TPMI

Patient Information

Name:_________________________________ DOB________________ E-Mail Address __________________________

Address:____

City:___________________________State:________ Zip:________

Primary Phone:____________(c?) Secondary Phone:____________(c?)

Occupation:____

Emergency Contact:__________________ Phone:_________________

Payment Info

- ☐ AUTO ___________________
- ☐ WORK COMP
- ☐ TOSD
- ☐ MEDICAL ________________

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Insurance Info

Medical

Policy Holder Information

Name/DOB: _________________________

Co. Name__________________ Employer: ___________________

ID/ Group # :____

Back Of Card

Ins Billing Address:_______________________ Number:____________

City:______________ State:______ Zip:______

Auto / Work Comp **Date of Collision** ____________

Policy Holder(auto)___________________________________

Claim Number_______________________________________

Adjuster______________________#____________________

Billing Address _____________________________________

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Primary Health Care Practitioner and/or Clinic:_____________________________________

Phone:____________________________

Patient Condition

Why are you visiting us Today? (C/C)____

____

When did you First Notice this condition? (Recent/Chronic/ Date of Onset) ______________________

Is the condition: ___ Getting worse? ___ Improving? ___ Staying the same? ___ Not Sure?

How often do you experience your symptoms?

___ Constantly (76% to 100% of the day)
___ Frequently (51% to 75% of the day)
___ Occasionally (26% to 50% of the day)
___ Intermittently (1% to 25% of the day)

What best Describes your current symptoms?

(check as many as needed)

___Sharp / Stabbing
___Dull
___Shooting
___Numbness
___Aching
___Burning
___Tingling

Currently, how much of the time does your condition interfered with your normal work?

___Not at all ___a little bit ___Moderately ___Quite a bit ___Significantly

Currently, how much of the time does your condition interfered with Everyday Activities?

___Not at all ___a little bit ___Moderately ___Quite a bit ___Significantly

What type of regular exercise do you perform?

___Not at all ___a little bit ___Moderately ___Quite a bit ___Significantly

Current Height and Weight? _____ft_____in _____lbs

For each of the conditions listed below, please indicate if you have a History of the condition, or of it is Currently affecting you:

History	Current		History	Current		History	Current	
☐	☐	Headache	☐	☐	High Blood Pressure	☐	☐	Breathing Difficulty
☐	☐	Neck Pain	☐	☐	Heart Disease/Attack	☐	☐	Sinus Problems
☐	☐	Upper Back Pain	☐	☐	Chest Pain	☐	☐	Tobacco Use
☐	☐	Mid Back Pain	☐	☐	Stroke			
☐	☐	Low Back Pain				☐	☐	Chemical Dependency
			☐	☐	Kidney Issues			
☐	☐	Shoulder Joint Pain	☐	☐	Bladder Infection	☐	☐	Allergies
☐	☐	Arm Pain-Numbness	☐	☐	Painful Urination	☐	☐	Depression
☐	☐	Wrist Pain- Numbness	☐	☐	Urinary Retention			
☐	☐	Hand Pain-Numbness	☐	☐	Excessive Urination	☐	☐	Lupus
			☐	☐	Loss of Bowel or Bladder Control	☐	☐	Rheumatoid Arthritis
☐	☐	Hip-Thigh Pain- Numbness				☐	☐	Osteo Arthritis
☐	☐	Knee-Shin-Calf Pain-Num	☐	☐	Recent Unexpected Weight Gain-Loss	☐	☐	Epilepsy
☐	☐	Ankle-Foot Pain-Numbness	☐	☐	Loss of Appetite	☐	☐	HIV Positive
			☐	☐	Abdominal Pain			
☐	☐	Facial Pain-Numbness	☐	☐	Liver – Gallbladder Problems			***FEMALES ONLY***
☐	☐	Jaw Pain	☐	☐	Excessive Thirst	☐	☐	Contraceptive Use
			☐	☐	Diabetes	☐	☐	Hormone Therapy
☐	☐	General Fatigue				☐	☐	Current Pregnancy
☐	☐	Irritability	☐	☐	Cancer-Location	☐	☐	
☐	☐	Visual Disturbance				☐	☐	Other Health Conditions
☐	☐	Memory Problems			_____			Not Listed Here-
☐	☐	Confusion-Disorientation				_____		Explain Below
☐	☐	Concentration Problems			_____			

Please list other conditions and/or explain all conditions if necessary

Please list all prescribed and over the counter medications, and supplements that you are currently taking:

_____

_____

Please list all hospitalizations and surgeries:

_____

_____

Other Comments/ Family History of Chronic or Genetic Conditions

Patient Signature _____ Date_____

Please read thoroughly, and initial at each section and sign at the bottom

Authorization to Release Information

_____ I hereby authorize this healthcare entity to release all information to the care I receive to my insurance company, or third party payer or their designee. I understand that this may be necessary for the payment of my bill, determination of my benefits, or for utilization and quality review purposes.

Information about Possible risk of Chiropractic Treatment

_____You have the right as a patient, to be informed about your condition, and the recommended treatment approach so that you may make a an informed decision whether or not to undergo the procedure knowing the potential risks involved. The statement is not meant to scare or alarm you, just to make you aware so that you may choose to, or not to undergo treatment. Doctors of Chiropractic, Medical Doctor, Osteopathic Doctors and Physical Therapists using manual therapy treatment for patients with headaches, and cervical spine (neck) pain are required to explain that there have been rare cases of injury to the vertebral artery as a result of treatment. The chance of this happening is extremely rare and estimated at about 1 per 400,00o to 1 per 10 million treatments. Appropriate testing will be performed to determine if you are susceptible to this type of injury, and you will be notified if that is the case. Should you have any questions, please discuss them with the Doctor. As with EVERY health procedure, complications may arise during treatment, these include soreness, muscle or ligament sprain or strain, dislocations, fractures, disc injury, or physiotherapy burns. Other than soreness, the others are extremely rare occurrences

Assignment of Benefits

_____I assign all insurance benefits payable to me for my care to Advanced Wellness and Sports Rehab (the entity). I understand that this healthcare entity may be paid directly by the insurance company or other payer. This assignment will remain in effect unless revoked by me in writing. I furthermore understand that I am responsible for all charges whether or not paid by insurance. In some cases, insurance company may remit payment to me, and I in turn will pay that immediately to the entity. I hereby authorize the signature on all insurance submissions.

Guarantee of Payment

_____I understand that guarantee payment of all charges incurred for treatment in accordance with the rates and terms of this entity, despite quotations by the insurance company to either myself or the entity. I fully understand that I am directly and fully responsible to the TPMI for all medical and/or surgical benefits, including major medical, submitted by the clinic for service rendered me and that this Agreement is made solely for the Advanced Wellness and Sports Rehab 's additional protection and in consideration of the clinic's awaiting payment. I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may recover said fee.

Consent for Treatment of a Minor

For _____

I hereby authorize the entity to administer treatment, as they deem necessary to my minor son/daughter. As of this date, I have legal authority to select and authorize such care for the minor named above.

_____ (Initials)

Consent for Treatment

After review of the above information, I authorize the performance of diagnostic tests, procedures and treatment deemed necessary by the personnel involved in my care.

_____

Patient Signature or Responsible Party Date Relationship to Patient

BACK PAIN QUESTIONNAIRE

TPMI

Patient Name: _____ **Date:** _____

Patient Signature: _____

This questionnaire is designed to enable us to understand how much your low back pain had affected your ability to manage your everyday activities. Please answer each section by checking the ONE CHOICE that most applies to you. Please select the one choice which most closely describes your problem right now

Pain Intensity

- ☐ The pain comes and goes and is very mild.
- ☐ The pain is mild and does not vary much.
- ☐ The pain comes and goes and is moderate.
- ☐ The pain is moderate and does not vary much.
- ☐ The pain comes and goes and is severe.
- ☐ The pain is severe and does not vary much.

Personal Care

- ☐ I would not have to change my way of washing or dressing in order to avoid pain.
- ☐ I do not normally change my way of washing or dressing even though it causes some pain.
- ☐ Washing and dressing increases the pain, but I manage not to change my way of doing it.
- ☐ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- ☐ Because of the pain, I am unable to do some washing and dressing without help.
- ☐ Because of the pain, I am unable to do any washing or dressing without help.

Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights, but it causes extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, eg. on a table.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can only lift very light weights, at the most.

Walking

- ☐ Pain does not prevent me from walking any distance.
- ☐ Pain prevents me from walking more than one mile.
- ☐ Pain prevents me from walking more than 1/2 mile.
- ☐ Pain prevents me from walking more than 1/4 mile.
- ☐ I can only walk while using a cane or on crutches.
- ☐ I am in bed most of the time and have to crawl to the toilet.

Sitting

- ☐ I can sit in any chair as long as I like without pain.
- ☐ I can only sit in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting more than one hour.
- ☐ Pain prevents me from sitting more than 1/2 hour.
- ☐ Pain prevents me from sitting more than ten minutes.
- ☐ Pain prevents me from sitting at all.

Standing

- ☐ I can stand as long as I want without pain.
- ☐ I have some pain while standing, but it does not increase with time.
- ☐ I cannot stand for longer than one hour without increasing pain.
- ☐ I cannot stand for longer than 1/2 hour without increasing pain.
- ☐ I cannot stand for longer than ten minute without increasing pain.
- ☐ I avoid standing, because it increases the pain straight away.

Sleeping

- ☐ I get no pain in bed.
- ☐ I get pain in bed, but it does not prevent me from sleeping well.
- ☐ Because of pain, my normal night's sleep is reduced by less than one than one quarter.
- ☐ Because of pain, my normal night's sleep is reduced by less than one-half.
- ☐ Because of pain, my normal night's sleep is reduced by less than three-quarters.
- ☐ Pain prevents me from sleeping at all.

Social Life

- ☐ My social life is normal and gives me no pain.
- ☐ My social life is normal, but increases the degree of my pain.
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, My e.g., dancing, etc.
- ☐ Pain has restricted my social life and I do not go out very often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have hardly any social life because of the pain.

Traveling

- ☐ I get no pain while traveling.
- ☐ I get some pain while traveling, but none of my usual forms of travel make it any worse.
- ☐ I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
- ☐ I get extra pain while traveling which compels me to seek alternative forms of travel.
- ☐ Pain restricts all forms of travel.
- ☐ Pain prevents all forms of travel except that done lying down.

Changing Degree of Pain

- ☐ My pain is rapidly getting better.
- ☐ My pain fluctuates, but overall is definitely getting better.
- ☐ My pain seems to be getting better, but improvement is slow at present.
- ☐ My pain is neither getting better nor worse.
- ☐ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.

NECK PAIN QUESTIONNAIRE

TPMI

Patient Name: _____ Date: _____

Patient Signature: _____

This questionnaire is designed to enable us to understand how much your neck pain had affected your ability to manage your everyday activities. Please answer each section by checking the ONE CHOICE that most applies to you. Please select the one choice which most closely describes your problem right now.

Pain Intensity	***Concentration***
☐ I have no pain at the moment.	☐ I can concentrate fully when I want to with no difficulty.
☐ The pain is very mild at the moment.	☐ I can concentrate fully when I want to with slight difficulty.
☐ The pain is moderate at the moment.	☐ I have a fair degree of difficulty in concentrating when I want to.
☐ The pain is fairly severe at the moment.	☐ I have a lot of difficulty in concentrating when I want to.
☐ The pain is very severe at the moment.	☐ I have a great deal of difficulty in concentrating when I want to.
☐ The pain is the worst imaginable at the moment.	☐ I cannot concentrate at all.
Personal Care (Washing, Dressing, etc.)	***Work***
☐ I can look after myself normally without causing extra pain.	☐ I can do as much work as I want to.
☐ I can look after myself normally, but it causes extra pain.	☐ I can only do my usual work, but no more.
☐ It is painful to look after myself and I am slow and careful.	☐ I can do most of my usual work, but no more.
☐ I need some help, but manage most of my personal care.	☐ I cannot do my usual work.
☐ I need help every day in most aspects of self care.	☐ I can hardly do any work at all.
☐ I do not get dressed, I wash with difficulty and stay in bed.	☐ I cannot do any work at all.
Lifting	***Driving***
☐ I can lift heavy weights without extra pain.	☐ I can drive my car without any neck pain.
☐ I can lift heavy weights, but it gives extra pain.	☐ I can drive my car as long as I want with slight pain in my neck.
☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table.	☐ I can drive my car as long as I want with moderate pain in my neck.
☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.	☐ I cannot drive my car as long as I want because of moderate pain in my neck.
☐ I can lift very light weights.	☐ I can hardly drive at all because of severe pain in my neck.
☐ I cannot lift or carry anything at all**.**	☐ I cannot drive my car at all.
Reading	***Sleeping***
☐ I can read as much as I want to with no pain in my neck.	☐ I have no trouble sleeping.
☐ I can read as much as I want to with slight pain in my neck.	☐ My sleep is slightly disturbed (less than 1 hour sleepless).
☐ I can read as much as I want to with moderate pain in my neck.	☐ My sleep is mildly disturbed (1-2 hours sleepless).
☐ I cannot read as much as I want because of moderate pain in my neck.	☐ My sleep is moderately disturbed (2-3 hours sleepless).
☐ I cannot read as much as I want because of severe pain in my neck.	☐ My sleep is greatly disturbed (3-5 hours sleepless).
☐ I cannot read at all.	☐ My sleep is completely disturbed (5-7 hours)
Headaches	***Recreation***
☐ I have no headaches at all.	☐ I am able to engage in all of my recreational activities with no neck pain at all.
☐ I have slight headaches which come infrequently.	☐ I am able to engage in all of my recreational activities with some pain in my neck.
☐ I have moderate headaches which come infrequently.	☐ I am able to engage in most, but not all of my recreational activities because of pain in my neck.
☐ I have moderate headaches which come frequently.	☐ I am able to engage in a few of my recreational activities because of pain in my neck.
☐ I have severe headaches which come frequently.	☐ I can hardly do any recreational activities because of pain in my neck.
☐ I have headaches almost all the time.	☐ I cannot do any recreational activities at all.