RUSSEAU | Team HealthCare Ltd.

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
Example: *Gall bladder removed*	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
Example. *Diabetes*	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
Example: *Car Accident*	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

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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?
Example: *Grandpa*	*Maternal*	*Prostate Cancer-1983*	*Yes*

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

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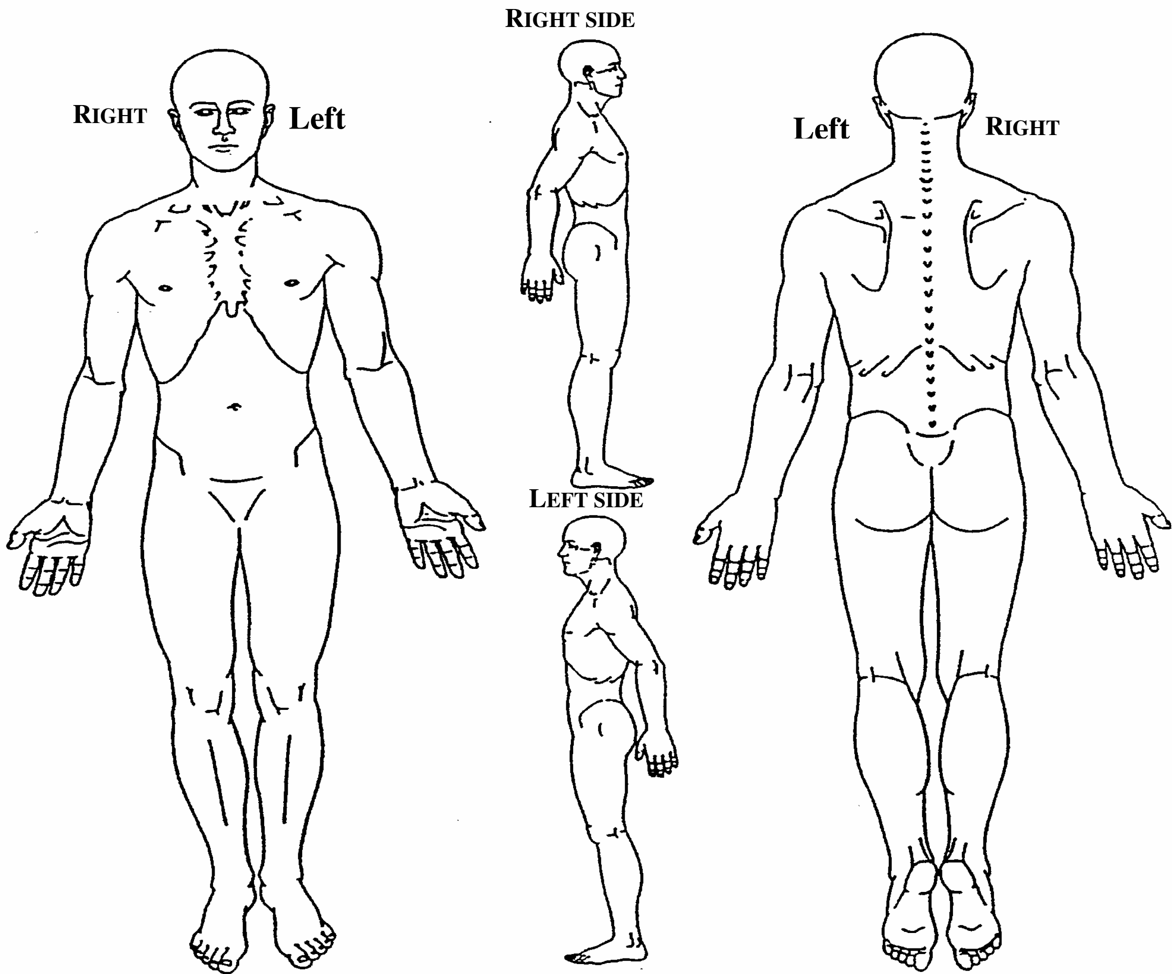
Patient Name ____

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____________

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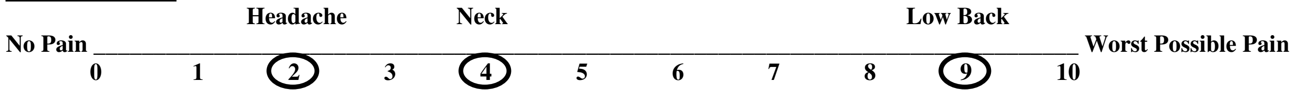
Patient Name

____

<u>INSTRUCTIONS:</u> 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.

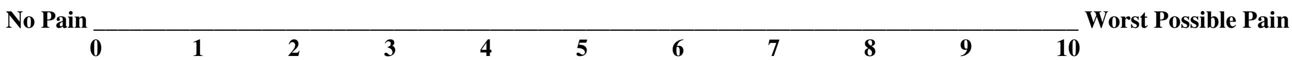
<u>NOTE</u>: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint.

<u>EXAMPLE:</u>

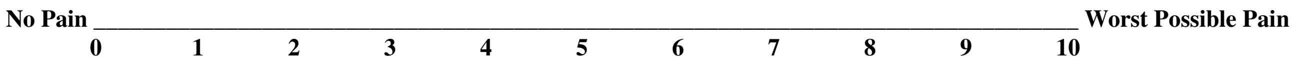


1 – What is your pain RIGHT NOW?

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**

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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)______________________________

____

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