MESSINGER Chiropractic ESSEX Physical Therapy

INTAKE FORM

PATIENT INFORMATION:

Name: _____
(last) (m) (first)

Address: _____
(street) (city) (state) (zip)

Cell Phone: _____ Home Phone: _____ Email Address: _____

Date of Birth: _____ Marital Status: _____ Spouse Name: _____

Emergency Contact Person: _____ Phone #: _____

Employer: _____ Employer Phone Number: _____

Employer Address: _____
(street) (city) (state) (zip)

Referring Doctor: _____

Primary Health Care Physician (PCP): _____ Phone: _____

Address: _____
(street) (city) (state) (zip)

Health Insurance Company: _____

Subscriber's Name: _____

Subscriber's ID: _____ Subscriber's DOB: _____

93 Washington Street, Haverhill MA 01832
16 Haverhill Street, Andover MA 01810

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ASSIGNMENT OF BENEFITS

PATIENT: _____

In consideration of the agreement between the above-referenced parties, I hereby irrevocably assign to said doctor my rights, title and interest in any and all type of insurance benefits, including but not limited to personal injury protection (PIP) and medical payment (med-pay) coverage to which I may be entitled to the extent of the amount of the bill for services rendered to me on and after the above-mentioned date that may be due to me. Furthermore, I authorize my doctor to provide my insurance company and attorney with a full report and bill concerning my condition and treatment including but not limited to dates of visits and charges incurred. I hereby authorize and direct the immediate payment of said benefits to said doctor and request and direct that the insurance company pay to said doctor such sums as maybe due to him upon receipt of an itemized statement for services rendered to me by said doctor. It is further understood and agreed that payment of said itemized statement by the insurance company shall be considered as if said payment was sent directly to me. I am aware that I am personally responsible to said doctor for the full amount of my bill incurred. This Assignment specifically allows the release of any and all information requested by said medical provider in the processing of this claim.

I HAVE READ AND UNDERSTAND THIS AFFIDAVIT.

SIGNED UNDER THE PAINS & PENALTIES OF PERJURY

_____

Patient Signature *(electronic signature)*

_____

Witness *(electronic signature)*

_____

Date

MESSINGER Chiropractic ESSEX Physical Therapy

RECORDS RELEASE AUTHORITY

To: _____

_____

_____

I, _____D.O.B._____, hereby request that you release all of my medical records including any radiology reports, lab findings, emergency room records, doctor's notes as well as any data pertinent to my care to: Messinger Chiropractic & Essex Physical Therapy.

Patient Signature: _____
(electronic signature)

Guardian signature:_____
(electronic signature)

Witness Signature: _____
(electronic signature)

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SYMPTOM FORM

PLEASE CHECK ANY OF THE FOLLOWING SYMPTOMS ASSOCIATED WITH YOUR CHIEF COMPLAINT:

- ❒ **Fever**
- ❒ **Chills**
- ❒ **Nausea**
- ❒ **Vomiting**
- ❒ **Chest Pain**
- ❒ **Shortness of Breath/Difficulty Breathing**
- ❒ **Loss of Memory / Concentration**
- ❒ **Loss of Balance**
- ❒ **Difficulty Speaking**
- ❒ **Difficulty Swallowing**
- ❒ **Stomach Pain**
- ❒ **Pain on Urination**
- ❒ **Blood in Urine or Stool**
- ❒ **Loss of Control of Bowel / Bladder**
- ❒ **Increased Pain Following Eating**
- ❒ **Pain which wakes you up at night**
- ❒ **Pain not relieved with rest**
- ❒ **Loss of Appetite**
- ❒ **Unexplained Weight Loss**
- ❒ **Women Only: Is there any chance you may be pregnant? Yes / No.**
- ❒ **Date of last cycle?_____**
- ❒ **Do you have any metal in your body?**
- ❒ **Do you have a pace maker?**
- ❒ **Are you Allergic to latex?**

Patient signature: _____ **Dated:** _____

(electronic signature)

Guardian signature: _____ **Dated:** _____

(electronic signature)

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PAST MEDICAL HISTORY FORM

What treatment have you already received for this condition?

- ❒ Medications
- ❒ Surgery
- ❒ Chiropractic care
- ❒ Physical Therapy care
- ❒ Massage Therapy
- ❒ None
- ❒ Other: _____

Name and address of other professionals who have already treated you for this condition:

_____

_____

Date of Last:

- ❒ Physical Exam: _____
- ❒ Spinal X-ray: _____
- ❒ Chest X-ray: _____
- ❒ Blood test: _____
- ❒ Urine test: _____
- ❒ MRI, CT-Scan, Bone Scan etc.: _____

Please check off any conditions that apply to your past or present medical history:

- ❒ AIDS/HIV
- ❒ Alcoholism
- ❒ Allergies (latex)
- ❒ Anemia
- ❒ Anorexia
- ❒ Appendicitis
- ❒ Rheumatoid Arthritis
- ❒ Asthma
- ❒ Bleeding disorder
- ❒ Breast lumps/cancer
- ❒ Bronchitis
- ❒ Bulimia
- ❒ Cancer: Active
  - ❒ Remission:
  - ❒ Site:
- ❒ Cataracts
- ❒ Chemical dependency
- ❒ Chicken pox
- ❒ Diabetes
- ❒ Emphysema
- ❒ Epilepsy
- ❒ Fractures/dislocations:
  When: _____
  Where: _____
- ❒ Glaucoma
- ❒ Goiter
- ❒ Gonorrhea
- ❒ Gout
- ❒ Heart Disease
- ❒ Hepatitis
- ❒ Hernia
- ❒ Herniated disc
- ❒ Herpes
- ❒ High Cholesterol
- ❒ Kidney disease
- ❒ Liver disease
- ❒ Measles/mumps/rubella
- ❒ Migraine headaches
- ❒ Miscarriage
- ❒ Mono
- ❒ Multiple Sclerosis
- ❒ Osteoporosis
- ❒ Pacemaker
- ❒ Parkinson's Disease
- ❒ Pinched nerves
- ❒ Pneumonia
- ❒ Polio
- ❒ Prostate problems/ Cancer
- ❒ Prostheses
- ❒ Psychiatric care
- ❒ Osteoarthritis
- ❒ Rheumatic Fever
- ❒ Scarlet Fever
- ❒ TIA's/Stroke
- ❒ Thyroid Problems: hyper/hypo
- ❒ Tonsillitis
- ❒ Tuberculosis
- ❒ Tumors/Growths
- ❒ Typhoid Fever
- ❒ Ulcers

Other: _____

Patient Signature: _____ Date: _____

(electronic signature)

Guardian Signature: _____ Date: _____

(electronic signature)

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CONSENT TO TREAT A MINOR

I, _____, consent to the examination and treatment of my son/daughter (a minor) _____ DOB _____ to be performed by the doctors at Messinger Chiropractic & Essex Physical Therapy Office.

Guardian Signature: _____ Date: _____
(electronic signature)

Witness Signature: _____ Date: _____
(electronic signature)

MESSINGER Chiropractic ESSEX Physical Therapy

CONSENT TO TREATMENT

To: All patients of Messinger Chiropractic and Essex Physical Therapy: Please discuss any and all questions or concerns that you may have regarding your treatment with the doctors prior to signing this consent form.

I hereby request and consent to the performance of chiropractic physical therapy care including examination, x-rays (if deemed necessary by the doctors), various forms of manual therapy as well as physical therapy modalities to be performed on me (or on the patient named below, for whom I am legally responsible for) by the doctors and or therapist of Messinger Chiropractic and Essex Physical Therapy.

I have had the opportunity to discuss with the doctors/therapists and or with the other office or clinic personnel the purpose and benefits of the prescribed course of treatment outlined below. Alternatives to treatment including no treatment at all have been discussed with me.

Every type of health care is associated with some risk of a potential problem. Though the treatment rendered in this office, including but not limited to joint manipulation are usually beneficial and seldom cause any problems, I understand and have been informed that there are some risks to treatment including, but not limited to: fractures, disc injuries, strokes, dislocations, sprains, soft tissue injury causing increased inflammation, potential burns as a result of heat generating machines as well as post treatment soreness.

I understand that I will be receiving the following treatment modalities at various times throughout my care in this office as prescribed by the doctors/therapist:

- **Joint mobilizations ranging from grade I-IV possibly including grade V manipulation** in an attempt to decrease pain, improve ROM and promote proper healing. This may include manual as well as static traction.
- **Various forms of electrical stimulation** including interferential current therapy, TENS, continuous and pulsed ultrasound and NMES (neuromuscular electrical stimulation). These electrical modalities are used in an attempt to decrease pain and inflammation as well as to increase tissue extensibility, circulation and promote a proper healing environment and strengthen associated muscles. Please notify the doctor if you are pregnant or have any type of metal implant such as a pacemaker.
- **Soft tissue massage** used to decrease pain, improve range of motion and decrease muscle tightness/spasms.
- Various forms of **soft tissue stretching techniques** (and other forms of manual medicine) are used to prevent scar tissue formation, decrease muscle tightness and to promote proper biomechanics.
- **Therapeutic exercises/stabilization techniques** will be used in the office and prescribed as part of a home exercise program to improve strength, range of motion, stability, balance, endurance etc. in an attempt to stabilize the injured areas and to prevent long term disability.

Messinger Chiropractic and Physical Therapy is a system of health care delivery, and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, disease or condition as a result of treatment in this clinic. We also cannot promise that at the point of discharge from this office that you will be pain free and "cured" of your condition. We will always provide you with the best evidence based care and if acceptable gains are not noted within an acceptable time frame, we will refer you to another health care provider who may further assist you with your condition.

I have had the opportunity to read this form and discuss with the doctor any questions that I may have had. My questions and concerns have been addressed to my satisfaction and thus by signing below, I consent to the proposed treatment plan.

Signature of Patient: _____ Dated: _____
(electronic signature)

Signature of Parent or legal Guardian: _____ Dated: _____
(electronic signature)

Witness Signature: _____ Dated: _____
(electronic signature)

Doctors Signature: _____ Dated: _____
(electronic signature)

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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.

By my signature below, I verify that the offices HIPPA Policy was shown to me and I was offered a copy for my personal use and review to take with me if requested.

Patient Signature: _____ Date: _____
(electronic signature)

Guardian Signature: _____ Date: _____
(electronic signature)

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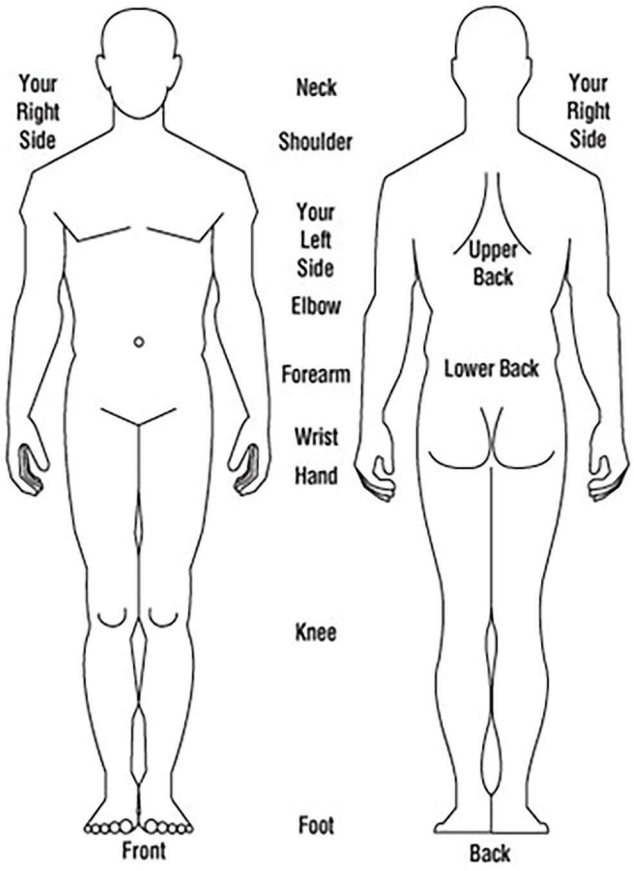
PAIN DRAWING

Please be sure to fill this diagram out accurately.
Mark the area of your body radiating pain with an X, described the sensation.

DOCTORS NOTES:



SEVERITY OF PAIN SCALE
List Area & Check Severity
Number (1-Least 10- Greatest)

1. _____
1 2 3 4 5 6 7 8 9 10

2. _____
1 2 3 4 5 6 7 8 9 10

3. _____
1 2 3 4 5 6 7 8 9 10

4. _____
1 2 3 4 5 6 7 8 9 10

5. _____
1 2 3 4 5 6 7 8 9 10

Pins & Needles - 00000

Burning Pain - xxxxx

Stabbing Pain - /////

Aching Pain - (((((

Numbness - _____

NAME: _____ **DATE:** _____

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