NEW PATIENT FORMS

WELCOME and THANK YOU for choosing Absolute Integrated Health Center for your care. We are a very unique team specializing in physical medicine and rehabilitation. These methods have enabled our patients to achieve their optimal health; even when many other systems have failed. Because of this specialized approach, we can ensure you are getting the best treatment available. Together we will develop a treatment plan that is specifically for you. Please know that we will make specific recommendations based upon our understanding that your health will become our TOP PRIORTY.

____

PATIENT NAME

____

DATE COMPLETED

Confidential Health Information

Please allow our staff to photocopy your driver's license and insurance details.
We comply with all federal privacy standards.
Please print clearly.

Today's Date: ____________________

Last Name: _________________________ First Name: ___________________Middle Initial: _________

Address: ____ City: _______________________

State: _______ Zip Code: ______________ Phone Number: ______________________ Male Female

Email Address: ____ Birth Date: __________________

Occupation: _________________________________ Employer: ________________________________

Address: ____ City: ________________________

State: ____________ Zip Code: _________________ Work Number: _____________________________

Emergency Contact: ________________________________ Phone Number: ______________________

Insurance Carrier: ____________________________ Policy Number: _____________________________

Insured's Name: ______________________________ Who carries the policy: Self Spouse Parent

Policy Holders Name: __________________________________ Policy Holder's DOB:
____

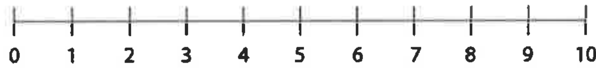
AIH
Absolute Integrated Health

Patient Evaluation Paperwork

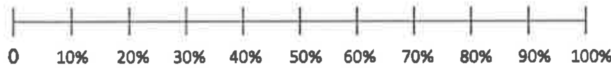
Patient Name: ______________________________ Date: ______________

Age: _________ Sex: M/F Height: _____ Ft. _____ In. Weight: _______ Lbs.

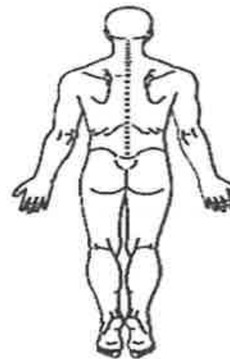
1. What are your complaints and how long have you been experiencing them? (please list them all)
   A. ______________________________ - ______________
   B. ______________________________ - ______________
   C. ______________________________ - ______________
   D. ______________________________ - ______________
2. On the scale below, please circle the severity of <u>each</u> of your complaints: (A, B, C, D)



3. On the scale below, please circle the percentage of time you experience your complaints: (A, B, C, D)



4. On the diagram below please show where you experience your present complaints:



Activities of Daily Living

How do these conditions currently interfere with your life and your ability to function?

	No Effect	Mild Effect	Mod. Effect	Severe Effect
Sitting				
Rising out of a chair				
Standing				
Walking				
Lying down				
Bending over				
Climbing Stairs				
Using a computer				
Getting in/out of car				
Driving a car				
Exercising				
Caring for family				

	No Effect	Mild Effect	Mod. Effect	Severe Effect
Grocery shopping				
Household chores				
Lifting objects				
Reaching overhead				
Showering or bathing				
Dressing myself				
Yard work				
Getting to sleep				
Staying asleep				
Concentrating				
Other:				
Other:				

Patient Signature: ______________________________

Consent to Care

A patient coming to the doctor gives him/her permission to care for them in accordance with appropriate testing, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases underlying physical defects, deformities or pathologies may render a patient susceptible to 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 from whatever he/she is suffering: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the physician.

I agree to settle any claim or dispute I may have with any of these persons or entities, whether related to the prescribed care or otherwise, and resolve by binding arbitration under the current malpractice terms which can be obtained by written request.
I have read and understand the foregoing.

______________________________ ____________________

Patient's 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: ____

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

  ____

  ____

Date of last menstrual period: ________________

Patient Signature: ____________________________ Date: ____________

Absolute Integrated Health Center

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

I, ____, hereby state that by signing this Consent, I acknowledge and agree to the following:

1.The Practice's Privacy Notice is available to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. The Practice explained to me that the Privacy Notice can be available to me in the future at my request.

2.The Practice reserves the **right to change its privacy practices** that are described in its Privacy Notice, in accordance with applicable law.

3.I consent to the following **appointment reminders** that will be used by the Practice: a) a postcard mailed to me at the address provided by me; b) telephoning my home and leaving a message on my voicemail or with the individual answering the phone; and/or c) text.

4.The Practice may use and/or **disclose my PHI** (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.

5.I understand that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive. **Assignment of Benefits:** I authorize the release of any medical or other information necessary to process this claim. I authorize payment of medical benefits to the supplier of services performed at AIH.

6.It is the practice of this office to provide chiropractic care in an "**open-adjusting environment**". "Open Adjusting" involves several patients being seen in the same adjusting room at the same time. Patients are within sight of one another and ongoing routine details of care are discussed within earshot of other patients and staff. This environment also involves the therapy room and fitness center. We are requesting this authorization of you due to various interpretations under Federal Law with respect to what is known as an "Incidental Disclosures" of health information. The use of this format is intended to make your experience with our office more efficient and productive as well as enhance your access to quality health care and health information.

7.**It is the practice of this office to take photographs** to use for patient files, posture programs and other assessment devices. These photographs may be used for display purposes in the office and may be sent to insurance companies as part of your medical records. It is up to the patient to inform Absolute Integrated Health Center if they do not want these photos included as part of your medical record.

8.**It is the practice of this office to take video recordings**. These video recordings may be used for display purposes in the office or be released to the public or may be sent to practice management company (business associate) for training purposes. It is up to the patient to inform Absolute Integrated Health Center if they do not want to participate in these video recordings.

9.This **authorization may be revoked** by you at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our procedures to be completed.

10.I understand that **I have a right to request that the Practice restrict** how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.

11.I understand that this Consent is **valid for seven years.** I further understand that I have the right to revoke this Consent, in writing, at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.

12.I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.

13.I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

____ ________________________________

Name of Individual (print) Signature of Individual

Date Signed ____/____/____

ALLERGY HISTORY

Patient Name ______________________ Date. ____________________

Patient Number ______________________ Age ______ M/F

Branson Allergy Symptom Evaluation™ (BASE)

COMPLAINTS:

Please circle the appropriate number 0 to 3 according to severity:

0 = absent (no symptoms evident) **2 = moderate** (tolerable)

1 = mild (symptoms present, but minimal awareness), **3 = severe**

Symptom		Symptom	
Nasal discharge (runny nose)	0 1 2 3	Headache	0 1 2 3
Nasal obstruction (stuffy nose)	0 1 2 3	Hives	0 1 2 3
Nasal itching	0 1 2 3	Eczema	0 1 2 3
Sneezing	0 1 2 3	Itching ears	0 1 2 3
Watery eyes	0 1 2 3	Sinus or ear infections	0 1 2 3
Itchy eyes	0 1 2 3	Frequent colds or sore throat	0 1 2 3
Gritty feeling (eyes)	0 1 2 3	Sensitivity to pet hair	0 1 2 3
Cough	0 1 2 3	Itchy throat	0 1 2 3
Wheezing	0 1 2 3	Sinus pressure	0 1 2 3
Difficulty breathing	0 1 2 3	Sinus pain	0 1 2 3

Other symptoms causing you problems?

____

MEDICATIONS:

How often do you take medications for your allergy symptoms?

0 = never 1 = occasionally (several times a month or less) 2 = frequently (several times a week) 3 = daily

Medication		Medication	
Antihistamines	0 1 2 3	Nasal Steroids (Flonase, Nasacort)	0 1 2 3
Oral Steroids	0 1 2 3	Asthma medication (Inhaler, Singulair, Advair)	0 1 2 3
Eye drops	0 1 2 3	Other allergy-related medications ____________	

Does any medication give you complete relief of symptoms? ____________________

GENERAL ALLERGY HISTORY:

How many months of the year do you have allergies? ______ How many years? ______

In what season are they worse (check all that apply): O Spring O Summer O Fall O Winter

Have you been allergy tested before? O Yes O No

If yes, which type: O Skin prick/Puncture O Blood draw

Have you previously received allergy shots? ____________ Allergy drops? ________ If yes, when? ________

Do you smoke or use tobacco products? ____________

List any animals you have in or around the home ______________________

Who else in your family has allergies? ______________________

PROVIDER ONLY

RAW SCORE: ________ /25 **0-25 = MILD** **26-50=SIGNIFICANT**

SCORE: __________ (Multiply raw score by 4) **51-100 = SEVERE** **100+= VERY SEVERE**