Achieve Improved Motion

NEW PATIENT INFORMATION

Name: _____ Date: _____

Female ☐ Male ☐ Age: _____ Date of Birth: _____

Preferred Language: ☐ English ☐ Spanish ☐ Other: _____

Race: ☐ White ☐ African-American ☐ Other: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Email: _____ SSN: _____

Employer: _____ Occupation: _____

Emergency Contact: _____ Relation: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

May we forward our findings to your primary care doctor? ☐ Yes ☐ No

How did you hear about our office? _____

Have you had chiropractic care before? ☐ Yes ☐ No

Region(s) of Complaint: _____ ☐ New ☐ Recurring

When did your condition begin? _____

Any other Doctors seen for this condition? _____

Any prior diagnostic imaging (X-Ray, MRI, CT Scan, etc.) for this complaint? ☐ Yes ☐ No

How would you describe your pain and/or symptoms? (check all that apply)

☐ Sharp ☐ Dull ☐ Burning ☐ Stabbing ☐ Achy ☐ Numb ☐ Other: _____

How would you rate the current severity of your pain? (circle one)

0 1 2 3 4 5 6 7 8 9 10

MEDICAL HISTORY

Current Medication(s): _____

Allergies (Medicine, Food, Environment): _____

Previous Surgeries: _____

Do you have a PERSONAL history of: ☐ Cancer ☐ Diabetes ☐ Heart Disease ☐ Stroke

Any other serious illnesses: _____

Check all symptoms that may apply to you:

☐ Headache ☐ Neck Pain/Stiffness ☐ Loss of Balance/Dizziness ☐ Chest Pain

☐ Shoulder Pain ☐ Shortness of Breath ☐ Unexplained Weight Loss ☐ Blurred Vision

☐ Back Pain/Stiffness ☐ Hip Pain ☐ Fever ☐ Night Pain ☐ Night Sweats ☐ Fatigue

☐ Tingling/numbness in arms/hands ☐ Tingling/numbness in legs/toes ☐ Blood in Urine

☐ Knee Pain ☐ Seizures ☐ Pain Unrelieved by Rest ☐ Bowel/Bladder Incontinence

☐ Other: _____

For Women Only:

Are you Pregnant? ☐ Yes ☐ No

PRIMARY HEALTH INSURANCE

Insurance Company: _____ Member ID#: _____

Policyholder Name (Self or Other): _____ Group ID#: _____

DOB: _____ Plan Type: _____

SECONDARY HEALTH INSURANCE (*OPTIONAL*)

Insurance Company: _____ Insurance ID#: _____

Policyholder Name (Self or Other): _____ Group ID#: _____

DOB: _____ Plan Type: _____

Is this injury related to a motor vehicle accident (MVA), a work-related incident, or a slip and fall?

☐ Yes ☐ No

If answered “yes”, are you currently being represented by a lawyer or are you involved in any litigation? If so, please explain.

_____

COVID-19 SCREENING

1. Are you currently experiencing any symptoms such as fever or chills, cough, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, or diarrhea?

☐ Yes ☐ No If yes, explain: _____

2. Have you traveled outside of Connecticut within the past 14 days, and if so, where did you travel?

☐ Yes ☐ No If yes, explain: _____

3. Have you or anyone else in your household tested positive for COVID-19 or have you knowingly been in close contact with a COVID-19 positive individual?

☐ Yes ☐ No If yes, explain: _____

Please add any additional information that you feel is important for your provider to know.

_____
_____
_____
_____

COVID-19 GUIDELINES

A face-cloth covering or mask is required for your appointment. We strongly ask that you sanitize your hands upon entering the facility as there will be hand sanitizer available in the lobby. The chairs in the lobby are strategically spread out to enforce adequate social distancing. A staff member will record your temperature before you are allowed to enter the clinic area. All tables and equipment are sanitized and cleaned in between patients. It is mandatory that you continue to wear a face-cloth covering or mask unless determined otherwise by your clinician. Thank you for cooperating with our practice guidelines as we attempt to maintain a safe and clean environment for all our patients and employees!

EMAIL/TEXT COMMUNICATION

You can opt to receive emails and/or texts to keep you informed of new bookings, changes to your bookings, and reminders for upcoming appointments.

☐ I would like to receive email notifications of new, cancelled, or rescheduled appointments.

☐ Email 2 days before appointment.

☐ Text message (SMS) 2 days before appointment.

☐ I would like to decline the option to receive email or text notifications.

CONSENT FORMS

Accuracy of Information

☐ I certify that the above medical information is correct to my knowledge.

Privacy and Sharing of Information

I authorize Achieve Improved Motion LLC and its associated health professionals to collect my personal and medical information as documented above. In addition, I authorize the clinic and its associated health professionals to communicate with my family doctor and/or referring doctor as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission. I further authorize them to disclose all or any part of my (patient's) record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or a family member or employer of the patient for all or part of the clinic's charge, including, and not limited to hospital or medical services companies, insurance companies, worker's compensation carriers, welfare funds, or the patient's employer.

☐ I agree

Insurance Information and Patient Financial Responsibility Statement

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. I understand that if an insurance company initially pays for my treatment and later requests reimbursement from Achieve Improved Motion LLC for any reason, I will be responsible for payment of my entire outstanding balance.

☐ I agree

Cancellation Policy

Your appointment time is reserved just for you. A late cancellation or missed visit leaves a hole in the therapists' day that could have been filled by another patient. As such, we require 12 hours notice for any cancellations or changes to your appointment. Patients who provide less than 12 hours notice, or miss their appointment, will be charged a cancellation fee of $25.

☐ I am aware of the cancellation policy.

Consent of Professional Services

I hereby authorize Achieve Improved Motion LLC and their affiliated providers to administer treatment, physical examination, X-ray studies, laboratory procedures, chiropractic care, or any clinic services that they deem necessary in my case; I do hereby give my consent for the performance of conservative non-surgical treatment, including, but not limited to manipulation, therapeutic modalities, soft-tissue massage and therapeutic exercises. I am aware there are possible risks and complications associated with these procedures, ranging from soreness to stroke. I understand there is no certainty that I will achieve benefits and acknowledge that no guarantee has been made regarding the outcome of these procedures.

☐ I agree

We invite you to discuss any questions you might have with us. The best health services are based on a friendly mutually understood relationship.

Patient's or Guardian's Signature: _____ Date: _____

CONSENT TO TREAT A MINOR (IF PATIENT IS UNDER 18)

I (we) being the parent, guardian or custodian of the minor being _____, age _____, do hereby authorize, request and direct Achieve Improved Motion LLC, it's doctors and staff to perform examinations, diagnostic x-rays, laboratory tests, and any treatment that in their judgment, is deemed advisable or required. It is the understanding of the undersigned that the physicians and their staff will have full authority from me as legal parent/guardian to continue with examinations, diagnostic tests, and treatments as will be needed while said minor shown above is under care in this office until legal age is attained.

As legal parent/guardian, I realize full responsibility for all charges and payments due.

Parent/Guardian or Custodian Signature: _____ Date Signed: _____

Witness _____