Keystone
PHYSICAL MEDICINE

Welcome to Our Office!

Please fill out the health record as completely and accurate as possible. If you have any questions, please do not hesitate to ask one of our qualified team members.

It is our pleasure to be of service to you.

*"Our mission at Keystone Physical Medicine is to create an environment to inspire health through integrated natural health care.
We will EMPOWER our community to be PROACTIVE in their health and to take PERSONAL RESPONSIBILTY to be well."*

About the Patient

Name _____ Date _____
Address _____
City _____ State _____ Zip _____
Home Phone (___)_____ Cell Phone (___)_____
Birthdate ___/___/_____ Age _____ Employer _____
Gender ☐ Male ☐ Female Marital Status _____# of Children_____
SSN _____ Email_____

Emergency Contact

Name _____ Relationship _____ Phone _____

Reason for This Visit

Describe the purpose of this visit: _____
_____

Is the purpose of this appointment related to ☐ Work ☐ Sports ☐ Auto ☐ Chronic Pain ☐ Other

Explain _____

If work related, have you made a report of your accident to your employer? ☐ YES ☐ NO

When did this condition begin? _____

Does this condition interfere with ☐ Work ☐ Sleep ☐ Daily Routine ☐ Other_____

Has this condition occurred before? ☐ YES ☐ NO Explain _____

Have you had treatment for this condition? ☐ YES ☐ NO

Type of Treatment _____ Results _____

Type of Treatment _____ Results _____

Primary Care Provider

Name _____ Practice _____ Specialty_____
Address _____ Phone _____
Date of last physical exam _____

Experience with Chiropractic

Who referred you to this office? _____
Have you been adjusted by a chiropractor before? ☐ YES ☐ NO
Reason for those visits _____
Doctor's Name _____ Date of last visit _____

Health Habits & Social History

Tobacco ☐ YES ☐ NO Quantity Per Day _____ Past Use? ☐ YES ☐ NO
Alcohol ☐ YES ☐ NO Quantity Per Day _____ Past Use? ☐ YES ☐ NO
Recreational Drugs ☐ YES ☐ NO Quantity Per Day _____ Past Use? ☐ YES ☐ NO
Caffeine/Coffee ☐ YES ☐ NO Quantity Per Day _____
Do you exercise regularly? ☐ YES ☐ NO Type of Exercise _____
Do you wear orthotics? ☐ YES ☐ NO Do you wear a brace? ☐ YES ☐ NO Type_____

Preventative Health

Date of Last:

Pap/Pelvic Exam _____ Eye Exam _____
Mammogram _____ Bloodwork (Lipid/Cholesterol) _____
Colonoscopy (Guaiac) _____ Vaccinations _____
Prostate Exam/PSA _____ Bone Density _____

Allergies

Do you have any allergies? ☐ YES ☐ NO

Allergy_____Reaction_____ Allergy_____Reaction_____
Allergy_____Reaction_____ Allergy_____Reaction_____
Allergy_____Reaction_____ Allergy_____Reaction_____

Medications/Supplements

Please list all prescribed and over-the-counter medications/supplements/vitamins you take regularly.

1._____ Frequency _____ 4._____ Frequency _____
2._____ Frequency _____ 5._____ Frequency _____
3._____ Frequency _____ 6._____ Frequency _____

Past Surgeries

1._____ Date _____ 4._____ Date _____
2._____ Date _____ 5._____ Date _____
3._____ Date _____ 6._____ Date _____

Family History

Heart Attack/Angina ☐ YES ☐ NO Relation _____ Diagnosis _____
Stroke ☐ YES ☐ NO Relation _____ Diagnosis _____
High Blood Pressure ☐ YES ☐ NO Relation _____ Diagnosis _____
High Cholesterol ☐ YES ☐ NO Relation _____ Diagnosis _____
Diabetes ☐ YES ☐ NO Relation _____ Diagnosis _____
Thyroid Disease ☐ YES ☐ NO Relation _____ Diagnosis _____
Cancer ☐ YES ☐ NO Relation _____ Diagnosis _____
Kidney Disease ☐ YES ☐ NO Relation _____ Diagnosis _____
Osteoporosis ☐ YES ☐ NO Relation _____ Diagnosis _____
Rheumatoid Arthritis ☐ YES ☐ NO Relation _____ Diagnosis _____
Asthma ☐ YES ☐ NO Relation _____ Diagnosis _____
Mental Health Disorder ☐ YES ☐ NO Relation _____ Diagnosis _____
Substance Abuse ☐ YES ☐ NO Relation _____ Diagnosis _____

Review of Systems

Please check each of the diseases or conditions that you currently have or have had in the past. While they may seem unrelated to the purpose of this appointment, they can affect the overall diagnosis and recommendation for care.

General
- ☐ Fever
- ☐ Sweats
- ☐ Hot Flashes
- ☐ Temperature Intolerance
- ☐ Excessive Thirst
- ☐ Fatigue
- ☐ Sleep Difficulties
- ☐ Drowsiness
- ☐ Unplanned Weight Change
- ☐ Anemia

Musculoskeletal
- ☐ Neck Pain
- ☐ Low Back Pain
- ☐ Mid to Upper Back Pain
- ☐ Osteoarthritis (OA)
- ☐ Rheumatoid Arthritis (RA)
- ☐ Psoriatic Arthritis (PA)
- ☐ Headaches
- ☐ Plantar Fasciitis

Genitourinary
- ☐ Pain or Burning with Urination
- ☐ Frequent Urination
- ☐ Excessive Urination
- ☐ Difficulty Emptying Bladder
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Venereal Diseases

Women Only
- ☐ Pregnant – Weeks? ____
- ☐ Nursing
- ☐ Painful Periods
- ☐ PCOS
- ☐ Endometriosis
- ☐ Irregular Cycles
- ☐ Breast Implants

Eyes
- ☐ Pain or Redness
- ☐ Vision Changes

Ear, Nose, Throat
- ☐ Hearing Loss
- ☐ Ringing in Ears
- ☐ Dizziness
- ☐ Bleeding Gums
- ☐ Nosebleeds
- ☐ Sinus Problems/Allergies

Endocrine
- ☐ Diabetes Type 1
- ☐ Diabetes Type 2
- ☐ Hypothyroid
- ☐ Hyperthyroid
- ☐ Hashimoto's
- ☐ Swollen Lymph Glands
- ☐ Blood Clots
- ☐ Excessive Bleeding

Neurological
- ☐ Pain/Tingling/Numbness in Extremities
- ☐ Peripheral Neuropathy

Cancer
- ☐ _____
- ☐ _____
- ☐ Chemotherapy ☐ Radiation

Other
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

Skin
- ☐ Rash
- ☐ Moles

Cardiovascular
- ☐ Chest Pain
- ☐ Heart Murmur
- ☐ Irregular Heart Beat
- ☐ Heart Attack
- ☐ Stroke
- ☐ Heart Surgery/Pacemaker
- ☐ High or Low Blood Pressure

Pulmonary
- ☐ Wheezing
- ☐ Shortness of Breath
- ☐ Chronic Cough
- ☐ Asthma

Gastrointestinal
- ☐ Constipation
- ☐ IBS
- ☐ Ulcers/Colitis
- ☐ Gallstones
- ☐ Liver Disease

Psychological
- ☐ Anxiety/Depression
- ☐ Memory Loss
- ☐ Mood Swings

Today's Primary Complaint

Primary Complaint: _____

Overall **frequency** of the complaint:

☐ Constant (100%) ☐ Frequent (75%) ☐ Intermittent (50%) ☐ Occasional (25%)

Overall **intensity** of the complaint: 0 = No Pain 5 = Moderate Pain 10 = Severe Pain

0 1 2 3 4 5 6 7 8 9 10

Does it interfere with your normal daily activities? (family, recreation, sports) ☐ YES ☐ NO

Do your symptoms increase while performing your normal work duties? ☐ YES ☐ NO

What aggravates the problem: _____

What relieves the problem: _____

If this problem went without being taken care of, how do you think it would affect you?

_____

My Health Insurance

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that the Doctor's Office will provide any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to the doctor's office will be credited to my account upon receipt. I also understand my insurance doesn't pay for all services, even some that I and my health care provider believe I need. I understand that if my insurance doesn't pay, I am responsible for payment.

Insurance Company _____ Member ID # _____
Address _____ Group # _____
Phone # (___)_____

Do you have a secondary insurance? ☐ YES ☐ NO

About the Insured Person

Name _____ Insured's SSN _____
Relation _____ Date of Birth ___/___/_____

Financial Agreement

I, _____, clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for all payment. I agree that I am responsible for all the bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered to me will become immediately due and payable. I hereby authorize assignment of my insurance right and benefits (if applicable) directly to the provider of services rendered.

_____ _____ _____ _____
Patient Signature Date Guardian or Spouse Signature Date

Who should receive bills for payment on your account?

☐ Patient ☐ Spouse ☐ Parent ☐ Worker's Comp. ☐ Medicaid
☐ Medicare ☐ Personal Health Insurance ☐ Auto Insurance ☐ Attorney

Today's Payment

Today's payment will be made by: ☐ Cash ☐ Check ☐ Credit Card ☐ Other: _____

Insurance: We will verify all insurance and your benefits per your agreement with your carrier. After verification, the Doctor will give his recommendations and an appropriate plan will be designed for each individual. *Please let the Front Desk Coordinator know if you have been in an accident or have been injured on the job. This will enable us to give you any and all information necessary to serve you completely and accurately.*

Agreement: My signature below signifies my agreement for payment in full on a cash basis if I have not provided Keystone Physical Medicine with all necessary documents and information by the time of the second visit.

I have read and agree to the above statement.

_____ _____ _____ _____
Patient Signature Date Guardian or Spouse Signature Date

Billing/EOB's

As Keystone Physical Medicine is an integrated office all practitioners review examination findings and treatment recommendations. Additionally, all practitioners will continue to monitor treatment rendered that is within their scope of practice, whether or not you have had an office visit with him/her. Therefore, please be advised that you may see a number of practitioner's names on your EOB's. If you have any questions or concerns regarding this matter please let us know.

_____	_____	_____	_____
Patient Signature	Date	Guardian or Spouse Signature	Date

Missed Appointment Policy

Here at Keystone Physical Medicine, we strive to provide you with the utmost professionalism and excellence of service. Our commitment to your health and well-being is something we take very seriously.

We care about you and realize it would be a disservice to you if we did not emphasize the importance of your own commitment to the care you need, and to the actions we recommend to you.

- Your faithfulness to the recommended number of adjustments/visits is key to ensuring optimum results.
- With the exception of emergencies, it is vital that you keep all your appointments. Reminder cards are provided to help you save the date. If you need to re-schedule an appointment please call our office and arrange for a make-up appointment with our Front Desk Assistants. We would prefer the make-up appointment be within the same week.

In the instance of a multiple rescheduled appointment, or multiple no show visits without notice by phone we reserve the right to charge you a $20.00 fee.

Thank you for your understanding. We greatly appreciate you as our patient and strongly desire excellent results and success for you!

I understand and agree to all of the information written above.

_____	_____	_____	_____
Patient Signature	Date	Guardian or Spouse Signature	Date

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature you have reviewed our notice before signing this consent. The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. The HIPPA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of information for treatment, payment, or healthcare operations.

By signing this form, I understand that:

-Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
-The practice reserves the right to change the privacy policy as allowed by law.
-The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
-The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments?	YES	NO
May we leave a message on your answering machine at home or on your cell phone?	YES	NO
May we discuss your medical condition with any member of your family?	YES	NO
If YES, please name the members allowed: _____		
May we discuss your medical condition with any other individuals?	YES	NO
If YES, please name the individuals: _____		

This consent was signed by: _____

(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____

INFORMED CONSENT FOR CHIROPRACTIC CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic and/or his/her preceptor and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with, or serving as back-up for the doctor of chiropractic including those working at the clinic or office listed below or any other office or clinic. I have had an opportunity to discuss with the doctor and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. It is not reasonable to expect the doctor to be able to anticipate and explain all risks and complications of a given procedure on any particular visit, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

Chiropractic treatment involves the science, philosophy and art of locating and correcting spinal misalignments and as such, is oriented toward improvement of spinal function relative to range of motion, muscular and neurological aspects. There has been no promise, implied or otherwise, of a cure for any symptom, disease or condition as a result of treatment in this clinic. I understand that the chiropractor will use his/her hands or a mechanical device upon my body to adjust a joint, which may cause an audible “pop” or “click.” It is my intention to rely on the doctor to exercise professional judgment during the course of any procedures, which he/she feels at the time to be in my best interest. Neither the practice of chiropractic or medicine is an exact science, but relies upon information relayed by the patient, information gathered during examination, and the doctor’s interpretation thereof, as well as the doctor’s judgment and expertise in working with like cases.

I understand that as part of my healthcare, Keystone Physical Medicine originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as a basis for planning my care and treatment; a means of communication among other health professionals who may contribute to my care; a source of information for applying my diagnosis and treatment information to my bill; and a means by which a third-party payer can verify that services billed were actually provided. I understand and have been provided with information that provides a more complete description of information uses and disclosures. I understand that I have the right to review this information prior to signing this consent. I understand that Keystone Physical Medicine reserves the right to change their information, policies and practices, and prior to implementation will mail a copy of any revised notice to the address I’ve provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that Keystone Physical Medicine is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that has already taken action in reliance thereon.

I have read, or have had read to me, the Informed Consent for Chiropractic Adjustments and Care. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_____ _____

Patient Name (Printed) Date Signed

_____

Signature: Patient or Legal Representative (Attorney, Guardian, Parent)

INFORMED CONSENT FOR MEDICAL TREATMENT

The purpose of this form is to document that you have been given your informed consent to the treatment(s) and/or procedures(s) and/or medications proposed and described by your medical provider. You have the right, as a patient, to be informed about and understand your medical condition, the alternative procedures and treatments that are available to address your condition, including non-treatment, the likelihood of success, risks, benefits and side effects for each treatment, procedure, non-treatment, medication, and your right to refuse and procedure

By my signature below, I confirm that I have received, understand, and have no further questions regarding the procedure. I hereby consent to my medical provider performing the procedure, and I understand that unforeseen conditions may arise during the procedure, which, in the judgement of my medical provider, and may require additional or different procedures and/or treatments and/or medications. In such an event, I hereby authorize my medical provider to do whatever he or she, in his or her professional medical judgment considers medically to be in my best interest. I further understand and agree that I have not been given any guarantee or assurance as to the result of any procedure.

_____ _____

Patient Name (Printed) Date Signed

_____

Signature: Patient or Legal Representative (Attorney, Guardian, Parent)

FOR DOCTOR'S USE ONLY

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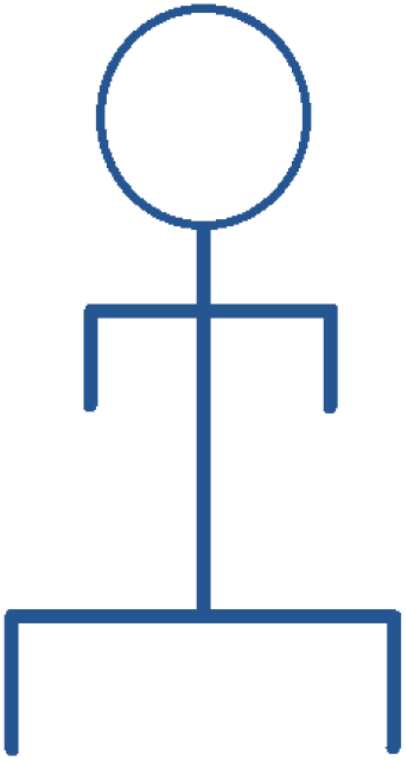

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EXAM FINDINGS

HISTORY