Peak
PHYSICAL MEDICINE AND WELLNESS

3200 Riverfront Dr. Ste 207
Fort Worth, TX 76107

Date: _____

## Patient Information

Name: _____
Last First MI

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Primary Phone: _____ Email: _____

Date of Birth: _____ Age:_____ Sex: ❑ Male ❑ Female ❑ SS#: _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑ Minor

Race: ❑ Caucasian ❑ African American ❑ Asian ❑ Native American ❑ Latin American ❑ Other _____

Occupation: _____ Employer: _____

Spouse's Occupation: _____ Spouse's Employer: _____

Name and Ages of children: _____

How did you hear about our practice?_____ Which search engine did you use? _____

Referral from family or friend? Name: _____ Other (specify): _____

Emergency Contact Name: _____ Relation: _____ Phone #: _____

## Accident Information - PLEASE PROVIDE THIS OFFICE WITH A CLAIM NUMBER

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

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: _____

## 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 DIRECTLY 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 hereby 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 (X)** _____ **DATE:** _____

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# Patient Health History

Who is your primary care physician? (Doctor and/or practice) _____

Primary Health Condition(s) (Concern): _____

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

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

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

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

Are you currently under any medical care? ❑ Yes ❑ No If yes, explain _____

Please list any medications you are currently taking (**Be sure to include dosage and frequency**):

_____

_____

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 _____

❑ Cancer _____ ❑ Arthritis _____ ❑ Other _____

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

  I give permission to disclose my information to this individual: _____

  I understand I have the right to revoke my decision in writing at any given time.

**SIGNATURE (X)** _____ **DATE:** _____

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# Review of Systems

Please mark if you have experienced any of these symptoms within the last month:

### Neurological
- Headaches
- Migraines
- Slurring of Speech
- Ringing in Ear

### Ears/Nose/Throat
- Altered taste/smell
- Earache
- Sore Throat
- Gingivitis
- Nose Bleeds

### Cardiovascular
- Palpitations/racing heartbeat
- Chest pain
- Swelling in hands/feet
- Anemia

### Respiratory
- Asthma
- Chest Congestion
- Wheezing
- Frequent Sneezing
- Recurrent Respiratory Infections

### Gastrointestinal
- Reflux/Heartburn
- Bloating
- Gas/Gas Pains
- Nausea/Vomiting
- Stomach pains/ Cramping

### Musculoskeletal
- Joint Pain
- Arthritis
- Chronic Pain
- Muscle Aches
- Poor Posture
- Scoliosis

### Genitourinary
- Uterine fibroids
- Ovarian Cysts
- Cancer (breast, ovarian, prostate, uterine)
- Prostate Problems

### Skin
- Eczema
- Dermatitis
- Excessive Sweating
- Rashes
- Brittle Nails
- Hair Loss
- Easy Bruising

### Emotional/Mental
- Depression
- Anxiety
- Mood Swings
- Irritability
- Memory Loss
- Confusion

### Energy
- Fatigue
- Hyperactivity
- Restlessness
- Insomnia
- Decreased Libido
- Stress

### Weight
- Weight Gain
- Decreased Appetite
- Inability to Lose Weight
- Food Cravings
- Binge Eating
- Water Retention

# Health Habits and Personal Safety

Please circle or fill in your answers.

**Exercise:** None Light Moderate Heavy 2x/week 3-5x/week Daily

**Diet:** None Patient Selected Physician Prescribed Diet Notes:_____

**Caffeine:** _____cups/day **Alcohol:** _____drinks/week **Tobacco Use:** _____packs/week or former user

**Do you need help?** : Dressing Eating Bathing Medication Mgmt

**Personal Safety:** Live Alone Strong Support System Hearing Loss Vision Loss Frequent Falls

**Socialize:** 2x/week Several times/week Daily

**Do you take sleep aides?** Yes No

**Do you take pain killers?** Yes No

**Have you ever taken CBD before?** Yes No If yes, for what issues?_____

Would you be interested in products that can help manage pain, anxiety, inflammation, energy and sleep using natural and non-addictive medicine? Yes or No

**Please list any comments or concerns you have for the Doctor:**

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# Neurological/MRI/Vascular Patient Questionnaire

For any YES answer, please include details.

1. Do you suffer from neck pain, with pain in your shoulder, arms, or hands? NO YES
   Comment: _____
2. Do you have weakness, numbness or burning in your shoulder, arms or hands? NO YES
   Comment: _____
3. Do you have reduced feeling (sensation) or swelling in your hands or arms? NO YES
   Comment: _____
4. Do you suffer from a loss of handgrip strength? NO YES
   Comment: _____
5. Do you suffer from back pain with pain in your buttocks, legs or feet? NO YES
   Comment: _____
6. Do you have weakness, numbness or burning in your buttocks, legs or feet? NO YES
   Comment: _____
7. Do you have reduced feeling (sensation) or swelling in your legs, feet? NO YES
   Comment: _____
8. Do you suffer from cold hands or feet? NO YES
   Comment: _____
9. Do have frequent falls or find that you trip over your feet while walking? NO YES
   Comment: _____
10. Do you suffer from headaches? If yes, how often, how severe, what has been tried? NO YES
    Comment: _____
11. Have you tried any medications such as anti-inflammatory? NO YES
    If yes, what kind of medication?
    _____
12. Have you ever tried any Physical Therapy or Chiropractic treatments before? NO YES
    If yes: When? How long? What kind?
    _____
13. Have you had an MRI? NO YES
    If yes: When? Who ordered it? What was it ordered for?
    _____

**Most patients that come to our office have one of two objectives in mind concerning their health care. Some patients come to simply ease their pain or discomfort (Relief Care). Others are interested in having the cause of the problem, as well as the symptoms corrected (Corrective care). Our team of Doctors will weigh your needs and desires when recommending your treatment plan.**

**Please check the type of care desired so that we may be guided by your wishes whenever possible.**

**Relief Care ___ Corrective Care ___Check here if you want the Doctor to select your care ___**

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# INFORMED CONSENT TO TREATMENT

Physicians, Chiropractors, Osteopaths, and Physiotherapists using manual manipulation are required to advise their patients:

1. With neck problems there have been rare incidents of injury to the vertebral artery during the course of treatment. These have caused STROKES OR STROKE-LIKE occurrences, which are usually of a temporary nature. The chances of this happening are approximately 2 in 1 million treatments.

2. With back or neck problems there have been rare incidents of rib separation or fracture, disc disease and more common pain, bruising, swelling, or aggravation of symptoms.

**APPROPRIATE TESTS WILL BE PERFORMED ON YOU TO MINIMIZE YOUR RISK.**

I hereby consent to the chiropractic treatment indicated as needed and explained to me. If during the course of treatment unforeseen conditions are discovered or unusual conditions develop, I further consent to such additional diagnostic measures and treatment as may be indicated by sound and prudent chiropractic practice which may require additional x-rays, chiropractic, orthopedic, neurological and or laboratory testing, or consulting with another doctor. To get the best result for my condition, the provider may utilize any of the following modalities throughout the course of treatment: Physical rehab, exercise therapies, neuromuscular remodeling, class IV laser, shockwave therapy, spinal decompression, and/or electric muscle stimulation.

No guarantee or warranty has been made to me that results will be to my complete satisfaction.

IF YOU HAVE ANY QUESTIONS ABOUT THIS PLEASE ASK YOUR CHIROPRACTOR.

I HAVE READ THE ABOVE, UNDERSTAND AND CONSENT TO TREATMENT.

_____ _____

**(SIGNATURE)** **(DATE)**

**CONSENT TO TREAT A MINOR:**

I, the undersigned, hereby authorize the doctors of Peak Physical Medicine and Wellness to administer chiropractic care as deemed necessary to my son or daughter (other_____).

_____

**(CHILD'S NAME)**

_____ _____

**(SIGNATURE OF PARENT/GUARDIAN)** **(DATE)**

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# PATIENT FINANCIAL POLICIES

**WORKERS' COMPENSATION.**
Peak Physical Medicine and Wellness does not accept workers' compensation.

**PERSONAL INJURIES/AUTO ACCIDENTS**
Listed below are ways we will accept your personal injury/auto accident case (In order that is most advantageous to the patient):

1. **PIP** – Personal Injury Protection – There is no out of pocket expense and it is a no fault coverage claim on your auto insurance policy. This will not go against your insurance record or affect your premiums.
2. **Attorney** – We can refer you to an attorney if needed. Your expenses may be covered with a "Letter of Protection" from your attorney or legal representative.
3. **Health Insurance** – You accept responsibility for your portion of the services rendered based on your insurance benefits.

If you suspend or terminate care, any fees for services are due immediately.

**GROUP/INDIVIDUAL INSURANCE**
Your health insurance is a contractual agreement between you, your insurance company and Peak Physical Medicine and Wellness. As a courtesy, our office will help you collect from your insurance company for services rendered. It is understood that you are personally responsible for payment of services if your insurance company does not meet their obligation.

**PATIENT'S WITH NO INSURANCE**
We request that each visit be paid in full at the time of service. For convenience payments may be arranged so as to only have to write one check per week. We happily accept MasterCard, Visa, Discover, and AMEX.

**MEDICARE**
Medicare only covers adjustments based on medical necessity. Medicare does not cover any type of physical therapy or rehab. This office is a participating provider and will file claims directly to Medicare.

**REFUNDS**
All refunds will be refunded back to you by check or credit card, through our accounting department and will be refunded no later than 1 week after the refund is requested as long as all insurance applicable has been applied and no other balances are due. This is necessary to give an accurate refund to the patient.

I have read and understand Peak Physical Medicine and Wellness' financial policy and I agree to the terms and conditions of the policy.

_____ _____

**(SIGNATURE)** **(DATE)**

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# APPOINTMENT POLICIES

- Please arrive early to your appointment in order to fill out the appropriate paperwork and allow us time to verify insurance for you.
- We require a **24-Hour notice** to cancel an appointment. If you call on the same day to cancel an appointment, we consider that a No-Show, and you will be charged a $25 fee. You will not be able schedule future appointments until the fee is paid.
- If you No-Show more than 2 appointments, you will not be able to schedule further appointments and unfortunately, we will no longer be able to provide care for you.
- Please be sure to arrive on time for your appointments. If you are more than 15 minutes late, we consider that a No-Show, and you will have to reschedule for another day along with the fee.

_____ _____

**(SIGNATURE)** **(DATE)**

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of this office's Notice of Privacy Practices. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the healthcare providers who may be directly involved in providing my treatment.
- Obtain payment from third-party payors.
- Conduct normal healthcare operations such as quality assessments and accreditation.

_____

**(PLEASE PRINT NAME)**

_____ _____

**(SIGNATURE)** **(DATE)**

**FOR OFFICE USE ONLY:**

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify) _____

STAFF SIGNATURE:_____ DATE:_____