Keystone
PHYSICAL MEDICINE

Welcome to our Office!

Please fill out our Health Record as completely and accurate as possible. If you have any questions, please don't 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 be proactive in their health and to take personal responsibility to be well."

About the Patient

Name _____
Address
_____
City _____ State _____ Zip _____
Home Phone
(___)_____
Cell Phone
(___)_____
Text Message Reminders? ____Yes ____No
Birthdate ___/___/_____ Age _____
Gender ☐ Male ☐ Female # of Children____
Employer _____
Work Address
_____
Work Phone (___)_____
Type of Work
_____
Marital Status ☐ Married ☐ Single ☐ Divorced
☐ Separated ☐ Widowed

SSN _____
Email_____

About the Spouse or Parent

Name _____
Home Phone
(___)_____
Employer
_____
Work Address
_____

Reason for This Visit

Describe the purpose of this visit: _____
_____

Is the purpose of this appointment related to:

☐ Work ☐ Sports ☐ Auto ☐ Fall

☐ Chronic Discomfort ☐ Home Injury ☐ Other

Explain _____

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

When did this condition begin? _____

Has this condition ☐ gotten worse ☐ stayed constant
☐ comes and goes

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

Explain _____

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

Have you seen other doctors for this condition?
☐ YES ☐ NO

Doctor's Name(s)
_____
Type of Treatment _____
Results _____

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 _____
Approximate date of last visit _____
Has any *adult* in your family seen a chiropractor? ☐ YES ☐ NO If yes, who? _____
Has any *child* in your family seen a chiropractor? ☐ YES ☐ NO If yes, who? _____

Patient Health History

Who is your primary care physician? (doctor and/ or practice)
What treatment have you already received for your condition: ☐ Medications ☐ Surgery ☐ Physical Therapy ☐ Chiropractic ☐ Other:_____

Name and address or other doctors(s) who have treated your condition: _____
_____

Date of last: Physical Exam: _____ Spinal X-Ray: _____ Spinal Exam: _____ MRI, CT-Scan: _____

Accident Information

Is this visit due to an accident? ☐ Yes ☐ No What type? ☐ Auto ☐ Work ☐ Home ☐ Other
Date of accident:_____ Day of Week:_____ Time of Accident:_____
To whom have you made a report of your accident? ☐ Auto Insurance ☐ Employer ☐ Work Comp ☐ None ☐ Other

Attorneys Name: _____Phone: _____

Medications I Currently Take

☐ Nerve Pills
☐ Pain Killers (including Aspirin)
☐ Muscle Relaxants
☐ Blood Pressure Meds
☐ Insulin
☐ Stimulants
☐ Blood Thinners
☐ Tranquilizers
☐ _____
☐ _____

Health Habits

Do you smoke? ☐ YES ☐ NO
Do you drink alcohol? ☐ YES ☐ NO
Do you drink coffee? ☐ YES ☐ NO
Do you exercise regularly? ☐ YES ☐ NO
Do you wear ☐ heel lifts ☐ sole lifts ☐ inner lifts ☐ arch supports

Health Conditions

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

☐ Severe or Frequent Headaches
☐ Sinus Problems
☐ Dizziness
☐ Loss of Sleep
☐ Pain Between the Shoulders
☐ Frequent Neck Pain
☐ Numbness or Pain in Arms/Legs
☐ Lower Back Problems
☐ Digestive Problems
☐ Ulcers/Colitis
☐ Heart Attack/Stroke
☐ Thyroid Problems
☐ Kidney Problems
☐ Hepatitis
☐ Cancer
☐ Congenital Heart Defect
☐ Heart Surgery/Pacemaker
☐ High/Low Blood Pressure
☐ Difficulty Breathing
☐ Asthma
☐ Arthritis
☐ Alcohol/Drug Abuse
☐ Venereal Diseases
☐ HIV/AIDS
☐ Diabetes
☐ Tuberculosis
☐ Shingles
☐ Chemotherapy
☐ Anemia
☐ Rheumatic Fever
☐ Psychiatric Problems

For Women Only:

Are you pregnant? ☐ YES ☐ NO How many weeks? _____
Are you nursing? ☐ YES ☐ NO
Are you taking birth control? ☐ YES ☐ NO
Do you experience painful periods? ☐ YES ☐ NO
Do you have irregular cycles? ☐ YES ☐ NO
Do you have breast implants? ☐ YES ☐ NO

Health Conditions

Primary Complaint(s):

_____

_____

Overall **frequency** of the complaint:

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

Overall **intensity** of the complaint:

☐ Minimal (an annoyance but no effect on activity) ☐ Moderate (tolerable with marked impairment of activity

☐ Slight (tolerable with some impairment to activity) ☐ Severe (intolerable and cannot perform any activities)

Does it interfere with your normal daily activities? (family, recreation, sports)

_____

_____

_____

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

Please mark pain level below at present time, 10 being the worst: 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐

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 _____ Policy # _____

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.
☐ Medicare ☐ Personal Health Insurance ☐ Auto Insurance

Ownership of X-ray Films

It is understood and agreed that the payments to the Doctor for X-Rays is for examination of X-rays only. The X-ray negatives will remain the property of this office. They are kept on file where they may be seen at any time while I am a patient of this office.

Office Fee Schedule and Financial Policy

Service	Fee
Consultation	$ 30
Initial Exam	$ 75- $150
Dynamic Re-exam/Progress evaluations	$ 40
X-Rays	$ 75- $150
Adjustments	$ 40- $70

Our experience has shown that it is wise to have an understanding with our clients as to our office policies and fees. Therefore, this form has been prepared for your convenience and information. We offer several methods of payment for your care at our office and you may choose the plan that you prefer. This information will enable us to better serve you and help to avoid misunderstanding in the future. Our main concern is your health and well-being, and we will do our best to help you.

IMPORTANT: All clients are responsible for full payment for the first visit, unless other arrangements have been made in advance.

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

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 Chiropractic Assistant know if you have been in some type of 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's Name Patient's 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's Name Patient's Signature

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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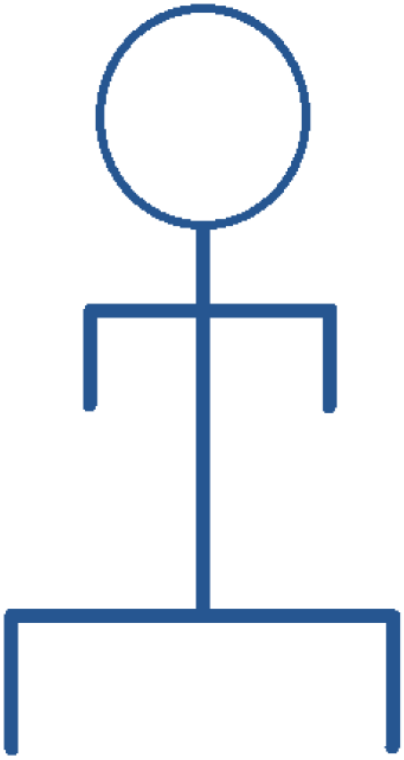

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EXAM FINDINGS

HISTORY