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:

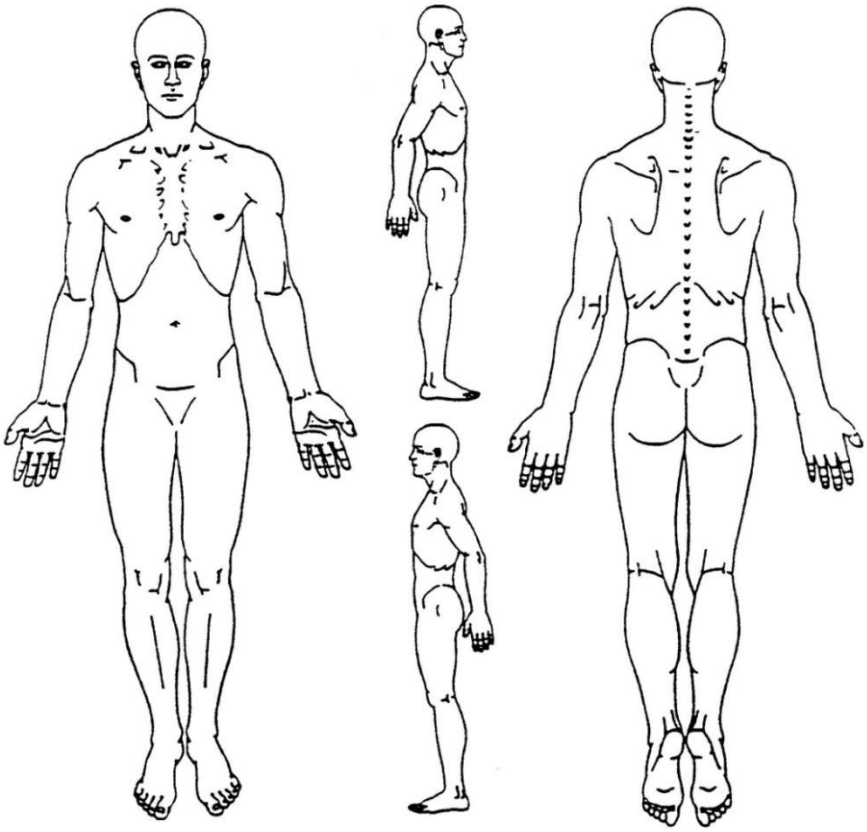
For Women:

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

Work Comp Questionnaire **Today's Date: _____**

Patient Information	
Last Name:	**First Name:**
Date of Accident:	

Employment Information (at time of accident)**:**		
Employer Name:		
Address:		
Phone:	**Fax:**	
Contact Person:	**Phone:**	**Email:**
How long have you worked for this employer? (prior to accident):	**Type of work performed at time of accident:**	
Have you reported your injury to your employer? Yes or No	**If yes, has your employer filed your claim? Yes / No / Not sure**	
Have you returned to work since your accident? Yes or No (If yes, please answer the next 2 questions):		
How long were you off work for your injury?		
Your current employment status: ( ) light duty ( ) regular duty ( ) full-time ( ) part-time		

Job Description:				
On the job I perform the following activities:				
	NEVER	**OCCASIONALLY**	**FREQUENTLY**	**CONTINUOUSLY**
Sit				
Stand				
Walk				
Bend / Stoop				
Squat / Kneen				
Crawl				
Climb				
Reach above shoulder level				
Balancing				
Pushing / Pulling				
On the job I lift:				
	NEVER	**OCCASIONALLY**	**FREQUENTLY**	**CONTINUOUSLY**
Up to 10 pounds				
Up to 25 pounds				
Up to 50 pounds				
Up to 75 pounds				
Up to 100 pounds				
Do you have to bend over while doing any lifting? Yes or No				
Is any repetitive motion required? If yes, please describe:				

Insurance Information:

Name of Work Comp Carrier:
Address:
Phone: **Fax:**
Adjuster Name:
Adjuster's Phone: **Fax:** **Email:**
Claim Number:
Has your claim been accepted as compensable? Yes / No / No sure **If yes, what is the compensable injury?**
Do you have an Attorney? Yes or No If yes, please provide name and phone number:

Injury Information:

In your own words describe the accident:
Have you been treated by another doctor for this accident? Yes or No **(if yes, please answer the next 4 questions):**
Doctors Name & Contact:
What type of treatment did you receive:
How long were treated by this Doctor?
Are you: ( ) Improved ( ) Unchanged ( ) Getting worse
Are you taking any medications for your injury? Yes or No (if yes please answer the next 2 questions):
List Medications:
Are the medications helping your condition:
Have you had Physical Therapy? Yes or No (if yes please answer the next 2 questions):
How often are you receiving physical therapy? ___ (#) Of times per week or ___ (#) Of times per month
Is the physical therapy helping?

Injury / Accident History

Prior to this accident, have you ever had any of the physical complaints similar to what you have now? **If yes, please describe:**
Were these similar complaints the result of a previous accident? If yes, please provide accident details:
Have you had any other serious accidents which required medical care? If yes, please describe:
Have you had any surgeries due to prior accidents? Yes or No If yes, list type and date:

Signature: _____ Date: _____

ADVANCED SPINE & SPORTS MEDICINE
4801 Spring Valley road ▪ Dallas, Texas 75244 ▪972-488-9686

Name: **Today's Date:**

WORK COMP **Patient Acknowledgement Form**	
Initial: _____	I am declaring my for treatment by Advanced Spine & Sports Medicine is due to an on-the-job injury that was properly report to my employer per the Texas Department Of Insurance Division Of Workers' Compensation (TDIDWC) guidelines.
Initial: _____	I understand that once my injury is found to be compensable by the commission, Advanced Spine & Sports Medicine will provide treatment as allowed by TDIDWC and will file charges for that treatment with the appropriate workers' compensation carrier.
Initial: _____	Should I choose to see additional treatment beyond TDIDWC guidelines, I am financially liable for the treatment.
Initial: _____	I understand that if at any time Advanced Spine & Sports Medicine is advised by TDIDWC or my employer that my injury status has changed to non-compensable, I become completely responsible for all charges including those already incurred.

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 <u>Attempts</u> to Obtain Acknowledgement of Receipt of Notice of Privacy Practice

PF - 2100

<u>Attempt to Obtain Acknowledgement</u>

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: _____