WELCOME

To Advanced Spine & Sports Medicine

About You			Today's Date:
Last Name:	First Name:		MI:
Age:	Date of Birth:	Gender: M / F	SSN:
Married? ☐ YES ☐ NO	Spouse's name:	Do you have children? ☐ YES ☐ NO	
Home Address:	Email Address:	Home Phone:	Cell Phone:
Employer Name & Address:	Employer Phone:	Occupation:	

Reason For Visit					
The reason for this visit is a result of:	Work	Sports	Auto	Trauma	Chronic
Please Explain:					
Please describe pain & its location:					
Date condition began?	Is your condition: ☐ Getting sores ☐ Comes & Goes ☐ Constant				
How would you describe the type of pain : ☐ Sharp ☐ Dull ☐ Achy ☐ Burning ☐ Shooting ☐ Stiff ☐ Numb ☐ Tingly ☐ Other:					
Is your condition interfering with:	Sleeping	Work	Daily Routine		
Have you had this or similar conditions in the past? ☐ YES ☐ NO If yes, please explain:					
Have you been treated by a Medical Physician for this condition? ☐ YES ☐ NO If yes, where:					
Have you treated with a Chiropractor before? ☐ YES ☐ NO					

Responsible for Account					
Please circle the proper box below to indicate how you would like us to file your bills:					
Personal Insurance	Attorney	Third Party (party at fault)	PIP (personal car insurance)	Work Comp	I am a cash
Name & Contact Info:	Name & Contact Info:	Name & Contact Info:	Name & Contact Info:	Name & Contact Info:	

In Event of Emergency		How did you hear about us
Whom should we contact? Relation:		Friend? Name:
Home Phone:	Cell Phone:	Attorney? Name:
Who is your Medical Doctor?	Phone:	Online? Site Name:

Health History

Please list ALL medications you are currently taking (Prescriptions & Over-The-Counter):

NAME	HOW OFTEN DO YOU TAKE?	CLINICAL REASON

Please ✓ if you have ever had any of the following:

	GENERAL				BONE / JOINT		
	Cancer		Night Sweats		Back Pain		Fractures
	Hepatitis		Unexplained Weight Loss		Gout		Rheumatoid Arthritis
	Diabetes		Fatigue		Joint Pain		Osteoarthritis
	Thyroid Disease		Anxiety / Panic Attacks		Muscle Cramps		Osteoporosis
	Recent Fever		Depression				
	EYES/EARS/HEAD		**ABDOMEN**		**URINARY TRACT**		**BREAST**
	Migraine Headaches		Peptic Ulcers		Kidney Failure		Mastectomy
	Glaucoma		Heartburn		Kidney Stones		Lump
	Cataracts		Hernia		Recent Infections		Biopsy
	Blindness		GERD		Recurrent Bladder Infections		Fibrocystic Disease
	Wear Contact Lenses		Frequent Nausea		Recurrent Kidney Infections		
	Partial plate/dentures		Frequent Vomiting		Dialysis		
	HEART		**LUNGS**		**NEUROLOGICAL**		
	Heart Attack		Shortness of breath		History of dizziness		Paralysis
	Chest Pain / Angina		Asthma		Alzheimer's		Numbness / Tingling
	Heart Failure		Recurrent Bronchitis		Head Injury		Weakness in arms/legs
	Heart Murmur		Emphysema		Memory Loss		Seizure
	Palpitations		Pulmonary Embolism		Blackout Spells		Epilepsy
	Pacemaker		Tuberculosis		Stroke		
	High Blood Pressure		Pneumonia				
	Other:						

List Allergies:

List previous surgeries / treatment with dates:

List any past serious accidents with dates:

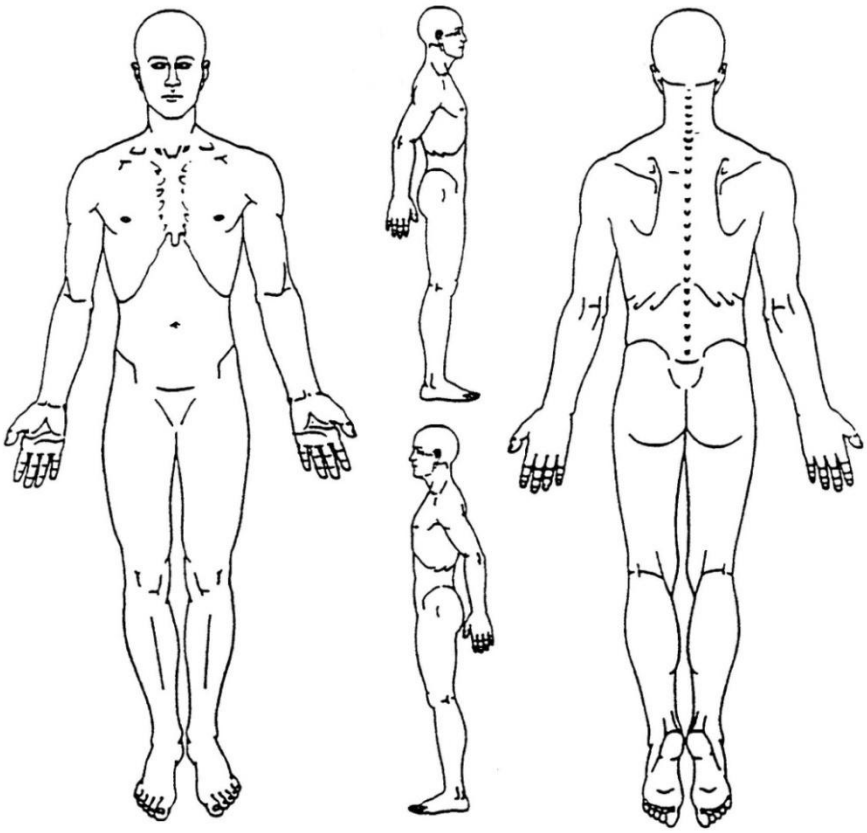
Lifestyle Questions:

Do you exercise	☐ Never ☐ Rare ☐ Occasional ☐ Weekly ☐ Several times per week ☐ Daily Type of Exercise:
How much are you on your feet	☐ 10% ☐ 25% ☐ 50% ☐ 75% ☐ 100%
Use of Alcohol	☐ Rare ☐ Occasional ☐ Moderate ☐ Daily ☐ Never ☐ No longer
Use of Tobacco	☐ Yes, _____Packs/day ☐ Quit /How long ago_____ ☐ Never
Do you use Recreation drugs	☐ Never ☐ Rare ☐ Occasional ☐ Moderate ☐ Daily ☐ Quit/How long ago _____ Type:
For Women:	
Taking birth control	☐ YES ☐ NO
Are you pregnant	If yes, how far along?
Nursing	☐ YES ☐ NO

Advanced Spine & Sports Medicine

On the drawings below, please indicate where you are experiencing pain by drawing in the letter abbreviation(s) that most accurately reflects the type of discomfort that you have been experiencing.

N	T	A	P	B	S
Numbness	Tingling	Dull Ache	Sharp Pain	Burning	Stiffness



Please Estimate Your Plain Level

(Circle the number accordingly)

Ex: Low Back	0 = No Pain	0 1 2 3 ④ 5 6 7 8 9 10	10 = Intolerable
Body area: _____	0 = No Pain	0 1 2 3 4 5 6 7 8 9 10	10 = Intolerable
Body area: _____	0 = No Pain	0 1 2 3 4 5 6 7 8 9 10	10 = Intolerable
Body area: _____	0 = No Pain	0 1 2 3 4 5 6 7 8 9 10	10 = Intolerable
Body area: _____	0 = No Pain	0 1 2 3 4 5 6 7 8 9 10	10 = Intolerable

Name: _____ **Date:** _____

ADVANCED SPINE & SPORTS MEDICINE

4801 Spring Valley road ▪ Dallas, Texas 75244 ▪972-488-9686

Name: **Today's Date:**

Patient Acknowledgement Form

ALL PATIENTS	
Initial: _____	I understand all out-of-pocket fees are due at time of visit
Initial: _____	A 24 hour cancelation notice is required. You will be charged a 50% fee if you fail to provide a 24 hour notice
Initial: _____	MASSAGE SERVICES: Once your massage is scheduled a timed-slot is blocked for you. If you should arrive late this will shorten your massage time. However, you will still owe for the time blocked as you requested when the appointment was scheduled.

INSURANCE PATIENTS ONLY	
Initial: _____	Advanced Spine & Sports Medicine allows 60 days for your insurance to pay on filed claims
Initial: _____	Advanced Spine & Sports Medicine will dispute Insurance denials up to 3 times. If a denial is not resolved after the third attempt, the claim becomes the patient's responsibility and payment arrangements must be made.
Initial: _____	The patient is responsible for understanding all insurance information pertaining to his/her benefits, including coverage, co-pays, max visits allowed, and non-covered services. In the event that you treat outside your allowed benefits you will be responsible for the charges
Initial: _____	In the event that a Doctor-recommended service, necessary service, or a patient-requested service is not covered by your insurance, an additional out-of-pocket cost will be required

Signature: _____ Date: _____

Advanced Spine & Sports Medicine
Dr. Jason Jodoin D.C.

The Nature of Chiropractic Treatment offered at Advanced Spine & Sports Medicine

Chiropractic treatment consist of evaluation, diagnosing and treating the conditions warranted through the means of using hands, mechanical instruments, various modalities as well as the use and instruction of exercise and/or stretching. When manipulations are performed, you may feel joint movement and you may hear joints "click" or other sounds. Some patients will feel some soreness and/or stiffness following the first few days after treatment. These are normal and not a cause for concern.

Informed Consent for Chiropractic

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 above, for whom I am legally responsible) by the doctor of chiropractic named above and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed and that each individual responds differently to the treatment.

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. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

Relative Contraindications: Adds significant risk of injury to the patient but does not rule out the use of dynamic trust. These conditions include: articular hypermobility, severe bone demineralization, benign bone tumors, bleeding disorders, anticoagulant therapy, progressive radiculopathy (meaning weakness, muscle loss, bowel/bladder symptoms).

Absolute Contraindications: Manipulation (including low force techniques) is absolutely contraindicated when the following are present: acute arthropathy, acute/unstable fractures, unstable dens, malignancy of the spine/involved region, infections of the spine, myelopathy, VBS in the cervical spine, arterial aneurysm in the area.

I understand and acknowledge that untreated conditions warranted for chiropractic care allows for adhesions, scar tissue, and other degenerative changes to occur. These changes can further reduce skeletal mobility and can cause chronic pain cycles. In addition, it is quite probable that the delaying or not following the recommendations of the doctor will complicate the condition and make future rehabilitation more difficult.

I have read, or have had read to me the above consent. I have also had an opportunity to ask questions about its consent, 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's Signature _____ Date _____

Print Name: _____

ADVANCED SPINE & SPORTS MEDICINE

4801 Spring Valley road ▪ Dallas, Texas 75244 ▪972-488-9686

Acknowledgment of receipt of Notice of Privacy Practice

Pf-2000

Advanced Spine & Sports Medicine* reserves the right to modify the privacy practices outlined in the notice.

Signature

I have received a copy of the notices of Privacy Practices for Advanced Spine & Sports Medicine*.

Patient's Name (print): _____

Patient's Signature: _____ Date: _____

Representative of patient Signature: _____

(Required if the patient is a minor or an adult who is unable to sign this form)

Documentation of Attempts to Obtain Acknowledgement of Receipt of Notice of Privacy Practice

PF - 2100

Attempt to Obtain Acknowledgement

An attempt was made to obtain an acknowledgment of receipt of the Notice Privacy Practices on _____. The acknowledgement was not obtained because:

	The Patient was undergoing emergency treatment
	The patient declined to sign the acknowledgment
	Other:

Name of patient (print): _____

Name of Staff Member: _____ Date: _____