Application for Knee Pain Treatment (Please Print Clearly)

Name:	Social Security#:	Date:
Date of Birth: Age:	Sex:	
Address:		
City:	State:	Zip Code:
Home Phone#:	Cell#:	
E-mail Address:		
Spouse's Name:	# of Children:	
Your Occupation:		Retired: Y N
Current or Previous Work: Clerical: Y N Light Labor: Y N Moderate Labor: Y N Heavy Labor: Y N		
In Case of Emergency Contact Name:	Phone Number:	
Primary Care Provider:	May we contact them Y N	

TELL US ABOUT YOUR PAST HEALTH:

PLEASE CHECK THE BOXES THAT APPLY

□	Lower Back Pain	□	Diabetes (A1C = _____)	□	High Cholesterol
□	Leg or Foot Pain/Numbness	□	Hand Problems	□	Shingles
□	Prior Spinal Surgeries	□	Neuropathy	□	Knee Surgery
□	Spinal Fractures	□	Heart Attack	□	Kidney Issues or Dialysis
□	Spinal Stenosis	□	Heart Problems	□	Gout
□	Spinal Arthritis	□	High or Low Blood Pressure	□	Hip Surgery
□	Sciatica	□	Vascular Leg Problems	□	Leg Fractures
□	Neck Pain	□	Vascular Surgery	□	Joint Replacement
□	Herniated Disc(s)	□	Stroke	□	Foot Surgery

1. What is your complaint?: □Right Knee □Left Knee □Both Knees

(If both knees: □*Right is worse than left* □*Left is worse than Right* □*Equally painful)*

2. Have you been Diagnosed with a Particular Condition (Such as Osteoarthritis)?: □Yes □No

If "Yes", what condition?:_____

3. When and How did the pain/symptoms begin? □Gradual Onset □Sudden Onset □Trauma.

_____

4. On a scale, how would you rate your symptoms? (10 is the worst) 1 2 3 4 5 6 7 8 9 10 (Circle).

5. Circle All That Describe Your Symptoms?

Stabbing-Sharp	Aching	Burning	Throbbing	Cramping	Stinging	Pins & Needles	Numbness
Cold	Dead Feeling	Tiredness	Electric Shocks	Swelling	Tingling	Locking	Unstable/Like Giving out
Stiffness after Rest	Stiffness w/Activity	Improves w/Movement	Feels like Falling	Other:			

6. How Frequent are the symptoms? □Constant (76 to 100% of the day) □Frequent (51 to 75% of the day)

□Occasional (26 to 50% of the day) □Infrequent (1 to 25% of the day) □No Symptoms (0% of the day)

7. What Makes the Symptoms Worse? □Going up stairs □Going down stairs □Prolonged Sitting □Prolonged Standing □Squatting □Lifting □Carrying Heavy Objects □Lying Down □Pushing □Pulling
□Other_____

8. What Makes the Symptoms Better? □Nothing □Rest □Exercise
□Other_____

9. Have you had any studies done of the area such as?: □EMG/Nerve Conduction Study □X-rays □CT Scan □MRIs
□Other Studies_____

If so Where and When were the studies done?: _____

_____

10.Have you had Physical Therapy? □Yes □No If you have, Where and When?:_____

_____

11. Have you had a prior consultation or seen anyone else for this condition?: □Orthopedics □Pain Management
□Neurosurgery □Physical Medicine & Rehabilitation □Neurologist □Rheumatologist □Primary Care
□Other_____

12. Please List All Other Treatments You Have Had for this Condition and if it was Helpful or Not?:

□Medications/Supplements:_____

□Bracing:_____

□Injections:_____

□Surgeries:_____

□Chiropractic:_____

□Regenerative:_____

□Alternative/Other Treatments:_____

13. Do you exercise regularly?: □Yes □No. If "yes", what type of exercise?:_____

14. Please List All your Medical Conditions?: _____

_____

_____

15. Please List All Surgeries you have had?: _____

_____

16. Please List any Medications and/or Vitamins you are currently taking, or attach medication list?:

17. Please List Any Allergies you have:_____

18. Do you also have any of the following issues (Circle all that apply to you):

Fatigue	Vomiting	Shortness of Breath	Muscle Weakness	Rashes	Nervousness/Anxiety
Fever/Chills	Constipation	Chest Pains	Headaches	Joint Swelling	Depression
Nausea	Diarrhea	Edema	Vision Problems	Excessive Thirst	Sleep Issues
Swallowing Issues	Abdominal Pain	Incontinence of Urine/Stool	Easy bleeding/bruising	Burning or Tingling	Unexpected Weight Changes

19. Which if the following is true for your condition: (check one of the following):

□It's getting better on its own □It's staying the same □It's getting worse as time goes

20. Circle any activities (you used to be able to do when you were feeling better) that are now limited:

Housework	Preparing Meals	Socializing	Driving	Other:
Yardwork	Bathing	Sleeping	Dressing	
Shopping	Exercising	Hobbies	Working	

21. Have you failed conservative treatments for more than 90 days (3 months)?: □Yes □No

22. Would you like to avoid more prescription medicines?: □Yes □No

23. Would you like to avoid possible surgery and have treatments to avoid surgery?: □Yes □No

24. List the three other main "health goals" that you would like to accomplish:

1.
2.
3.

Walking Scale Questionnaire

These questions ask about limitations to your walking due to knee pain during the past 2 weeks. For each statement please circle the one number that best describes your degree of limitation. Please check you have circled one number for each question.

In the last 2 weeks, how much has your knee pain…	Not at all	A little	Moderately	Quite a bit	Extremely
Limited your ability to walk?	1	2	3	4	5
Limited your ability to run?	1	2	3	4	5
Limited your ability to climb up or down stairs?	1	2	3	4	5
Limited your ability to perform tasks while standing?	1	2	3	4	5
Limited your balance while standing or walking?	1	2	3	4	5
Limited how far you are able to walk?	1	2	3	4	5
Increased the effort you needed to walk?	1	2	3	4	5
Made it necessary for you to use support while walking indoors (e.g. holding onto furniture, using a cane, etc.)?	1	2	3	4	5
Made it necessary for you to use support while walking outdoors (e.g. using a cane or walker, etc.)?	1	2	3	4	5
Slowed down your walking?	1	2	3	4	5
Affected how smoothly you walk?	1	2	3	4	5
Made you concentrate on your walking?	1	2	3	4	5

Walking Scale Disability Score: <12=Normal, 13-27=Mild, 28-45=Moderate, >63=Severe Disability

How did you hear about us? _____

Authorization for use or disclosure of protected health information

I hereby authorize release of any medical information necessary to evaluate my case or process any future claims.

A. I authorize payment of any medical benefits from third parties for any future charges submitted to be paid directly to this office.

We invite you to discuss with us any questions regarding our services and or fees. The best health services are based on a friendly, mutual understanding between the provider and patient. 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 or insurance status.

Informed Consent to Care

A patient coming to the doctor gives him/her permission and authority to care for them in accordance with appropriate test, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare case, underlying physical defects, deformities or pathologies may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the physician. This office does not perform breast, pelvic, prostate, rectal, or full skin evaluations. These examinations should be performed by your family physician, GYN, and dermatologist to exclude cancers, abnormal skin lesions that should undergo biopsy/removal or other treatments. This clinic does not provide care for any condition (such as high blood pressure, diabetes, high cholesterol) other than those addressed in your physical medicine care plan.

We also do not prescribe or refill ANY controlled substances. All such prescriptions should be refilled by your original prescriber. The patient assumes all responsibility/liability if the patient does not report on health forms any past medical history, illnesses, medicines, or allergies. I agree to settle any claim or dispute I may against or with any of these persons or entities, whether related to the prescribed care or otherwise, will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

REGARDING: X-rays/Imaging Studies

FEMALES ONLY please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.

□ The first day of my last menstrual cycle was on _____-_____-_____

□ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

I have read, understand, and agree to all the above consents.

Print First/Last Name:_____

Signature:_____ Date:_____

Office Staff Signature_____ Date:_____

NOTICE OF OFFICE POLICIES

As a potential new patient, we feel it is important that you understand our office policies regarding, how patients of this practice are cared for, and the various methods we offer to facilitate payment for that care. Please read each policy carefully so there is no misunderstanding as to what you can expect as a patient of this practice, and what we expect in return. Once you have read "Our Office Policies", if you have any questions or any of these policies are unclear to you, and you would like further explanation before submitting your ***Application for Care*****,** please let our front desk know and a member of our staff will be happy to discuss them with you further. We believe it is in everyone's best interests to provide potential new patients as much information as possible about how the doctors at this office practice chiropractic and other health care services so that an informed decision can be made as to whether they wish to become a patient.

Over time, individuals who are accepted, as patients at this office, gain a greater understanding as to the purpose of their condition. Since most of the patient care occurs in an open bay area, patients have a unique opportunity to observe firsthand the positive results that are achieved, and the benefits derived from being under chiropractic care, or any services we may offer. This knowledge and awareness reaps a positive environment that promotes healing and encourages families to maintain good health. We want your experience with us to be an exceptional one, so help us to help you and together we can make affirmative changes in your life and the lives of those you care about.

- **PATIENT PRIVACY –** Since most of the patient care takes place in an open bay area it is important to understand that any conversations you have with the doctor can be overheard by other patients. To maintain patient privacy, it is the policy of this practice to refrain from discussing any confidential matters with patients during treating hours while patients are being adjusted. If you have a confidential matter you wish to discuss, please let us know and we will schedule time for you to speak to the doctor in a private consultation room. These consultations must be scheduled in advance.
- **YOUR CARE** - When a patient seeks chiropractic health care and we agree to provide that care, it is essential for the patient and the doctor to be working toward the same objective. Chiropractic care at Advanced Health Solutions is rendered primarily to minimize and reduce subluxations, which are a major interference to the expression of the body's innate wisdom. The doctors use Clear institute, Pettibon and other techniques to accomplish this goal. It is important that you understand both the objective and the method(s) so there is no confusion or disappointment. Tremendous progress has been made in the rehabilitating and correction of spinal problems. Your doctor will outline a course of treatment that will take you beyond simple pain relief, through two distinct phases of care to make a structural correction to your spine that will enable your central nervous system to function optimally, thereby improving you overall health. Other therapies, but not limited to, Neurofeedback, PEMF, Decompression, Trigenics, Oxygen Therapy and Nutrition may be used with the intent of enhancing results through the intended and appropriate use of that particular therapy which will be discussed and agreed upon by you before use.
- **FIRST THINGS FIRST**- Prior to receiving care at this office, a health history and examination will be completed. Imaging studies as well as any other necessary diagnostics may also be ordered, to confirm the true nature of your condition and exact location of subluxations and relevant treatment sites. The results of these procedures will aid in assessing your presenting problem, your overall health, and the condition of your presenting problem. They will also assist the doctor in determining the type and amount of care you will need. All relevant findings will be reported to you along with care plan recommendations so that you can make the best possible decision. Our gold standard for care is to ensure the reduction of spinal subluxations and presenting symptoms while teaching patients what they need to do to maintain their health for a lifetime.
- **PATIENT'S REPORT OF FINDINGS** – To enhance your understanding of the chiropractic and other conditions treated and related services that will be used to manage your health, shortly following your first visit, you will be scheduled for a 'Doctors Report of Findings'. The information you receive at this appointment will be both informative and clinically relevant to your case, therefore attendance is required for individuals who wish to become new patients of this practice. Because the results of your x-rays and all examinations as well as the doctors' recommendations for care, will be discussed at that time, we strongly urge new patients to invite their spouse or significant other to attend. We know from experience that when a patient's family understands the goals and objectives of care and how restoring and maintaining good health can affect their lives as well, they become infinitely supportive and helpful in making important decisions concerning treatment options.

Note: Patient retains the Notice of Office Policies and Advanced Health Solutions *retains the signature sheet*.

Patient/Guardian initials: _____-retaining pages 1 of 2

I hereby authorize payment to be made directly to Advanced Health Solutions, for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Advanced Health Solutions for any and all services I receive at this office.

"I/We agree that if our balance becomes delinquent, defined as 90 days past due, and is referred to a collection agency or attorney, we shall be responsible for collection fees equal to 33 1/3% of the balance due in addition to the balance. We further understand and agree that if legal action is taken to collect the balance, we shall also be responsible for all court costs. We hereby waive our rights under the laws and constitution of Alabama, or any other state, to exempt our real or personal property from execution.

_____(initial)

In the event my account becomes more than 60 days past due, I authorize Advanced Health Solutions, and any of its officers, agents, or employees to request a credit report on me. I also understand any past due balances may be reported to one or all the national credit bureaus. I also authorize Advanced Health Solutions, and any of its officers, agents or employees to contact me by phone, cell phone, "Text Message", E-mail or any other universally used modes of communications to confirm appointments, send newsletters, provide essential treatment information, or secure payment of outstanding past due balances. _____(initial)

I hereby acknowledge receiving a copy of the practices 'Office Policies' a two-page document, the first page of which I have read and retained. This second page is recognized by me as the signature page and will be retained by the practice as evidence of my receiving and understanding this 'Notice'. I further acknowledge that any concerns regarding these 'Policies 'as well as all my questions have been answered by a qualified member of the staff to my complete satisfaction.

_____ _____ _____

Print Patient's Name DOB VRC#(Office Use Only)

_____ _____

Patient/Guardian Signature Date

_____ _____

Office Staff Signature Date

NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your **P**ersonal **H**ealth **I**nformation. In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as **dictated by our office policy,** we are permitted to disclose information about you to a third party without your authorization. Below is a summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have several copies in report folders labeled **'HIPAA'** available, please check with the front desk. Once you have read this notice, please sign the last page, and return only the signature page (page 2) to our front desk receptionist. Keep this page for your records.

PERMITTED DISCLOSURES:

1. Treatment purposes - discussion with other health care providers involved in your care
2. Inadvertent disclosures - open treating area means open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes- to process a claim or aid in investigation
5. Emergency - in the event of a medical emergency we may notify a family member
6. For Public health and safety - to prevent or lessen a serious or eminent threat to the health or safety of a person or public.
7. To Government agencies or Law enforcement – to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner, and government benefits purposes.
9. Deceased persons – discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls, text messages, or emails and appointment reminders - **we may call your home and leave messages** regarding a missed appointment or apprize you of changes in practice hours or upcoming events or office messages.
11. Change of ownership - in the event this practice is sold, the new owners would have access to your PHI.

YOUR RIGHTS:

To receive an accounting of disclosures

1. To receive a paper copy of the comprehensive "Detail" Privacy Notice
2. To request mailings to an address different than residence
3. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
4. To inspect your records and receive one copy of your records at no charge, with notice in advance
5. To request amendments to information. However, like restrictions, we are not required to agree to them.
6. To obtain **one copy** of your records at no charge, when timely notice is provided (72 hours). **X-rays** are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call (251) 928-5058. You may make an appointment with our receptionist to speak with an office representative within 72 hours or 3 working days. If you are still not satisfied with the way this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Ave. SW
Room 509F HHH Building
Washington DC 20201

JDD,DC 6/2020

*Patient/Guardian initials: _____**-retaining page 1 of 2***

ADVANCED HEALTH SOLUTIONS NOTICE REGARDING YOUR RIGHT TO PRIVACY continued….

I have received a copy of Advanced Health Solutions' Patient Privacy Notice. I understand my rights as well as the practices duty to protect my health information and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this 'Notice of Privacy Practice" at any time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me and several copies are available at the front desk. At this time, I do not have any questions regarding my rights or any of the information I have received.

_____ _____ _____

Print Patient's Name DOB VRC#(Office Use Only)

_____ _____

Patient/Guardian Signature Date

_____ _____

Office Staff Signature Date