PRO SPORTS
ORTHOPEDICS

Patient Registration

Patient Information:

Patient Name: ______________________ ______________________ ____________
(last) (first) (MI)

DOB: _______/_______/_______ Gender: M F SSN: ______-______-________

Street Address: ____

City/State:_________________________________ Zip Code: _________________

Home Phone: (_______) ______-_________ Cell Phone: (_______) ______-__________

E-Mail: ____

Primary Care Doctor: __________________________ Phone: (_______) ______-_______

Race: ____________ Preferred Langue: ___________ Ethnicity: Hispanic / Not-Hispanic

Insurance Information:

Do you have Medical Insurance? Yes No

Name of Insurance:____

Insurance ID: ________________________ Group Number: _______________________

Insurance Address (*PO BOX "medical claims"*)__________________________________

Insurance Phone: (_______) ______-_________

****** If this injury is related to a motor vehicle accident or a workman's compensation claim please ask for an additional form******

New Exam: 99202 99203 99204 **DX:** ________ _________ _________ _________ _________

98940	98941	97140	97112	97012	97014	97124	97010	97110
½ area	¾ area	man ther	re-ed	mech trac	e-stim	massage	h/c pack	ther exer

Chief Complaint- Present Condition

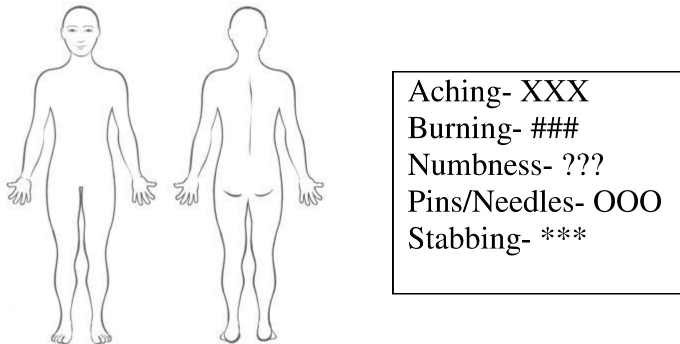
When did your complaints and/or symptoms begin? ______________________________

Describe your current injury/current problem.

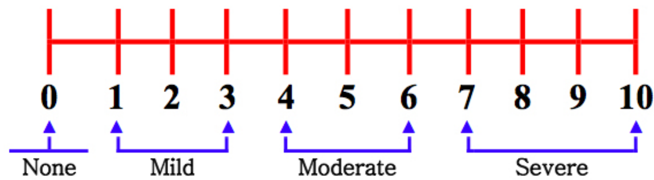
____

____

Please Mark your symptoms on the diagram.



Rate your pain right now. Right now (mark as N), Worst (mark as W), Best (mark as B).



Please check all present symptoms related to your current condition:

Head & Face

	Base of skull		Side/temple		Nausea/vomiting		Ear pain		Throbbing		migraine
	Incapacitating		Front		Ringing in ears		Nose bleeds		Eyelids heavy		top
	Double vision		Pressure		Head feels heavy		Eye pain		Jaw pain		Flushing
	Light sensitive		Blurry vision		Headache affects vision		Dizziness		Sinus problem		

Neck

	Weakness		Spasms		Pain on motion		Limited motion		Pain		Swelling
	Lumps		Throat tight		Radiating pain		Difficulty swallowing		stiffness		

Shoulder

	Local pain		Limited movement		Pain on movement		Pain from neck		Radiated down arm		

Arm & Hand

	Local pain		Pain on movement		Swelling		Cold hands		Weakness		Radiated from neck
	Numbness		Tingling		Can not raise arm						

Mid-back & Low Back

	Weakness		Pain		Spasms		Rib pain		Chest pain		Stiffness
	Swelling		Pain on motion		Limited motion		Radiating pain				

Hip, Legs, Knees, & Feet

	Local pain		Radiating		From back		Down leg		Swelling		numbness
	Tingling		Spasms		Cramping		Cold feet		Weakness		Pain on motion

Nerves

	Burning		Numbness		Tingling		Tremor		Dizziness		Loss of balance
	Loss of consciousness		Coordination		Twitching		Difficulty with memory		Seizures		Generalized weakness

Sleep

	Good		Fair		Poor		Poor due to pain		Deep burning pain		Difficulty falling asleep
	Difficulty staying asleep		Wake often								

Fatigue

	Must rest during day		Can't get enough rest		Intermittent fatigue		Constant fatigue		Worse with exercise		Mental fatigue
	Physical fatigue										

Have you seen another doctor because of your current condition? Yes No

If so please list the doctors that have seen you.

Doctor: ____ Phone: (_______) ______-_______

Doctor: ____ Phone: (_______) ______-_______

Have you had any diagnostic tests preformed? Yes No

	MRI		X-Ray		Lab Work		Functional testing		Psychological testing		EMG/Nerve Study

Other: ____

Please add any additional comment about your condition you feel would be important.

____

____

____

To help the doctor determine your needs, please indicate your specific interests:

	Chiropractic adjustments		Neurological evaluation		Nutritional counseling		Dietary counseling		Exercise consultation		Life style coaching

Past Medical History

Have you ever been hospitalized? Yes No

If so where, when, and why. ____

Please list all allergies:

Allergy	Reaction

Please list your surgery (ies)

Date	Type of surgery/ Results

Are you taking any medication (s)? Yes No

Medication name	Dosage/How Often taken	How long have you been taking this medication?

Are you taking any supplements? Yes No

Supplement name	Dosage/How Often taken	How long have you been taking this medication?

Systems Review

Please check any of the following that you have experience in the *past 6 months*.

Head, Ears, Eyes, Nose, and Throat

	Vision problems		Eye pain		Hearing difficulty		Dental problems		Headaches		Earache/ infection
	Sore throat		Ringing in ears		Sinus congestion		Nose bleeds		Bleeding in gums/ lips		Loss of smell
	Poor night vision										

Cardiovascular & Respiratory

	Chest pain/tightness		Low blood pressure		Fainting		Shortness of breath		Cold hands/ feet		High blood pressure
	Varicose veins		Dizziness		Swelling of legs/ feet		Coughing blood		Lung problems		Persistent cough
	Light headed		Irregular/ fast heartbeat								

Gastrointestinal

	Nausea		Vomiting		Heartburn		Gas/bloating		Bloody stools		Esophageal reflux
	Constipation		Hemorrhoids		Ulcers		Diarrhea		Gallbladder problems		Bowel incontinence
	Abdominal pain/ crams										

Genitourinary

	Pain with urination		Frequent urination		Kidney stones		Loss of bladder control		Infection		Wake to urinate
	Blood in urine		Sexual dysfunction		Urgency with urination		STD				

Male & Female Systems

	Prostate problems		Irregular periods		Sexual dysfunction		Vaginal pain/infection		Menopause		Menstrual cramps
	Breast pain/lumps		# of pregnancies		# of live births		# of c-sections				

Musculoskeletal

	Joint pain		Muscle pain		Back stiffness		Joint stiffness		Back pain		Muscle stiffness
	Joint swelling		Difficulty with limb movement								

Nervous System

	Nervousness		Anxiety		Seizures		Dizziness		Depression		Forgetfulness
	Confusion		Paralysis		Numbness		Tingling		Weakness		

General

	Weight loss		Weight gain		Night sweats		Excessive thirst		Chills		Fever
	Insomnia		Fatigue		Bruise/bleed easily		Itching		Spots on fingernails		Fragile/ brittle nails
	Headaches		Skin rash		Skin sores						

Personal and Family History

Have you ever suffered from or been diagnosed having:

	YES	NO			YES	NO
Broken/Fractured bones				Ulcers		
Vascular disease				Epilepsy		
Rheumatoid arthritis				Pacemaker		
Seizures/convulsions				Strokes		
Congenital disease				Ruptures		
Eating disorder				Dizziness		
Coughing blood				HIV positive		
Speech problems				Head problems		
Eye/vision problems				Tumors		
Difficulty breathing				Insomnia		
Loss of bowel control				Diarrhea		
Ear/hearing loss				Nervousness		
Loss of bladder control				Constipation		
Digestion problems				Gallbladder		
Thyroid disorder				Polio		
Rheumatic fever				Chicken pox		
STD				Circulatory		

Please mark the appropriate boxes to identify ALL illness or conditions which you know have occurred in you or your blood relatives. Indicate "none" if unsure.

	Self	Mother	Father	Brother	Sisters	Grandparents
Cancer						
Heart Disease						
Diabetes						
Asthma						
Eczema/Psoriasis						
Migraine headaches						
Seizure Disorder						
Stroke/TIA						
High Cholesterol						
Abnormal Bleeding						
High Blood Pressure						
Anemia						
Osteoporsosis						
Alcohol/Drug Abuse						
Depression						
Psychological/ Mental Illness						
Suicide (or attempted)						
Genetic Disorder						
TB						
Colon Polyp						
Hepatitis						
Obesity						
Other:						

If any family member is deceased due to any of the conditions listed above, please list who and of what condition:

____

Social History

Are you currently married? Yes No In a relationship/partnership? Yes No

Have you been: Separated Divorced Widowed In the past year? Yes No

What is your current employment status?

Full Time Part-Time Unemployed Retired Disabled

Occupation: ____

Stress Screening:

	Trouble dealing with stress		Stress induced digesting problems		Health feels out of your hands
	In therapy or counseling		Suicidal thought		Use food/alcohol to deal with stress

Do you find any dysfunction of concerns with:

	Relationship with family		Relationship with friends		Intimate relationships
	Career/work/school		Religious/spiritual path		Physical appearance

Substance Review

Do you use tobacco? Yes No Pack per day________ # of years__________

Previously Used? Yes No

Do you use alcohol? Yes No Servings per day__ Days per week ___ # of years ___

Previously Used? Yes No

Do you use caffeine? Yes No Servings per day__ Days per week ___ # of years __

Previously Used? Yes No

Self Care/ Home Environment Assessment

In an average week, how many minutes of moderately vigorous physical activity do you get? ___________________________________

Do you have any special Dietary needs? ____

How many servings of fruit do you have in a typical day? __________________________

Describe your typical diet? ____

What are your current living arrangements? ______________________________________

Do you live: alone with spouse/family with others

Upon signature of this document I am certifying that all the information provided is true, correct, and complete. If more information about my illness becomes known, I will tell the doctor so that it can be added to my record.

Patient/Parent/Guardian Signature: __________________________________ Date: _____

Marchese Sports Therapy
Authorization to Receive Care

(Informed Consent)

The receipt of **informed consent** is required of all health care providers prior to initiating any medical procedure, treatment or therapy program. The purpose of which is to help the patient make an informed decision as to available treatment options and to ensure that the patient is informed of the inherent risks and benefits of the proposed treatment. In your case, treatment options include the therapy program proposed by our providers, your right to seek the advice and or treatment of another provider (such as your primary care physician or other licensed health care providers) and also your choice for no treatment at all.

As with all the medical disciplines, chiropractic care also has potential risks that you as a patient have the right to be informed of. You have the right to ask your provider directly and at any time any question you may have regarding the safety profile of any procedure or treatment provided or recommended by this office.

Generally speaking chiropractic care has an excellent safety profile. In comparing the risks of chiropractic treatment to the risks of traditional medicine's use of drugs and surgical procedures for treating similar conditions, the risk of serious injury is much less with chiropractic care. This is not stating that traditional medicine is unsafe or may not be a viable option in some cases, but rather to put into perspective the relative safety of chiropractic care. The overall safety profile for chiropractic is probably more similar to that of traditional physical therapy.

With this perspective in mind, please consider the following adverse side effects.
-Minor side effects: As with most manual therapies such as massage therapy or physical therapy, chiropractic treatment could possibly irritate the area being treated. These minor side effects are usually mild and may include: Localized stiffness and or soreness of the muscles and soft tissues being treated. Skin irritation could possibly occur from lotions or therapies such as massage, ice packs or heat packs. These symptoms are self limiting and may last a few hours or possibly a few days.
-Moderate very infrequent side effects: It is fairly rare that the manual therapies such as massage therapy, physical therapy and chiropractic therapy cause injury which could include strained muscles, sprain of ligaments or cartilage, nerve irritation, and bruising or minor injury of the soft tissues (such as skin or fatty tissue).
-Extremely rare adverse effects: As the manual therapies including chiropractic care have such a good safety profile, serious adverse side effects are extremely rare. Extremely rare adverse effects could include fracture or dislocation of bone or injury to blood vessels. Because the incidents are so rare, the statistics regarding the incidence of major neurological complications due to cerebrovascular injury or CVA resulting from manual therapy is not conclusive and more information is needed to further define the actual frequency. The existing studies and literature suggests the incidence of CVA following manual cervical manipulation as provided by physical therapists, doctors of osteopathy and doctors chiropractic collectively to be somewhere around 1 in 4 million. This is more than 100 times safer than the regular use of NSAIDs such as Ibuprofen/Advil/Motrin or Naproxen/Aleve.

Preexisting conditions such as osteoporosis, artery weakening diseases, high blood pressure, cancer, smoking, hormone therapy, steroid use, some medications and previous injury may put some individuals at higher risk than others. For this reason it is important that you share with all your providers your detailed medical history. For your safety, our providers routinely perform screening procedures which may help identify preexisting complicating factors.

Authorization:
I have read and understand the preceding **informed consent** document. I also understand that particular results of therapy can not be guaranteed. I hereby give my consent to receive care.

Signature: ____ Date: ________________

Patient Right to File a Complaint

If you believe any of your privacy rights have been violated by us you can file a written complaint with our privacy officer. Your complaint must be filed within 180 days of when you know or should have known that act occurred. In addition, you can also file a written complaint either of paper or electronically with the office of civil rights. Please note that the privacy laws prohibits out office from taking any regulatory actions against you.

I have received a copy of this office's notice of privacy practices and consent to the use and disclosures of protected health information by Marchese Sports Therapy, for treatment, payment, healthcare operations, and additional uses. I have reviewed, acknowledged, understand the content of the notice of privacy practices have had all my questions answered to my satisfaction.

Printed Patients Name: ____

Signature: ____ Date: ________

Patient Right to Clinical Summary

A Clinical Summary is an after-visit summary that provides a patient with relevant and actionable information and instructions containing the patient name, provider's office contact information, date and location of visit, an updated medication list, updated vitals, reason(s) for visit, procedures and other instructions based on clinical discussions that took place during the office visit, any updates to a problem list, immunizations or medications administered during visit, summary of topics covered/considered during visit, time and location of next appointment/testing if scheduled, or a recommended appointment time if not scheduled, list of other appointments and tests that the patient needs to schedule with contact information, recommended patient decision aids, laboratory and other diagnostic test orders, test/laboratory results (if received before 24 hours after visit), and symptoms.

In order to eliminate the use of paper our office uses an EMR (electronic medical record) system. I understand that by signing this form I will notify the office if I want copies of my medical records and sign a medical record release. My records will not be printed and given to me without my consent.

Printed Patients Name: ____

Signature: ____ Date: ________