Sports Chiropractic Performance Therapy

Today's Date: ____________________ **Patient SS#**_____________________**Patient Office ID**:____________

Patient Name:____
Address: ____
____
City State Zip

Sex □ M □ F Age______ Date of Birth _____________

□ Single □ Married □ Widowed □ Separated □ Divorced
Home Phone____
Work Phone ____
Cell ____
Email: ____
Occupation____
Employer:____
Employer Phone_______________________________________
Spouse's Name____Spouse's Birthdate ________________
Spouse's Occupation___________________________Spouse's Employer____________________________

How did you hear about us? □ Advertisement □ Friend □ At an Event □ Other:_____________________
Who may we thank for referring you?________________

In Case of Emergency contact

Name____ Relationship________________________
Home Phone_________________ Work Phone _______________________ Cell__________________________

Insurance Information

Subscriber's Name: ____________________________Birth Date__________ Relationship to Patient __________
Insurance Company Name:____
Policy#________________________________
Insurance Company Address: _______________________________________ Group/Claim # _____________
SS#________________________________
Is patient covered by additional insurance? □ Yes □ No
Subscriber's Name: ____________________________ Birth Date__________ Relationship to Patient _____________
Insurance Company Name:____
Policy#________________________________
Insurance Company Address: _______________________________________
Group/Claim # ___________________________

Sports Chiropractic Performance Therapy

INFORMED CONSENT

I, the undersigned, so hereby agree and give my consent to Dr. Frank Valente to provide and perform chiropractic services and other procedures that are considered proper in accordance with New York State law.

I understand that I will be receiving one or more of the following treatments: Spinal Manipulation/Mobilization therapy, Hot/Cold packs, Electrical Stimulation, Ultrasound, Myofascial release, Traction (Flexion-Distraction), therapeutic exercises/activities.

I acknowledge understanding and have had the opportunity to discuss the purpose, benefits, and associated risks of chiropractic treatments (manipulations) and other treatments outlined above. We discussed the different outcomes that could occur and possible complications. I am aware that other complications could occur that could not be foreseen. Alternative treatments to chiropractic have been reviewed.

I have had the opportunity to read this form and ask questions. Any questions I have had regarding treatment have been answered to my satisfaction prior to me signing this consent form. I have made my decision and agree to the recommended treatment voluntarily and freely.

______________________________ ______________________________
Printed Name Date

____
Signature

____
Signature of parent or guardian (if patient is a minor)

Sports Chiropractic Performance Therapy

OFFICE FINANCIAL POLICY

Patient's Name: ____

1. We have verified your benefits and while your insurance company did not guarantee payment, they stated that you have a $_______ deductible, $_________ of which has been met. Additionally, your insurance will pay _____% of covered charges, leaving _____% of each visit due by you.

2. We have verified your benefits and while your insurance company did not guarantee payment, they stated that you have a $______ deductible, $_______ of which has been met. Additionally, your insurance will pay _____% of covered charges, leaving a $_____ co-pay of each visit due by you.

INSURANCE FORMS/PAYMENT

If you receive any correspondence from your insurance carrier pertaining to the care you have received at this office or a request of more information regarding your care, please bring it in as soon as possible. It is very important that we keep your file as up to date as possible. Occasionally, either by mistake, or due to provisions in your policy, the check issued by the insurance company for payment of services rendered in our office, may come to you instead of our office. If you should receive any unexpected check in the mail, please contact us to see if it does represent payment of your bill here.

I have read and understand the payment policy of Frank. J. Valente, DC, PC. I understand that my insurance is an arrangement between myself and my insurance company, NOT between Frank J. Valente, DC, PC and my insurance company. I request that Frank J. Valente DC, PC prepare the customary forms at no charge so that I may obtain insurance benefits. I also understand that if my insurance does not respond within 60 days, or if I suspend or terminate my schedule of care as prescribed by the doctors at Frank J. Valente, DC, PC that fees will be due and payable immediately.

____
Patient's signature (or guardian if patient is a minor) Date

____
Witness

Sports Chiropractic Performance Therapy

INSURANCE ASSIGNMENT

Our Insurance Assignment Program is designed to keep your out-of-pocket expenses to a minimum. As a courtesy to you, we will bill your health insurance carrier on your behalf and wait up to 30 days for payment. Please remember, however, that you are ultimately responsible for payment. As a prerequisite, we ask that you leave a credit card to guarantee payment.

Filing Procedure

Claims for initial services are submitted within 48 hours after your first visit.

On Day 30, if the bill has not been paid by your insurance company, we will charge your designated credit card below for the amount of the claim. You will be sent a payment voucher. Any payments made on these claims thereafter will be immediately refunded to you.

Personal Balances

Estimated personal portions are paid at the time of services unless you prefer to pay weekly. Weekly payments also require this credit card guarantee, and any personal balance not paid by Friday will also be automatically charged to your designated card below.

Cancellation Policy

If you are unable to make an appointment, you are responsible for calling or emailing the office ahead of time to cancel. **If you do not contact us and you do not show up, you will be charged for your visit.** As long as you call or email ahead of time, you will not be charged.

Credit Card on File:

Please Check
- ❑ Visa
- ❑ MasterCard

Credit Card #____Expiration date_______________________

Name on Credit Card___________________________________ Security Code (3 digit on back) ___________

Authorized Signature ___________________________

Sports Chiropractic Performance Therapy

INTAKE QUESTIONNAIRE

Patient Name:

1. Reason for visit or your Chief Complaints

____

2. What do you hope will happen as a result of this visit?

____

3. When did your symptoms appear? When did you realize it's time to see a doctor for this problem? Pick one

□ I don't know how it began □ It comes and goes □ I've had it a long time (about _________ years)

□ Specific injury (date of injury ____________________) □ When did the symptom begin?_______________________

4. Explain how the injury happened

____

____

5. Overall my state of health is □Excellent □Good □Fair □Improving □ Failing

6. Rate the severity of your **LOW BACK** pain on a scale from 1 (least pain) to 10 (severe pain)

1. Right now ______/10 2. At its worst today _____/10 3. At its worst overall since beginning _____/10
4. How often do you have this pain Daily?□ Constant (76-100%) □ Frequent (51-75%) □ Occasional (26- 50%)

□ Intermittent (25% or less)

7. Rate the severity of your **RIGHT/LEFT** □ **HIP**, □ **THIGH**, □ **KNEE**, □ **ANKLE**, and/or □ **FOOT** pain on a scale from 1 (least pain) to 10 (severe pain)

1. Right now ______/10 2. At its worst today _____/10 3. At its worst overall since beginning _____/10
4. How often do you have this pain daily? □ Constant (76-100%) □ Frequent (51-75%) □ Occasional (26- 50%)

□ Intermittent (25% or less)

8. Rate the severity of your **NECK / MID BACK PAIN** on a scale from 1 (least pain) to 10 (severe pain)

1. Right now ______/10 2. At its worst today _____/10 3. At its worst overall since beginning _____/10
4. How often do you have this pain daily? □ Constant (76-100%) □ Frequent (51-75%) □ Occasional (26- 50%)

□ Intermittent (25% or less)

9. Rate the severity of your **RIGHT/LEFT** □ **Shoulder**, □ **Arm**, □ **Elbow**, □ **Forearm**, □ **Wrist**, and/or □ **Hand** pain on a scale from 1 (least pain) to 10 (severe pain)

1. Right now ______/10 2. At its worst today _____/10 3. At its worst overall since beginning _____/10
4. How often do you have this pain daily? □ Constant (76-100%) □ Frequent (51-75%) □ Occasional (26- 50%)

□ Intermittent (25% or less)

10. Rate the severity of your _______________ pain on a scale from 1 (least pain) to 10 (severe pain)

1. Right now ______/10 2. At its worst today _____/10 3. At its worst overall since beginning _____/10

How often do you have this pain daily? □ Constant (76-100%) □ Frequent (51-75%) □ Occasional (26- 50%)

□ Intermittent (25% or less)

Sports Chiropractic Performance Therapy

Patient name:

11. Do you have the following problems? Please check your answer (R= right, L=Left, B=Both)

Weakness	□None □__Shoulder □__Arms □__Elbow □__Forearm □__Wrist □__Hand
	□__Hip □__Thigh □__Knee □__leg □__Ankle □__Foot □__Toes
Numbness (loss of feeling)	□None □__Shoulder □__Arms □__Elbow □__Forearm □__Wrist □__Hand
	□__Hip □__Thigh □__Knee □__leg □__Ankle □__Foot □__Toes
Tingling (Pins & Needle Sensation)	□None □__Shoulder □__Arms □__Elbow □__Forearm □__Wrist □__Hand
	□__Hip □__Thigh □__Knee □__leg □__Ankle □__Foot □__Toes

12. Is your pain worse at night? □ Yes □ No.

13.Does your pain awaken you from sleep? □ Yes □ No

14. Does coughing affect your pain □ Yes □ No.

15. Do your legs hurt/tire when you walk far? □ Yes □ No

16. Lost or gained weight recently? □ Yes □ No.

17. Experienced night sweats □ Yes □ No

18. Been out of the country □ Yes □ No.

19.Lost bladder or bowel control □ Yes □No

20. Had trouble with sexual function □ Yes □ No.

21.Seen a primary care physician in last year □ Yes □ No

22. Since your problem began, the condition has? □ Increased □ Decreased □ Not Changed

23. Does your problem "flare up" and get worse at any point? ________________________________

24. Are your complaints affecting your ability to work or otherwise be active?

□ No effect on my activity level □ I have some physical restrictions □ I Need limited assistance with common everyday tasks □ I have a significant inability to function without assistance □ Totally disabled(impaired) and cannot care for self

25. Does it interfere with your □ Work □ Sleep □ Daily Routine □ Recreation

26. Type of complaint: □ Sharp □ Dull □ Throbbing □ Numbness □ Aching □ Shooting □ Burning □ Tingling □ Cramps □ Stiffness □ Swelling □ Other

Sports Chiropractic Performance Therapy

Patient name:

27. What makes your problems Worse**:** □ Sitting □ Standing □ Walking □ Bending □ Lying down
□ Lifting □ Twisting □ Movement □ Rising from a chair

28. What makes your problems *Better*: □ Sitting □ Standing □ Walking □ Bending □ Lying Down
□ Lifting □ Twisting □ Movement □ Hot shower/hot pack
□ Cold pack □ Rise from chair □ Physical activity

29. When you wake up, the problem is □ BETTER □ WORSE □ NO CHANGE

30. As the day goes along the problem gets □ BETTER □ WORSE □ NO CHANGE

31. Have you ever injured this area before? □ Yes □ No

If yes, how many times have you experienced this problem? □ 1-4 □ 5-8 □ >8

32. What treatment have you already received for your current condition?

□ Medications □ Surgery □ Chiropractic Services □ Physical Therapy □ Other ____________________

33. Name, address, and phone number of doctor(s)/healthcare providers who have treated you for this condition:

PCP Dr. ____________________________________ Dr.____________________________________

____________________________________ ____________________________________

____________________________________ ____________________________________

City State Zip City State Zip

34. Current Medications, including vitamins, supplements, and over-the-counters

Medication Names (& Reason):

____

____

____

35. **Surgeries (Date & Reason):** (Please include all surgeries, especially spine procedures)

____

____

____

Sports Chiropractic Performance Therapy

Patient name:

36. **Hospitalizations (Date & Reason):**

____
____
____

37. **Fractures/Dislocations/Falls/Car Accidents/Trauma (Date & Reason):**

____
____
____

38. **Known Allergies**

____
____

39. Please **CIRCLE** all the conditions that you have currently or had previously.

□ Heart attack □ Emphysema □ Heart murmur □ Angina □ Asthma
□ HBP □ Anemia □ Stroke/TIA □ Bleeding disorder □ Varicose Veins
□ Sexual difficulty □ Stomach ulcer □ Enlarged prostate □ Duodenal problems □ Menstrual problems
□ TB □ Colon problems □ Migraines □ Diabetes □ HIV/AIDS
□ Hepatitis □ Scoliosis □ Cirrhosis □ Prosthetic joints/pins/screws
□ Kidney stones □ Kidney infection □ Psoriasis □ Depression
□ Degenerative Arthritis □ Rheumatoid Arthritis □ Cancer type:_______________

VITAL INFORMATION

Blood Pressure: ____/____mm/Hg **Weight:** _________lbs. **Height**____'____"

EXERCISE ACTIVITY

40. Do you do any exercise on a regular basis? □ Yes □ No Days/Week____
If yes, specify _______________________

41. Are you a member of a gym/fitness facility? □ Yes □ No

Which?___________________________________

WORK ACTIVITY

□ Sitting □ Standing

□ Light Labor □ Heavy Labor

420 Madison Avenue, Suite 803, New York, NY 10017 (917)338-7917 Office (212)319-0435 Fax Email: info.drvalentedc@gmail.com www.midtown-chiropractor.com

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Patient name:

HABITS

□ Smoking Packs/Week__________________ If yes, last chest x-ray? ___________________

□ Smokeless Tobacco If yes, last dental visit ___________ □ Used to smoke but quit…how long ago? _____

□ Alcohol Drinks/Week ________________□ Coffee/Caffeine Cups/Day __________________

□ High Stress Level Reason___________________

Female Health Questions

42. Do you have an OB/GYN Provider? If yes, who ____________________Last visit _________________
43. Are you pregnant? □ Yes □ No No Have you ever been pregnant? □ Yes □ No If yes, how many pregnancies ________
44. Complications during pregnancy/delivery? □ Yes □ No If yes describe__________________________
45. Children and age(s)?_____________________________
46. Date of LMP __________
47. Birth Control? Method _____________________
48. Have you ever had a PAP smear? □ Yes □ No If yes, approx. date _____________
49. Have you ever had a mammogram? □ Yes □ No
50. Any history of breast, ovarian, cervical, uterine cancers/polyps/growths in you or family? □ Yes □ No
51. Ever had a routine or baseline EKG done? □ Yes □ No
52. CRP/Homocysteine levels? □ Yes □ No
53. Have you checked your Cholesterol levels? □ Yes □ No
54. Do you perform monthly breast self exams? □ Yes □ No

Male Health Questions

55. Have you ever had a digital prostate exam? □ Yes □ No
56. PSA Test? Blood test for prostate cancer □ Yes □ No
57. Do you perform testicular self exams? □ Yes □ No
58. Ever had a routine/baseline EKG done? □ Yes □ No
59. Checked Cholesterol level? □ Yes □ No
60. Checked CRP/Homocysteine levels? □ Yes □ No

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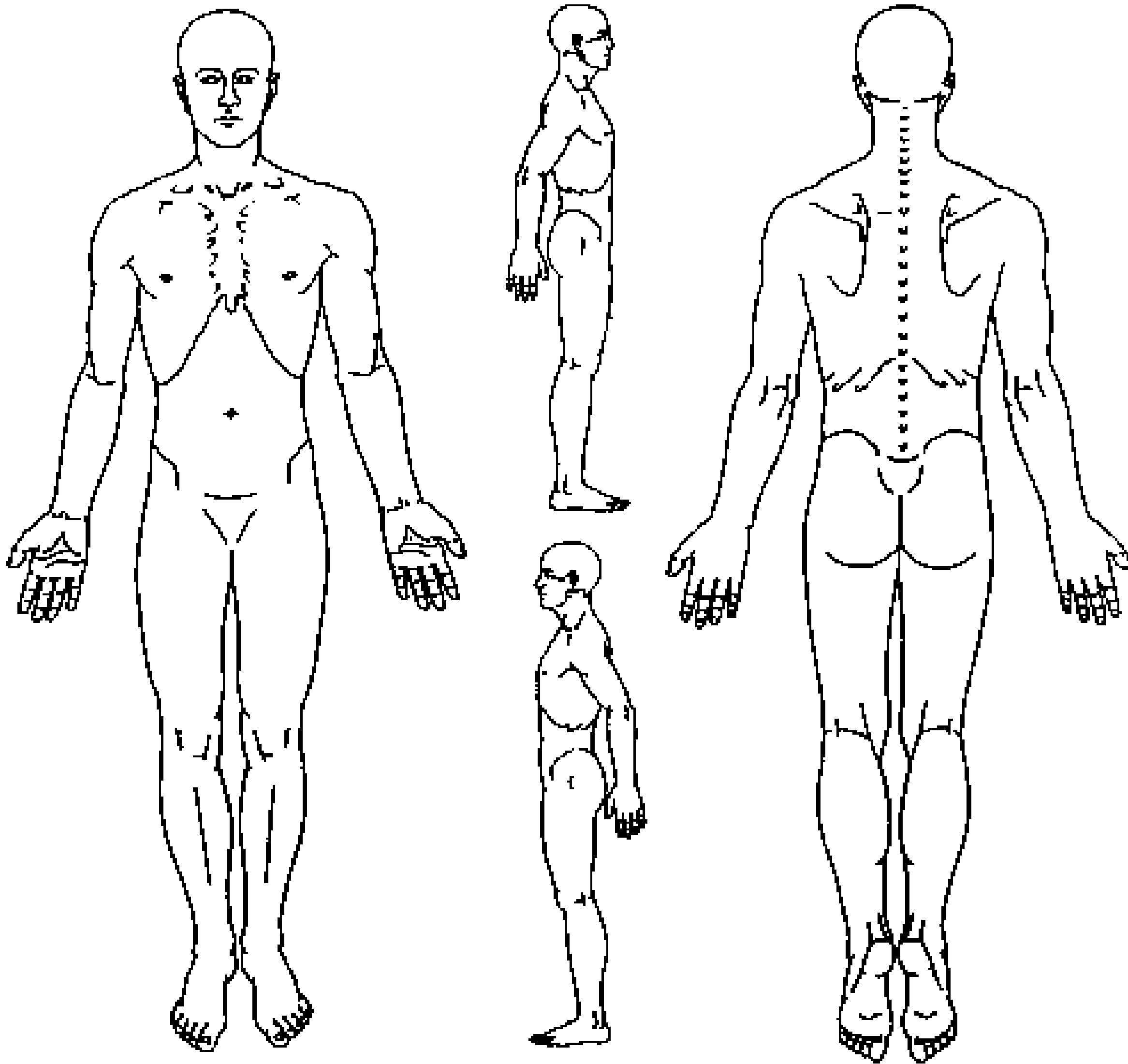
Pain Diagram



A = ACHE
S = STABBING

P = PINS & NEEDLES
N = NUMBNESS

B = BURNING
O = OTHER

420 Madison Avenue, Suite 803, New York, NY 10017 (917)338-7917 Office (212)319-0435 Fax Email: info.drvalentedc@gmail.com www.midtown-chiropractor.com