

ABOUT YOU:

Today's Date: ___/___/___ Name: _____

How would you like to be addressed by our staff? _____ Acct. #: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Home Phone #(____)____-____ Daytime Phone#:(____)____-____ E-Mail: _____

Occupation: _____ Employer: _____ Employer's address: _____

Referred by: _____ Your primary care (medical physician) is: _____

Phone # (physician)(____)____-____ May we send a report to him/her about your examination and treatment? Yes No

Social Security #: _____ - _____ - _____ DOB: ___/___/___ Age: _____ Sex: Male Female

Hand Dominance: Right Left Ambidextrous

What is your complaint? _____

Is your complaint related to a car accident or work injury? Yes No If yes, date of injury? _____

PLEASE CHECK EITHER YES OR NO IN THE SPACES PROVIDED BELOW

Surgeries: None Yes – *Please list on blank spaces below with approximate year (if known)*

Surgery	Year Performed	Surgery	Year Performed
<i>Example: Gall bladder removed</i>	1992		

Previous Illness or Diseases (i.e. Cancer): None Yes *Please list with approximate year of diagnosis:*

Disease/Disorder	Year Diagnosed	Disease/Disorder	Year Diagnosed
<i>Example. Diabetes</i>	1992		

Past/Present Injuries: None Yes *Please describe with approximate date* (may include injury for which you are here today)

Injury	Approx. Date	Injury	Approx. Date
<i>Example: Car Accident</i>	1980		

List below any **FRACTURES**, along with the date/year of the injury: None Yes

INJURY	DATE	INJURY	DATE

Past Treatments for current condition: NONE Chiropractic Physical Therapy Medications
 Massage Trigger Point Injections Epidural Injections Surgery Herbal or homeopathic remedies

Current Medications: None Non-steroidal anti-inflammatory drugs Muscle relaxants Pain relievers
 Contraceptives **Other – Please List** _____

Vaccinations: Received no immunizations/vaccinations Received typical childhood immunizations Unknown

Family History of Health Problems: Please indicate Paternal (Father's side) or Maternal (Mother's side)

Family Member	Maternal or Paternal	Disease (and date or year of onset)	Deceased?
<i>Example: Grandpa</i>	<i>Maternal</i>	<i>Prostate Cancer-1983</i>	<i>Yes</i>

Exercise: None Frequent Infrequent Occasional Regular

Family Status: Married Single Divorced Widowed **Children - How many do you have?:** _____
 Are you currently expecting? (Check for yes)

Substance Usage: Alcohol: None Rare Social/light Moderate Heavy Recovered alcoholic

Tobacco: None Cigarettes ___ Packs per week Previous, but quit Cigar Pipe Chewing Tobacco

Work environment: Requires prolonged sitting Requires prolonged standing Computer work Typing

Constant standing Constant sitting Repetitive lifting Stressful Phone usage Headset for phone

Please check the box/boxes below if you have experienced any of the following:

QUESTION	YES	QUESTION	YES	QUESTION	YES
Open sore that does not heal		Headaches		Ringing in the ears	
Difficulty swallowing		Family history of stroke		Loss of consciousness or momentary black	
Nagging hoarseness		Pain wakes me from a deep sleep		Temporary loss of understanding	
Vertigo, dizziness or lightheadedness		Loss of bladder or bowel control		Problems with balance, gait or coordination	
Night Sweats		Loss of weight without trying		Sensation problems – i.e. numbness	
Coughing up blood or noticing it in your stools		Weakness or strength loss		Problems or changes in vision	

FINANCIAL POLICY

You are required to pay the uncovered percentage of your charge (20%, co-pays, etc.) including the deductible at each visit. If after 90 days, you have a balance at our clinic, and you have not made financial arrangements with our office, your account will be forwarded to a collection agency. You will be responsible for any legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collections. These charges will be added to your bill.

As an office that has a good record of running right on time, we ask that you try as hard as possible to be on time for your appointments. If you need to be late, please call ahead so arrangements can be made. However, if you are late there may be times when we have to turn you away in order to be courteous and on time for our other patients. Please understand that this is done in an effort to strive for excellence in our service to you.

We reserve the right to charge \$20.00 for missed appointments without any advanced notice. There is a \$10.00 charge that is added to your account for all checks that are returned for non-sufficient funds. If you require a copy of your x-rays, there is a \$10.00 per sheet fee. If you suspend or terminate your care at any time, your portion of all charges for professional services is immediately due and payable to this office.

I have been notified and understand that my insurance company will/may deny or reduce payment for the following possible reasons:

- The physician being seen today is not a participating provider in or is not contracted with my insurance company.
- A referral has not been issued to the office by my primary care physician (only required with HMO or sometimes POS plans)
- Services that are rendered are not a covered benefit or are determined to be "not medically necessary" under the terms of my insurance plan.
- Benefits were misquoted to our office
- These are *not* the only reasons for which payment may be denied, just the most common. Based on the above information, I agree to pay for all charges incurred in this office if my insurance company denies or reduces payment for any reason (Russeau Team HealthCare, Ltd. will follow the requirement in its contract(s) with each individual insurance carrier).

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge. I understand it is my responsibility to inform this office of any changes in my medical status. I also understand that no guarantee or assurance has been made as to the results that may be obtained.

Signature of Patient (parent/guardian if minor) _____ **Date** ___/___/___
Print Name _____ keyed Initials _____

Complete only if Applicable

CONSENT TO TREAT MINOR (18 and Under)

PATIENT NAME _____

I hereby request and authorize Dr. Kevin J. Russeau to perform diagnostic tests and render chiropractic adjustments and other treatment to _____. This authorization also extends to all other doctors and staff members and is intended to include radiographic examination at the doctor's discretion.

As of this date, I have the legal right to select and authorize health care services for the minor child named above.

(If applicable) Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

DATE

SIGNATURE

WITNESS SIGNATURE

PRINTED NAME

WITNESS PRINTED NAME

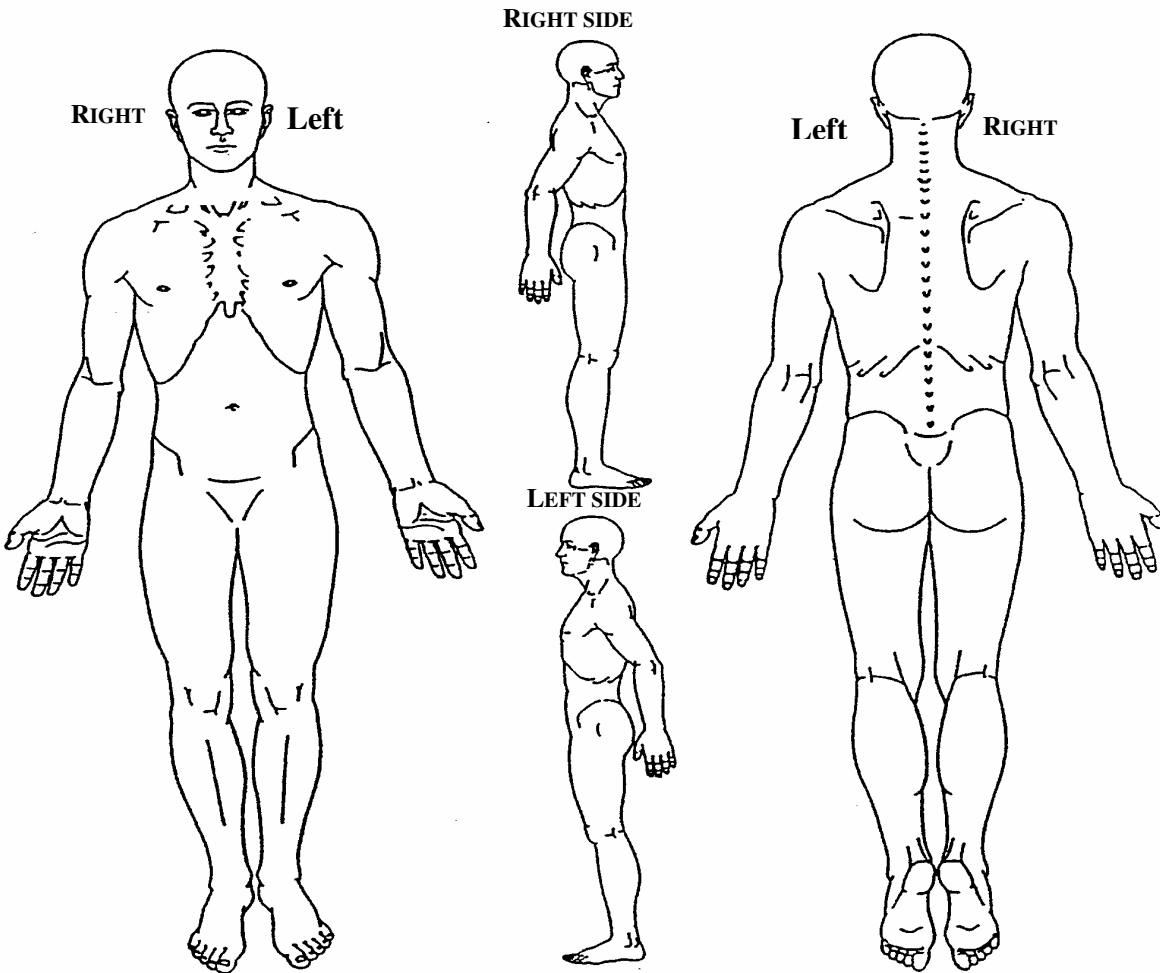
RELATIONSHIP TO PATIENT

Patient Name _____

Instructions: Use the symbols in the “key” below to indicate the type and location of the discomfort AS IT FEELS TODAY. Place the letters on the part of the body that you feel the discomfort.

KEY

A = ACHE	B = BURNING	C = STABBING
N = NUMBING	P = PINS & NEEDLES	O = OTHER
S = SORE	T = TIGHT	ST = STIFF



Patient Signature _____ Date _____

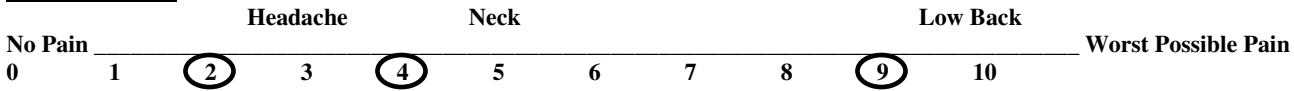
Patient _____

Name _____

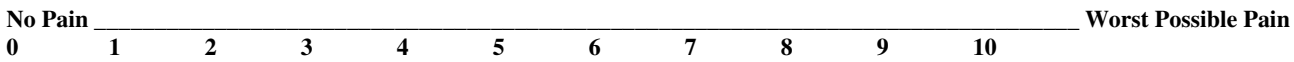
INSTRUCTIONS: Please circle the number that best describes the question being asked. Please indicate your pain level right now, average pain, and pain at its best and worst.

NOTE: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint.

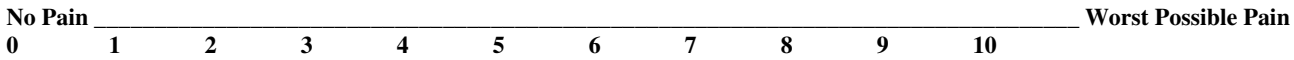
EXAMPLE:



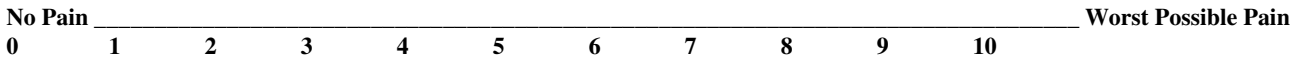
1 – What is your pain RIGHT NOW?



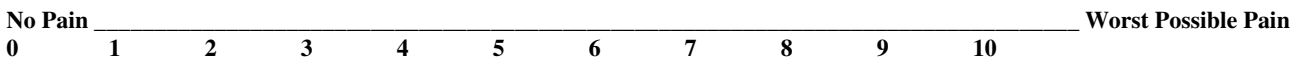
2 – What is your TYPICAL or AVERAGE pain?



3 – What is your pain level AT ITS BEST (How close to “0” does your pain get at its best)?



4 – What is your pain level AT ITS WORST (How close to “10” does your pain get at its worst)?



OTHER COMMENTS:

Patient signature _____

Date _____

Examiner Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.

PI History Form

Patient Name: _____

Date: _____

Date of Collision: ____/____/____

Following your collision was the vehicle: drivable towed totaled

What was the monetary damage to the vehicle you were in: \$ _____

Did the police come to the scene and make a report? Yes No

You were the: Driver Front passenger Rear Passenger

Describe the collision: _____

Brakes: on at time of impact off at time of impact

Estimated speed of your vehicle at the time of collision: _____ mph

Estimated speed of other vehicle at the time of the collision: _____ mph

Description of the vehicle you were in at the time of the collision:

Year, make, and model: _____

- | | | | |
|--------------------------------------|--|---|--|
| <input type="checkbox"/> Compact car | <input type="checkbox"/> Mid-sized car | <input type="checkbox"/> Full-sized car | <input type="checkbox"/> Pickup truck |
| <input type="checkbox"/> SUV | <input type="checkbox"/> Minivan | <input type="checkbox"/> Full sized van | <input type="checkbox"/> Larger than 1-ton vehicle |

Description of other vehicle:

Year, make and model: _____

- | | | | |
|--------------------------------------|--|---|--|
| <input type="checkbox"/> Compact car | <input type="checkbox"/> Mid-sized car | <input type="checkbox"/> Full-sized car | <input type="checkbox"/> Pickup truck |
| <input type="checkbox"/> SUV | <input type="checkbox"/> Minivan | <input type="checkbox"/> Full sized van | <input type="checkbox"/> Larger than 1-ton vehicle |

During and after the impact, your vehicle:

- | | |
|--|--|
| <input type="checkbox"/> Kept going straight, not hitting anything | <input type="checkbox"/> Spun around, not hitting anything |
| <input type="checkbox"/> Kept going straight, hitting car in front | <input type="checkbox"/> Spun around, hitting another car |
| <input type="checkbox"/> Was hit by another vehicle | <input type="checkbox"/> Spun around, hitting object (not car) |

Describe yourself during the impact:

- | | | |
|--------------------------|--------------------------|--|
| Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | Aware of the impending collision |
| <input type="checkbox"/> | <input type="checkbox"/> | Relaxed before the collision |
| <input type="checkbox"/> | <input type="checkbox"/> | Braced yourself |
| <input type="checkbox"/> | <input type="checkbox"/> | Body, torso, and head were facing straight ahead |
| <input type="checkbox"/> | <input type="checkbox"/> | Had your head and/or torso turned at the time of collision: <input type="checkbox"/> To the left <input type="checkbox"/> To the right |
| <input type="checkbox"/> | <input type="checkbox"/> | Intoxicated (alcohol) at the time of the crash |
| <input type="checkbox"/> | <input type="checkbox"/> | Wearing your seat belt. If yes, does your seat belt have a shoulder harness? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> | <input type="checkbox"/> | Were your hands on the steering wheel or dashboard during the impact? |
| <input type="checkbox"/> | <input type="checkbox"/> | Did your body slide under the seat belt? |
| <input type="checkbox"/> | <input type="checkbox"/> | At any time did you experience a loss of consciousness? If yes, for how long? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Did your body strike anything within the vehicle? If YES describe: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Did the air bag deploy? |
| <input type="checkbox"/> | <input type="checkbox"/> | Did you have glasses (prescription OR sun) on at time of impact? |

If yes, were they still on after impact? Yes No

Have you lost any time at work as a result of the collision?

If yes, were you off work, how many days have you missed: _____

Rear-end collision only:

Does your vehicle have the following:

- Movable headrests
- No headrests
- Fixed, non-moveable headrests

At the time of the impact, the headrest was in the following position:

- In the highest position
- In the middle position
- In the lowest position

Estimated distance between the back of your head & front of head restraint _____ inches

Pain and Medical care:

How soon after the collision did you begin to notice symptoms?

Immediately _____ Hours after collision _____ Days after collision

Emergency Department

Yes No

Did you go to the emergency department after the collision?

If yes, name of the ER: _____

Date and Time: _____

Did you go to the ER in an ambulance?

Did you or another person drive you to the ER?

Were you hospitalized overnight?

Did the ER doctor take x-rays?

Skull Lower back Other: _____

Neck Arm or leg

Did the ER doctor give you pain medication?

Did the ER doctor give you muscle relaxants?

Did you have any cuts or lacerations?

Did you require any stitches for cuts?

Were you given a neck collar or back brace to wear?

Have you sought medical care (other than in an Emergency Room) for complaints related to this collision?

Yes **No**

If yes, whom have you seen?

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

As required by the Federal Privacy Regulations, I hereby acknowledge that I have received a current copy of **Russeau Team HealthCare, Ltd.'s "NOTICE OF PRIVACY PRACTICES,"** revision date MAY 17, 2005.

I have read the Privacy Notice and understand my rights contained in the notice.

Patient's Name (print)

Patient's Signature

Date

(OFFICE USE ONLY)

Signed form received by: _____ Date: _____

Good faith effort to obtain receipt: (Describe) _____
