

\_\_\_\_\_  
(DATE)

**FOR MINORS:** I, \_\_\_\_\_ being the parent or legal guardian of \_\_\_\_\_,  
(Print Guardian Name) (Print Minor's Name)

have read and fully understand the above terms of acceptance & grant permission for my child to receive treatment.

\_\_\_\_\_  
(SIGNATURE)

\_\_\_\_\_  
(DATE)

**X-ray Questionnaire: For women only** Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

Name: \_\_\_\_\_ Date of last menstrual period: \_\_\_\_\_

- There is a possibility that I may be pregnant at this time
- No, I am definitely not pregnant at this time
- Yes, I am definitely pregnant
- I request that x-ray films not be taken because:

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

### NEUROLOGICAL/MRI/VASCULAR PATIENT QUESTIONNAIRE

- |   |        |                                      |        |
|---|--------|--------------------------------------|--------|
| 1. Weakness, numbness or burning in your shoulder, arms or hands? | NO YES | 8. Cold Hands/Feet?                  | NO YES |
| 2. Do your hands or arms fall asleep regularly?                   | NO YES | 9. Have you had an MRI?              | NO YES |
| 3. Reduced feeling (sensation) or swelling in your hands or arms? | NO YES | If yes to MRI, When? Who ordered it? |        |
| 4. Loss of handgrip strength?                                     | NO YES | What was it ordered for?             |        |
| 5. Weakness, numbness or burning in your buttocks, legs or feet?  | NO YES | _____                                |        |
| 6. Do our legs or feet fall asleep regularly?                     | NO YES | _____                                |        |
| 7. Reduced feeling (sensation) or swelling in your legs, feet?    | NO YES | _____                                |        |

# Allergy, Food, Chemical Sensitivity, & Inflammation

Gender: M / F      Height: Feet \_\_\_\_ Inches \_\_\_\_      Weight: \_\_\_\_ lbs.

*Please complete the following allergy, food and chemical sensitivity questionnaire. Score each symptom based upon your experiences over the last 90 days. Circle appropriate number 0-5 according to severity.*

**0=No Problem at All**

**1=Extremely Mild Symptoms**

**2=Mild to Moderate Symptoms Occasionally**

**3=Moderate Symptoms Frequently**

**4=Moderate to Severe Symptoms**

**5=Very Severe Symptoms**

## Digestive Symptoms

- 0 1 2 3 4 5 Stomach Pains or Cramping
- 0 1 2 3 4 5 Constipation
- 0 1 2 3 4 5 Diarrhea
- 0 1 2 3 4 5 Reflux or Heartburn
- 0 1 2 3 4 5 Bloating
- 0 1 2 3 4 5 Gas
- 0 1 2 3 4 5 Nausea or Vomiting

## Weight

- 0 1 2 3 4 5 Inability to Lose Weight
- 0 1 2 3 4 5 Food Cravings
- 0 1 2 3 4 5 Binge Eating
- 0 1 2 3 4 5 Water Retention

## Sinus/Respiratory

- 0 1 2 3 4 5 Stuffy or Runny Nose
- 0 1 2 3 4 5 Asthma
- 0 1 2 3 4 5 Chest Congestion
- 0 1 2 3 4 5 Chronic Cough
- 0 1 2 3 4 5 Wheezing
- 0 1 2 3 4 5 Frequent Sneezing or Nasal Discharge

## Head/Ears

- 0 1 2 3 4 5 Migraines
- 0 1 2 3 4 5 Headaches
- 0 1 2 3 4 5 Earaches
- 0 1 2 3 4 5 Sinus or Ear Infections
- 0 1 2 3 4 5 Ringing in Ears

## Eyes/Throat

- 0 1 2 3 4 5 Itchy Eyes
- 0 1 2 3 4 5 Watery Eyes
- 0 1 2 3 4 5 Sore Throats or Colds
- 0 1 2 3 4 5 Persistent Canker Sores

## Emotional/Mental

- 0 1 2 3 4 5 Depression
- 0 1 2 3 4 5 Anxiety
- 0 1 2 3 4 5 Mood Swings
- 0 1 2 3 4 5 Irritability
- 0 1 2 3 4 5 Poor Concentration/Memory

## Energy

- 0 1 2 3 4 5 Fatigue
- 0 1 2 3 4 5 Hyperactivity
- 0 1 2 3 4 5 Lethargy
- 0 1 2 3 4 5 Restlessness
- 0 1 2 3 4 5 Insomnia

## Skin Disorders

- 0 1 2 3 4 5 Eczema
- 0 1 2 3 4 5 Dermatitis
- 0 1 2 3 4 5 Excessive Sweating
- 0 1 2 3 4 5 Rashes
- 0 1 2 3 4 5 Hives

## Other Symptoms:

- 0 1 2 3 4 5 Joint Pain
- 0 1 2 3 4 5 Arthritis
- 0 1 2 3 4 5 Irregular Heartbeat
- 0 1 2 3 4 5 Chest Pains
- 0 1 2 3 4 5 Muscle Aches

Please list any symptoms not mentioned above:

\_\_\_\_\_

\_\_\_\_\_

**TOTAL SCORE:** \_\_\_\_\_



Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

## PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In the course of your care as a patient PM HEALTH ALLIANCE LLC, we may use or disclose personal and health related information about you in the following ways:

- Your personal health information, including your clinical records, may be disclosed to another healthcare provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
- Your healthcare records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or may be responsible for the payment of your services.
- Your name, address, phone number, and healthcare records may be used to contact you regarding appointment reminders, information about alternative to your present care, or other health related information that may be of interest to you.

If you are not at home to receive an appointment reminder, a message may be left on your answering machine. Furthermore, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provided to you or the reimbursement avenues associated with your care.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in the following circumstances:

- If we are providing healthcare to you based on the orders of another healthcare provider.
- If we provide healthcare services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain our consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
- If we are ordered by the courts or another appropriate agency.

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization.

We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your healthcare or about the status of your account. If you would like to receive this information at an address other than your home or if you would like the information in a different form, please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. In addition you have the right to request an amendment to your health information. Requests to inspect, copy or amend our health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to: DR. ADAM HALL. If you would like further information about our privacy policies and practices please contact: DR. ADAM HALL OR PM HEALTH ALLIANCE LLC.

This notice is effective as of September 1, 2017. This notice, and any alterations or amendments made hereto will expire seven (7) years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

\_\_\_\_\_  
Name (Print)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date