PATIENT INFORMATION FORM

PI ACU CASH WC PT CHIRO

Referring Doctor_____ **Treating Doctor**_____

First Name _____ M.I.___ Last Name _____

Birth Date __/__/____ Age ___ SS#____-___-_____ Male__ Female__ Height____ Weight___

Marital Status_____ Spouse Name_____ DL#/STATE_____

Address _____ City _____ State_____

Zip _____ Home Phone_____ Wk Phone_____

Cell Phone _____Circle Best Contact Phone Number: Home Work Cell

Email _____ Employer _____

Referred By _____ Primary Doctor _____

We may send your primary doctor a status report regarding your condition. Authorization signature _____

Primary Health Insurance _____Secondary/ Other Insurance Co. _____
(Medicare only): Are you receiving home health? _____

I understand and agree that health and accident insurance policies are an agreement between and insurance carrier and me. I authorize payment from my insurance carrier directly to this office with the understanding that all monies be credited to my account upon receipt. I clearly understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment. I understand that if I suspend or terminate my care and treatment, all fees for professional services rendered me will be immediately due and payable. In the event of my default, I promise to pay legal interest on the indebtedness together with such collection costs and reasonable attorney fees as may be required to effect collection. I also authorize the release of any medical or other information necessary to process this claim.

If the insurance company pays me directly I will bring the payment for the treatments along with an explanation of benefit endorsed by my signature to this office promptly.

Patient Signature _____ **Date** _____/_____/_____

I hereby request and consent to physical therapy and/or chiropractic and/or acupuncture treatment for me (or my legal charge) provided by the providers at Back To Wellness. I do not expect the provider to be able to anticipate and explain all known risks and complications, and I wish to rely on the provider to exercise judgment during the course of the procedure, which, the provider determines is in my best interest. I understand that there are some risks to treatment, including but not limited to, fractures, disc injuries, strokes, dislocations, and sprains. .I may request another person of my choice to be present in the treatment room during treatment.

Patient Signature _____ **Date** _____/_____/_____

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice of privacy practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment of health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures or Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities or your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical student's, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition we may use a sign in sheet at the registration desk where you will be asked to sign your name and indicate your physician.. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use and disclose your protected health information in the following situations without your authorization. These situations include: as required by Law, Public Health issues and required by Law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors, and Organ Donation, Research, Criminal Activity, Military, and National Security, Worker's Compensation, Inmates, Required uses and Disclosures, Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken action in reliance on the use or disclosure indicated in the authorization.

Your Rights: Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care of fore notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another health care professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.

You have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before April 14, 2003.

We are required by law to maintain privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPPA Compliance officer in person or by phone at our main phone number.

Signature below is only acknowledgment that you have received this notice of our Privacy Practices.

Print Name:_____ Signature:_____ Date: _____

Doctor's Lien

TO: Attorney _____
_____
_____
_____

Patient Name: _____

RE: Medical Reports and Doctor's Lien

Doctor: _____, D.C.

I do hereby authorize the above doctor to furnish you, my attorney, with a full report of his examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing to him for medical service rendered me both by reason of this accident and by reason of any other bills that are due his office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor. And I hereby further give a lien on my case to said doctor against any and all proceeds of any settlement, judgment or verdict which may be paid to you, my attorney, or myself as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for service rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

Dated: _____ _____
Patient's Signature

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor above named.

Dated:_____ _____
Attorney's Signature:

Mr. Attorney: Please date, sign and return one copy to doctor's office at once. Keep one copy for your records.

Doctor's Lien

TO: Attorney _____
_____
_____
_____

Patient Name: _____

RE: Medical Reports and Doctor's Lien

Doctor: _____, D.C.

I do hereby authorize the above doctor to furnish you, my attorney, with a full report of his examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing to him for medical service rendered me both by reason of this accident and by reason of any other bills that are due his office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor. And I hereby further give a lien on my case to said doctor against any and all proceeds of any settlement, judgment or verdict which may be paid to you, my attorney, or myself as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for service rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

Dated: _____ _____
Patient's Signature

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor above named.

Dated:_____ _____
Attorney's Signature:

Mr. Attorney: Please date, sign and return one copy to doctor's office at once. Keep one copy for your records.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

To: (Provider) _____

Address: _____

I, _____ request the following information:

□ X-rays □ History □ Records □ Diagnosis □ Treatment □ Reports
□ Billings

Concerning my: □ Accident □ Injury □ Illness □ Other _____

From Date: _____ to _____

For the purpose of: _____

Patient Name (Print) : _____

Patient DOB: _____

Signed _____Date:_____

Check one box: □ Patient □ Spouse □ Guardian

To be released to:

Dr. _____

12526 Riverside Drive
Valley Village, CA 91607
Ph. (818) 985-2559
Fax (818) 985-4459

Patient Rights
1. You have the right to revoke this authorization at anytime during the effective dates by sending written notice.
2. You may refuse to sign this authorization without negative consequence to your treatment at this office.
3. You may restrict what is disclosed by this authorization.
4. I understand that the recipient of these records may not lawfully further disclose the health information unless another authorization is obtained from me or unless such use of disclosure is specifically required or permitted by law.
5. You may receive a copy of this authorization.

Automobile Accident Questionnaire

Name: _____

Date of Accident: _____ **Time:** _____:_____ **AM/PM**

Lawyer's Name: _____ **Phone:** _____

Your Car Insurance Co. _____ **Policy#** _____ **Med pay?** _____

Other Vehicle Car Ins. _____ **Policy #** _____**Phone:** _____

Adjuster Name: _____ **Phone:** _____

Your Vehicle: 1) Auto 2) Light Truck 3)Truck 4) Motorcycle 5) SUV 6)Bus 7) _____

Other Vehicle: 1) Auto 2) Light Truck 3)Truck 4) Motorcycle 5) SUV 6)Bus 7) _____

Were You: 1) The driver 2) The Passenger 3) Right Rear 4) Left Rear 5) _____

Were you wearing your seat belt? 1) Yes 2) No **Did the airbags deploy?** 1) Yes 2) No

Where was your vehicle hit? 1) Front 2) Rear 3) Lt. Side 4) Rt. Side 5) _____

Does your vehicle have: 1) adjustable headrest 2) Fixed headrest 3) No headrest

Please indicate how your headrest was positioned: 1) High 2) Centered 3) Low

How was your neck positioned? Circle all that apply:

1) Straight 2) Turned to Right 3)Turned to Left 4) Flexed 5) Extended

How was your back positioned? 1) Against seat 2) Turned to Left 3) Turned to Right

Please describe the accident:

_____

_____

_____

Please Circle the part of body that was injured: 1) Head 2) Neck 3) Shoulder 4) Arm
5) Elbow 6) Wrist 7) Hand 8)Upper Back 9) Lower Back 10) Knee 11) Ankle 12) Foot 13) _____

If you did not see a doctor for the first time within the first two weeks after injury, indicate why? (*Circle all that apply)*

No pain was noticed	No appointment schedule available
No transportation	Work/home schedule conflicts
I thought pain would go away	I had no insurance and couldn't afford it
I self-treated with over-the-counter drugs	Other: _____

Did you receive medical aid at the site of the accident? 1) Yes 2) No

Where did you go after the accident? 1) Hospital 2) Emergency Room 3) Home
4) Work 5) To this office 6) Resumed activities

Name of Hospital: _____

What treatment did you receive? _____

What is the estimated cost of damage to the vehicle you were in? _____

Are your current injuries interfering with your job performance? Missed any work?

_____

Are your current injuries interfering with your lifestyle?

_____

_____ _____

Patient's Signature **Date**

HISTORY FORM

1. Complaint:	severity 1-10	frequency	quality (sharp, dull, achy)
____________________	1 2 3 4 5 6 7 8 9 10	100-75% 75-50% 50-25% 25-0%	____________________
____________________	1 2 3 4 5 6 7 8 9 10	100-75% 75-50% 50-25% 25-0%	____________________
____________________	1 2 3 4 5 6 7 8 9 10	100-75% 75-50% 50-25% 25-0%	____________________
____________________	1 2 3 4 5 6 7 8 9 10	100-75% 75-50% 50-25% 25-0%	____________________
____________________	1 2 3 4 5 6 7 8 9 10	100-75% 75-50% 50-25% 25-0%	____________________
____________________	1 2 3 4 5 6 7 8 9 10	100-75% 75-50% 50-25% 25-0%	____________________

____

Have you had these pains before? ____

Do these complaint/pain radiate or travel (shoot) to any areas of your body? Where?____________________

Do you have any numbness or tingling in your body? Where? ________________________________

Is your complaint getting better, getting worse, or unchanged since it began? ______________________

Is there any daily activity you have difficulty with or can no longer do? __________________________

How long before you can't tolerate each activity? ____________________________________

Does anything aggravate the complaints? ____

Does anything make the complaints better? ____

Additional complaints**:** 1) Difficulty Sleeping 2) Anxiety 3) Memory 4) Fogginess 5) Nausea 6) ________

Did your symptoms develop: 1) Immediately 2) A few hours later 3) Next Day 4) After a few days

2. Previous interventions, treatments, medications, surgery, or care you've sought for your complaint:

____

3. Past Health History:

A. List all previous car accidents, falls, work or sports injuries: ______________________________

____

B. Previous illnesses you've had in your life: ____________________________________

C. Allergies ____

D. Medications:

Medication	Reason for taking
________________________________	________________________
________________________________	________________________
________________________________	________________________

E. Surgeries:

____

4. Family Health History:

Associated health problems of relatives: _____

Deaths in immediate family:

Cause of parents or siblings death	Age at death
_____	_____
_____	_____
_____	_____

5. Social and Occupational History:

A. Job physical demands: _____

B. Recreational activities: _____

C. Sleeping position: _____

D. Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet):_____

_____

Doctors Signature _____ Date _____

PHYSICAL EXAMINATION

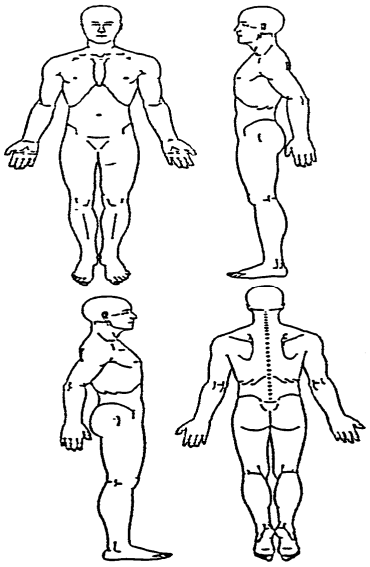
Patient _____ Date _____ BP: P:

□ Mental Status_____ □ Cranial Nerves I-XII _____

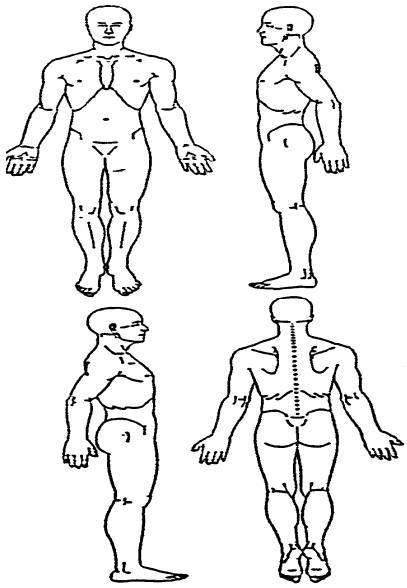
□ Posture _____ □ Distress _____

□ Gait _____ □ Antalgic position _____

□ Muscle Spasm / Joint Pain



□ Muscle Weakness



Lumbar □

_____ Flexion (90) □ P end ROM

_____ Extension (30) □ P end ROM

_____ _____ Lat flexion (30) □ □ P end ROM

_____ _____ Rotation (30) □ □ P end ROM

Cervical □

_____ Flexion (45) □ P end ROM

_____ Extension (55) □ P end ROM

_____ _____ Lat flexion (45) □ □ P end ROM

_____ _____ Rotation (70) □ □ P end ROM

Other □

_____ _____ Flexion ( )

_____ _____ Extension ( )

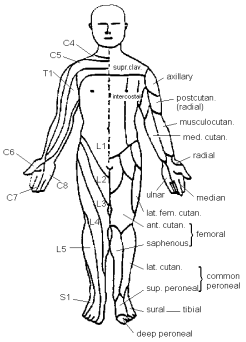
_____ _____ Internal rotation ( )

_____ _____ External rotation ( )

_____ _____ Abduction ( )

_____ _____ Adduction ( )

□ Dermatomes



□ Reflexes

Biceps		
Triceps		
Brachiorad		
Pateller		
Achillis		

□ Heel walk L3, **L4, L5**
□ Toe walk S1
□ Finger to nose
□ Trendelenburg
□ Cervical resistive muscle tests
□ Cervical compression neutral, max □ L, □ R
□ Cervical distraction
□ Shoulder depression
□ Shoulder abduction
□ Soto Hall / Brudzinski's
□ Allen's (posterior scalene)
□ Adson's (anterior scalene)
□ Eden's (costoclavicular)
□ Wright's (pectoralis minor)
□ Spinous percussion
□ Dynamometer
□ Active cervical flexion (supine)
□ Valsalva
□ O'Donoghues

□ Leg length (visualized) FIXATIONS
□ Kemp's
□ SLR
□ Braggard's
□ Goldthwait's
□ Patrick Fabere's
□ Thomas
□ Gaenslen's
□ Yeoman's
□ SI distraction
□ Active hip abduction
□ Sit up
□ Dejerines's Triad
□ Nachlas, Ely's, Hibb's
□ Milgram
□ Active hip extension
□ Minor's Sign
□ _____
□ _____

Assessment: _____

Plan: ____ **X** a week □ Based on medical necessity □ As prescribed by PTP □ As long as symptoms □ Maintenance

Prognosis: □ Excellent □ Good □ Fair □ Poor □ Guarded □ Complicating factors: _____

Short-term goals: ↓ Ms. Spasm ↓ Inflamm. ↑ ROM ↓ Pain In: 1 wk 2 wk 3 wk 4 wk

Long-term goals: ↑ Function ↑ Strength ↑ Balance ↑ ADLs ↑ Stability In: 4 wk 6 wk 8 wk

Functional goals: Inc. Sitting _____ Standing_____ Bending_____Grooming_____Stairs_____ Driving____ Sleeping_____

Chores_____ Physical goals_____

Treatment: □ Manual Therapy □ Therapeutic Exercise □ Kinetic Activities □ Gait Training □ NMS Reed. □ Traction
□ Ultrasound □ Physical perf. Test □ Electrical Stim □ Spec. Man. Th □ Massage □ _____

The patient was referred/dispensed _____

The patient was instructed _____

Treatment Plan: Cervical Thoracic Lumbar Shoulder Elbow Wrist Hip Knee Ankle _____

□ Acute phase protocol □ Progress from passive to Active Tx. □ Reeducate proper muscle activity □ Increase strength/stability