WELCOME

(Office Use Only)

☐ New Patient ☐ Reactivation _____

PATIENT INFORMATION

Date _____

SS _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____
City _____
State _____ Zip _____

E-mail _____

Sex ○ M ○ F Age _____

Birthdate _____

○ Married ○ Widowed ○ Single ○ Minor
○ Separated ○ Divorced ○ Partnered for ____ years

Occupation _____

Patient Employer/School _____

Employer/ School Address _____

_____
Employer / School Phone _____

Spouse's Name _____
Birthdate _____
SS# _____
Spouse Employer _____

Whom may we thank for referring you? _____

PHONE NUMBERS

Home Phone (____) _____

Cell Phone (____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY , CONTACT
Name _____
Relationship _____
Home Phone (____) _____
Work Phone (____) _____

INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ID # _____

ASSIGNMENT AND RELEASE

I certify that I, and or my dependent(s), have insurance coverage with _____ and assign directly to
Name of Insurance Company
NOVA Pain & Rehab Center all insurance benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorized the use of my signature on all insurance submissions.

NOVA Pain & Rehab Center may use my health care information and may disclose such information to the above-named Insurance Compay(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for relates services. The consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

HEALTH HISTORY

Place a mark on "Yes or "No" to indicate if you have had any of the following:

AIDS/HIV	☐Yes ☐No	Chicken Pox	☐Yes ☐No	Liver Disease	☐Yes ☐No	Rheumatoid Arthritis	☐Yes ☐No
Alcoholism	☐Yes ☐No	Diabetes	☐Yes ☐No	Measles	☐Yes ☐No	Allergy Shots	☐Yes ☐No
Emphysema	☐Yes ☐No	Migraine	☐Yes ☐No	Stroke	☐Yes ☐No	Ulcer	☐Yes ☐No
Anemia	☐Yes ☐No	Epilepsy	☐Yes ☐No	Miscarriage	☐Yes ☐No	Anorexia	☐Yes ☐No
Fracture	☐Yes ☐No	Mononucleosis	☐Yes ☐No	Suicide Attempt	☐Yes ☐No	Vaginal Infections	☐Yes ☐No
Appendicitis	☐Yes ☐No	Glaucoma	☐Yes ☐No	Multiple Sclerosis	☐Yes ☐No	Thyroid Problems	☐Yes ☐No
Arthritis	☐Yes ☐No	Goiter	☐Yes ☐No	Mumps	☐Yes ☐No	Tonsillitis	☐Yes ☐No
Asthma	☐Yes ☐No	Gonorrhea	☐Yes ☐No	Osteoporosis	☐Yes ☐No	Tuberculosis	☐Yes ☐No
Bleeding	☐Yes ☐No	Gout	☐Yes ☐No	Pacemaker	☐Yes ☐No	Tumors, Growths	☐Yes ☐No
Breast Lump	☐Yes ☐No	Heart Disease	☐Yes ☐No	Parkinson's	☐Yes ☐No	Venereal disease	☐Yes ☐No
Bronchitis	☐Yes ☐No	Hepatitis	☐Yes ☐No	Pinched Nerve	☐Yes ☐No		
Bulimia	☐Yes ☐No	Hernia	☐Yes ☐No	Pneumonia	☐Yes ☐No	OTHER	
Cancer	☐Yes ☐No	Herniated Disk	☐Yes ☐No	Polio	☐Yes ☐No	Ligament Sprain	☐Yes ☐No
Cataracts	☐Yes ☐No	Herpes	☐Yes ☐No	Prostate Problem	☐Yes ☐No	Broken Bones	☐Yes ☐No
Chemical	☐Yes ☐No	High Cholesterol	☐Yes ☐No	Prosthesis	☐Yes ☐No	Surgery	☐Yes ☐No
Dependency	☐Yes ☐No	Kidney Disease	☐Yes ☐No	Psychiatric Care	☐Yes ☐No	High Blood Pressure	☐Yes ☐No

PATIENT SUBJECTIVE COMPLAINTS

Complaints (area): Primary _____ Second _____ Third _____

Pain Scale: (Primary) no pain 1 2 3 4 5 6 7 8 9 10 worst pain (Secondary) 1 2 3 4 5 6 7 8 9 10

Date of Injury / Onset? (Primary Complaint) _____ (Secondary Complaint) _____

Please explain the cause ofthe injury / problem. _____

_____

_____

Is the problem getting: ☐ Better / ☐ Worse / ☐ No Change

Have you ever had this complaint before this onset? ☐Yes ☐No

If so, when: _____ How many times? ☐ one time ☐ two or more times

Have you been treated by a chiropractor previously ☐Yes ☐No If so, when _____

Have you been treated by a physical therapist previously ☐Yes ☐No If so, when _____

Have you seen any other physicians for your complaint(s)? ☐Yes ☐No Who? _____ When? _____

What concerns / issues would prevent you from receiving care in this clinic? (☐ Time ☐ Finances ☐ Transportation)

ACTIVITY HISTORY

What activities or movements cause pain / discomfort _____

_____

What have you done that has helped? _____

What makes you feel better? _____

What are your goals? _____

What do you want to do better? _____

What are your limitations? _____

OSWESTRY REVISED QUESTIONNAIRE

Section 1 - Pain Intensity
- ☐ Pain comes and goes and is mild.
- ☐ Pain is mild and does not vary.
- ☐ Pain comes and goes and is moderate.
- ☐ Pain is moderate and does not vary much.
- ☐ Pain comes and goes and is severe
- ☐ Pain is severe and does not vary much.

Section 2 - Personal Care
- ☐ Does not change habits to avoid pain.
- ☐ Does not change habits/Some Pain.
- ☐ Does not change habits/increases Pain.
- ☐ Changes habits/Increases Pain.
- ☐ Unable to do some personal care without help.
- ☐ Unable to wash or dress without help.

Section 3 – Lifting
- ☐ Lifts heavy weights with no pain.
- ☐ Lifts heavy weights with pain.
- ☐ Cannot lift heavy weights off the floor.
- ☐ Can lift heavy weights from a table.
- ☐ Can lift fight weights from a table.
- ☐ Can lift only very fight weights.

Section 4 - Walking
- ☐ Pain does not prevent walking.
- ☐ Cannot walk more than one mile.
- ☐ Cannot walk more than 1/2 mile.
- ☐ cannot walk more than 1/4 mile.
- ☐ Can walk only with crutches.
- ☐ Bedridden and must crawl to the toilet

Section 5 - Sitting
- ☐ Can sit in any chair as long as desired.
- ☐ Can sit only in the favorite chair as long as desired.
- ☐ Can sit no more than 1 hour.
- ☐ Can sit no more than 1/2 hour.
- ☐ Can sit no more than 10 minutes.
- ☐ Cannot sit at all due to pain.

Section 6 - Standing
- ☐ Can stand for an unlimited time without pain.
- ☐ Some pain standing, doesn't increase with time
- ☐ Cannot stand for more than 1 hour.
- ☐ Cannot stand for more than ½ hour.
- ☐ Cannot stand more than 10 minutes.
- ☐ Cannot stand at all.

Section 7 - Sleeping
- ☐ No pain in bed.
- ☐ Gets pain in bed, but sleeps well.
- ☐ Normal sleep reduced by 1/4.
- ☐ Normal night's sleep reduced by 1/2.
- ☐ Normal night's sleep reduced by 3/4.
- ☐ Cannot sleep at all due to pain.

Section 8 - Traveling
- ☐ Travel without pain
- ☐ Travel causes some pain. but not made worse.
- ☐ Causes extra pain / No change in form.
- ☐ Causes pain / Uses alternate travel.
- ☐ Pain restricts all forms of travel.
- ☐ Pain restricts travel except lying down.

Section 9 - Social
- ☐ Normal and causes no pain.
- ☐ Normal but causes extra pain.
- ☐ Limits energetic interests.
- ☐ Pain limits/doesn't go out as often.
- ☐ Pain restricted social life to home.
- ☐ Pain restricts all social life.

Section 10 - Changing Degree of Pain
- ☐ Pain is rapidly improving.
- ☐ Pain fluctuates but is improving,
- ☐ Improvement is slow.
- ☐ Pain level is unchanged.
- ☐ Pain is gradually worsening.
- ☐ Pain is rapidly worsening.

Office Policy and Rules

1. I agree to the appointment schedule that I assign myself with the office. I may be charged a no show fee of **$25.00** if I miss any appointments without notification to cancel any appointment prior to that appointment time.

___ (initial)

2. I understand that a **$10.00** administrative fee will be assessed to each bill after the first sent from NOVA Pain & Rehab Center for any outstanding fees not paid at the time of service. If you chose, we can keep your credit card / bank information on file to avoid this bill fee.

___ (initial)

3. I understand that any recommendation for future care will be made only after a physical examination is performed. Please call the office ahead of time if you experience a flare-up or a new injury so that we may take the necessary time to evaluate your condition.

___ (initial)

4. I agree to uphold the financial agreement between the office and myself unless other arrangements are made.

___ (initial)

5. I agree to make payment on any bills from NOVA Pain & Rehab Center (if applicable) including co-payments and deductibles that may apply

___ (initial)

6. I understand that if I am using a credit card, I must allow the bank that processes the card to keep the card information on file during the duration of my treatment with NOVA Pain & Rehab Center. I also agree to inform NOVA if my card information changes.
Payment may also be made with checks or cash if preferred.

___ (initial)

7. I understand that if there is any change in my scheduled treatment plan, I will notify the office manager as soon as possible so that we may make the necessary changes to your schedule. Failure to do so may result in insurance complications.

___ (initial)

NOVA Pain & Rehab Center

Consent to Treatment:

1. I, _____, authorize the performance upon myself of
Patient Name
the following procedure(s): Physical Therapy Modalities, Manipulation of the spine and extremities, Massage and Exercise instruction / therapy.

2. I also consent to the performance of other diagnostic and therapeutic procedures in addition to or different from those stated above, whether or not arising from presently unknown conditions, that the above named doctor associates, or assistants may consider necessary or advisable in the course of my health care.

3. The nature and purpose of the procedures, possible alternatives, the risks involved, the possible consequences, and the possibility of complications have been explained to my satisfaction by the above named doctor, associates, or assistants.

4. I acknowledge that no guarantee or assurance of the results that may be obtained from the procedure has been given by the above named doctor, associate, or assistant.

5. I prefer to be contacted by: (please check all that apply and list info.)

- ☐ **Email: _____**
- ☐ **Phone: _____**

Credit Card Authorization

I authorize NOVA Pain & Rehab Center to debit my credit card for any expenses or balances owed to NOVA Pain & Rehab center (including but not limited to copayments and deductible) I understand that my credit card information will be securely kept by the merchant service bank that processes our credit cards and will not be held within *OUT* company. We will not be able to process payment by credit card without this authorization.

☐ Accept ☐ Do Not Accept

Date:_____ Signed:_____

Notice Of Information Practices

Protecting the privacy of your personal health information is important to us. This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review carefully.

Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment, or practice operations will be made only after obtaining your consent. You may request restrictions on disclosures.

Disclosure of protected health information are limited to the minimum necessary for the purpose of disclosure. This provision does not apply to the transfer of medical records for treatment.

You may inspect and receive copies of your records within 30 days a request to do so. There may be a reasonable cost-based fee for photocopying, postage and preparation.

You may request changes to your records. Our practice has the right to accept or deny your request.

We maintain a history of protected health information disclosures that is accessible to you.

In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff. Our practice is required to abide by this notice. We have the right to change. this notice in the future. Any revisions will be permanently displayed in a clearly visible location in our office.

You may file complaint about privacy violations by contacting out Office Manager.

Name: _____ Date: _____

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