Appointment Date and Time: ____

Consultation Terms

1. I understand that this consultation is used to determine whether or not I am a candidate for care.
2. I understand that the consultation process does not establish me as a patient under the Doctors' care and there is no doctor-patient relationship or obligation.
3. I am aware that after the consultation, I may not be accepted as a patient.
4. I understand that the Doctors' are not able to and do not accept every case. The Doctors' schedule is extremely busy and they strictly limit the number of new patients they accept so as to ensure a high quality of care.
5. Please fill out all paperwork completely to the best of your knowledge. **Do not leave <u>anything</u> blank.** If paperwork is not filled out completely our staff may refuse to do the consultation.

____ _____________________________

Primary Physician Phone Number

I have read, understood and accepted the terms of the complimentary consultation.

____

Print

____

Signature Date

Pivotal Health Physical Medicine
12479 South Access Road • Suite 1 • Port Charlotte, FL 33981
(941) 697-3001
www.pivotalhealth4you.com

Welcome

Patient Information

PIVOTAL HEALTH
PHYSICAL MEDICINE

Date ___________________________

Name: ______________________________ ___________________________________ ____________________
Last First Middle Initial

Email address: ____

Mailing Address: ________________________________ City: _____________________ State: _____ Zip: _________

Phone #: (H) ________________________ (C) __________________________ (W) _______________________

Can We Call You? ☐ Yes or ☐ No Date Of Birth: ____________________________

Sex: ☐ Male ☐ Female SS#: ____________________________________

Marital Status: ________________________________

Occupation: _______________________________________ Employer: ______________________________________

Employer Address: ____ Phone #: _________________________

How did you hear about our practice? ____

Emergency Contact: Name: __________________________ Relation: ____________________ Phone: _____________

Phone #: (H) ___________________________ (C) ________________________ (W) _______________________

Are you a permanent resident of FL? ☐ Yes ☐ No If no, estimated departure date: __________________________

Alternate contact address (Full Address): ____

Accident Information

Is this visit due to an accident? ☐ Yes ☐ No If yes, what type? ☐ Auto ☐ Work ☐ Other

Has it been reported? ☐ Yes ☐ No If yes, to whom? ________________________________

Insurance Information

Policy Holder Name: ____ D.O.B: ___________________________

Relationship to patient (if other than self): ___________________________ Phone #: _________________________

Do you have health insurance? ☐ Yes ☐ No Name of Carrier: _______________________________________

Do you have secondary insurance? ☐ Yes ☐ No Name of Carrier: ________________________________

State that your Medicare originated from: ____________________________

PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR INSURANCE CARD(S)

Assignment and Release (insured patients)

I certify that I (or my dependent) have insurance coverage with ___________________ and I AUTHORIZE, REQUEST and ASSIGN MY INSURANCE COMPANY TO PAY DIRECLTY TO THE PHYSICIAN/MEDICAL PRACTICE, INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I understand that I am financially responsible for all charges whether or not paid by insurance. I herby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

Signature: ____ Date: _____________________________

Health History

PIVOTAL HEALTH
PHYSICAL MEDICINE

Patient Name: ____________________

Date: ____________________

Who is your primary care physician? (doctor and/or practice) ____

Please check to indicate if you are currently experiencing and of the following conditions:

☐ Neck Pain/Stiffness	☐ Pins/Needles in Arms	☐ Light Bothers Eyes	☐ Sudden Weight Loss
☐ Back Pain/Stiffness	☐ Nausea	☐ Pins/Needles in Legs	☐ Depression
☐ Cold Feet	☐ Arm/Hand Pain	☐ Fatigue	☐ Nervousness
☐ Loss of Memory	☐ Chest Pain	☐ Leg/Knee Pain	☐ Sleeping Difficulties
☐ Tension	☐ Jaw Problems	☐ Fever	☐ Headaches
☐ Loss of Smell	☐ Cold Sweats	☐ Constipation	☐ Fainting
☐ Dizziness	☐ Allergies	☐ Stomach Problems	☐ Shortness of Breath
☐ Asthma	☐ Blurred Vision	☐ Night Pain	☐ Bowel Bladder Changes

Please check to indicate if you have ever had any of the following:

☐ Aids/HIV	☐ Cancer	☐ Hepatitis	☐ Osteoporosis
☐ Stroke	☐ Alcoholism	☐ Cataracts	☐ Hernia
☐ Pacemaker	☐ Suicide Attempt	☐ Allergy Shots	☐ Chemical Dependency
☐ Herniated Disc	☐ Parkinson's Disease	☐ Thyroid Problems	☐ Anemia
☐ Chicken Pox	☐ Herpes	☐ Pinched Nerve	☐ Tonsillitis
☐ Anorexia	☐ Diabetes	☐ High Cholesterol	☐ Pneumonia
☐ Tuberculosis	☐ Appendicitis	☐ Emphysema	☐ Kidney Disease
☐ Polio	☐ Tumors/Growths	☐ Arthritis	☐ Epilepsy
☐ Liver Disease	☐ Prostate Problems	☐ Typhoid Fever	☐ Asthma
☐ Fractures	☐ Measles	☐ Prosthesis	☐ Ulcers
☐ Bleeding Disorders	☐ Glaucoma	☐ Migraines	☐ Psychiatric Care
☐ Vaginal Infections	☐ Breast Lump	☐ Goiter	☐ Miscarriage
☐ Rheumatoid Arthritis	☐ Venereal Disease	☐ Bronchitis	☐ Gonorrhea
☐ Mononucleosis	☐ Rheumatic Fever	☐ Whooping Cough	☐ Bulimia
☐ Gout	☐ Multiple Sclerosis	☐ Scarlet Fever	☐ Heart Disease
☐ Mumps	☐ High Blood Pressure	☐ Other ____________________	

Height: ________________ Weight: ________________

Are you currently under drug and/or medical care? ☐ Yes ☐ No If yes, Explain ________________________________

Please list any medications you are currently taking: ____

Please list any surgeries and/or hospitalizations you have had (type & date): ________________________________

Please list any allergies: ____

Please List any supplements you are currently taking (vitamins/herbs/minerals):________________________________

____

Is there a family history of any of the following conditions? (Indicate family member including parents, grandparents & siblings)

Heart Disease: ______________________ Diabetes: ______________________ Arthritis: ____________________

Cancer: ______________________ Other: ____

Do you exercise: ☐ Frequently ☐ Moderately ☐ Occasionally ☐ None

What do your work activities mostly involve: ____

What is your daily/weekly intake of the following: ____

Caffeine ________ cups/day Alcohol ____________ drinks/week Cigarettes ____________packs/day

1. I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.

Signature: ____ **Date:** ________________

Neurological, MRI, Vascular Patient Questionnaire

Name: ____ **Date:** ______________________

For any YES answer, please include details.

1. Do you suffer from neck pain in your shoulder, arms or hands? ☐ Yes ☐ No
Comment: ____

2. Do you have weakness, numbness or burning in your shoulder, arms or hands? ☐ Yes ☐ No
Comment: ____

3. Do your hands or arms fall asleep regularly? ☐ Yes ☐ No
Comment: ____

4. Do you have reduced feeling (sensation) or swelling in your hands or arms? ☐ Yes ☐ No
Comment: ____

5. Do you suffer from a loss of handgrip strength? ☐ Yes ☐ No
Comment: ____

6. Do you suffer from back pain with pain in your buttocks, legs or feet? ☐ Yes ☐ No
Comment: ____

7. Do you have weakness, numbness or burning in your buttocks, legs or feet? ☐ Yes ☐ No
Comment: ____

8. Do your legs or feet fall asleep regularly? ☐ Yes ☐ No
Comment: ____

9. Do you have reduced feeling (sensation) or swelling in your legs or feet? ☐ Yes ☐ No
Comment: ____

10. Do you suffer from cold hands or feet? ☐ Yes ☐ No
Comment: ____

11. Have you tried any medications such as anti-inflammatories? ☐ Yes ☐ No
If yes, what kind of medication? ____

12. Have you tried any Physical Therapy or Chiropractic treatments before? ☐ Yes ☐ No
If yes: When? For how long? What kind? ____

13. Have you had an MRI? ☐ Yes ☐ No
If yes: When? Who ordered it? What was it ordered for? __________________________________

14. Have you used any splint or braces or other prescribed treatment by an MD? ☐ Yes ☐ No
If yes: When? What kind? Who ordered it? ____

15. If you have tried any treatment or medications, did this make your problem better? ☐ Yes ☐ No
Comment: ____

For any yes answer, rule in/out the diagnosis with these two tests:

A) NCV/EMG tests _________________________ ☐ Indicated ☐ Not Indicated (pick one)
B) Vascular test ___________________________ ☐ Indicated ☐ Not Indicated (pick one)

Patient Name: ____ DOB: ___________________

Please rate your ability to perform the following activities, in the first column, on a scale of 1-10, with 1 being you can't perform the activity at all and 10 being 100% ability to do the activities without any restrictions.

Activities of Daily Living	**Exam** __________ Date: ___/___/___	**Exam** __________ Date: ___/___/___	**Exam** __________ Date: ___/___/___	**Exam** __________ Date: ___/___/___
Personal Care				
Pulling				
Twisting				
Lifting				
Lifting Overhead				
Walking				
Bending				
Driving				
Getting in and out of car				
Sitting for long periods				
Standing for long periods				
Working at a computer				
Family				
Sex				
Playing with Children				
Lifting Children				
Lifting children in and out of car				
Household Activities				
Cleaning the House				
Vacuuming				
Washing Dishes				
Cleaning the Bath Tub				
Cooking				
Gardening				
Washing Car				
Loading items in and out of Trunk				
Folding Laundry				
Carrying Groceries				
Shopping				
Sports & Recreation				
Running				
Jogging				
Working out at Gym				
Golfing				
Walking the Dog				
Tennis				
Walking				
Bicycling				
Swimming				

Physician Signature: _______________ _______________ _______________ _______________

Patient Signature: ____ Date:_____________

Name: ____ Date: ________________

Circle your pains/complaints from MOST severe to LEAST severe. Please Only Circle ONE in each column.

	Circle **Primary** Concern	**Secondary**	**Third**	**Fourth**
Today, you have the following physical complaints	Hips L/R Shoulder L/R Knee L/R Lower Back Feet Upper Back Neck Pain/Headaches	Hips L/R Shoulder L/R Knee L/R Lower Back Feet Upper Back Neck Pain/Headaches	Hips L/R Shoulder L/R Knee L/R Lower Back Feet Upper Back Neck Pain/Headaches	Hips L/R Shoulder L/R Knee L/R Lower Back Feet Upper Back Neck Pain/Headaches
Circle the word the best describes the complaint.	Sharp Throbbing Achy Shooting Dull Burning Numb Tightness Stiff	Sharp Throbbing Achy Shooting Dull Burning Numb Tightness Stiff Other	Sharp Throbbing Achy Shooting Dull Burning Numb Tightness Stiff Other	Sharp Throbbing Achy Shooting Dull Burning Numb Tightness Stiff Other
How often do you feel this complaint? Circle the best description.	Constant Daily Weekly Off and On	Constant Daily Weekly Off and On	Constant Daily Weekly Off and On	Constant Daily Weekly Off and On
How long have you had this complaint?	1-3yrs. 7-10 yrs. 4-6 yrs. 10+ yrs.	1-3yrs. 7-10 yrs. 4-6 yrs. 10+ yrs.	1-3 yrs. 7-10 yrs. 4-6 yrs. 10+yrs.	1-3yrs. 7-10 yrs. 4-6yrs. 10+ yrs.
Is it getting better, worse, or staying the same?	Better Worse Same	Better Worse Same	Better Worse Same	Better Worse Same
What makes it better, if anything?	Movement Heat Nothing Cold Creams/Meds Other	Movement Heat Nothing Cold Creams/Meds Other	Movement Heat Nothing Cold Creams/Meds Other	Movement Heat Nothing Cold Creams/Meds Other
What makes it worse, if anything?	Movement Heat Nothing Cold Creams/Meds Other	Movement Heat Nothing Cold Creams/Meds Other	Movement Heat Nothing Cold Creams/Meds Other	Movement Heat Nothing Cold Creams/Meds Other
On a scale of 0-10, rate your discomfort. (*0 means no discomfort and 10 means excruciating*)	Circle Response 0 1 2 3 4 5 6 7 8 9 10	Circle Response 0 1 2 3 4 5 6 7 8 9 10	Circle Response 0 1 2 3 4 5 6 7 8 9 10	Circle Response 0 1 2 3 4 5 6 7 8 9 10
How have you taken care of this in the past? How has that worked for you?	Meds Creams Surgery Other Acupuncture Stretching	Meds Creams Surgery Other Acupuncture Stretching	Meds Creams Surgery Other Acupuncture Stretching	Meds Creams Surgery Other Acupuncture Stretching
Circle the ways this issue is affecting your life. (*Circle all that apply*)	Job Childcare Sex Marriage Golf Sports Finances Walking Playing with children Standing Bowels Urinary Other	Job Childcare Sex Marriage Golf Sports Finances Walking Playing with children Standing Bowels Urinary Other	Job Childcare Sex Marriage Golf Sports Finances Walking Playing with children Standing Bowels Urinary Other	Job Childcare Sex Marriage Golf Sports Finances Walking Playing with children Standing Bowels Urinary Other
Improving this issue in my life would improve my quality of life by.... (*Circle the best response*)	10-20% 30-40% 50-60% 70-80% 90% 100%	10-20% 30-40% 50-60% 70-80% 90% 100%	10-20% 30-40% 50-60% 70-80% 90% 100%	10-20% 30-40% 50-60% 70-80% 90% 100%

Acknowledgement of Receipt of Notice of Privacy Practices

Name: ____ Date: _____________________

I acknowledge that I have reviewed the Notice of Privacy Practices of Superior Health Care. (Please initial one of the following options and sign below.)

____________ I wish to receive a paper copy of Privacy Notice.

____________ I do not request a copy of the Privacy Notice at this time. I acknowledge that I can request a copy at any time and the Privacy Notice is posted in the office.

____________ I acknowledge that it is the policy of this office to leave reminder messages on my answering machine or with another person in my home. I may make a request of an alternative means of communication (within reason) in writing.

____________ I acknowledge that if I should have a problem or question in regard to my rights, I may speak with the Privacy Officer about my concerns.

____ __________________________

Signature of Patient/Guardian Date

____ __________________________

Witness (Office Staff) Date

X-Ray Questionnaire: For Women Only

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

Name: ____

☐ There is a possibility that I may be pregnant at this time

☐ Yes, I am definitely pregnant

☐ No, I am definitely not pregnant at this time

☐ I request that x-ray films not be taken because: ____

____

____

Date of last Menstrual period: ___________________________

Signature: ____ Date: _____________________

PIVOTAL HEALTH
PHYSICAL MEDICINE

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 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 treatment. 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 prescriptions should be refilled by your original prescriber and any new prescriptions should be issued by your primary care provider.

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.

Chiropractic care, like all forms of health care, while offering considerable benefit may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral artery injury.

Prior to receiving chiropractic care this Chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, your spine health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care. I understand and accept that there are risks associated with chiropractic care and give consent to the examinations that the doctor deems necessary, and to the chiropractic care including spinal adjustments, as reported following my assessment.

This notice is effective as of the date it is signed and will expire seven years after the date on which you last received services from us.

____   ____________________

Patient Signature   Date