NEW PATIENT QUESTIONNAIRE

Name:____
Primary Phone:__________________ **Secondary Phone**___________________
Address:____
City:_______________________ **State:** ________ **Zip:**__________________
Social:_____________________________
Age:_____________________ **DOB:**___________________
Height:__________________ **Weight:**__________________
Primary Physician: _______________________________
Referral Source:__________________________________
Email Address:____________________________________

HISTORY

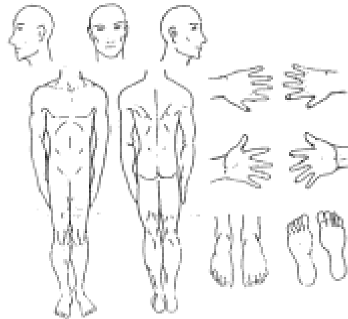
Chief Complaint:____
Where is your pain located:____
Describe your Pain:

☐ Sharp	☐ Burning	☐ Achy	☐ Twisting	☐ Pressure
☐ Deep	☐ Dull	☐ Heavy	☐ Gnawing	☐ Shooting
☐ Electric	☐ Knife like			

How severe is your pain?

☐ 0 Absent (no pain)
☐ 1-2 Tolerable (tolerate without medication)
☐ 3-4 Bearable(some activities
☐ 5-6 Nearly intolerable(sedentary: watch tv, reading, sitting)
☐ 7-8 Intolerable (Can not read, watch TV, need to visit ER)
☐ 9-10 Devastating (need hospitalization for pain control)

Please Mark the figure with the location of your symptoms:
Pain=X Numbness/Tingling= O



How long have you had your pain:____
When do you have your pain:____
What makes your pain worse:____
Are you having difficulty with sleeping because of your pain: Y ☐ **N** ☐
How long can you:____Sit:______________ Stand:____________Walk:_____________
Have you lost any control over bowel or bladder function: Y ☐ **N** ☐
Is your pain related to a specific injury: Y ☐ **N** ☐
if yes please explain:____
Is the injury/pain motor vehicle related: Y ☐ **N** ☐
if yes, date of injury ______________________
Is injury/pain work related: Y ☐ **N** ☐
Is there a lawsuit (pending or considered): Y ☐ **N** ☐
Have you had any physical therapy (PT): Y ☐ **N** ☐
How many sessions?_____________________
Has PT helped? **Y** ☐ **N** ☐
Have you been treated by other clinicians for this problem: Y ☐ **N** ☐
If yes, please list name, date seen, and treatment given:
____
Have you had epidural or facet injections: Y ☐ **N** ☐
How many_________________ Did they help:________________________________
Have you had a previous back or neck injury: Y ☐ **N** ☐
Have you had diagnostic test performed:
☐ CT ☐ EMG ☐ XRAY ☐ Other:________________________________
What do you hope/wish we can accomplish today:__________________________
____

WORK HISTORY

Are you working: Y ☐ **N** ☐
☐ Full Time ☐ Part Time☐ Restricted Duty:_________________________
☐ Unemployed/Date last worked:______________________
Occupation:____
Employer:____
How long:____

MEDICATIONS

List all medications that you *currently* take:______________________________
List any medications that you have *previously* taken and if they did or did not help:____
Medicine Allergies: Y ☐ **N** ☐
Please list:____

PAST MEDICAL HISTORY

Please check the boxes that apply

- ☐ Psychiatric Problem
- ☐ High Blood Pressure
- ☐ Liver Disease/Hepatitis
- ☐ Seizure Disorder
- ☐ Asthma
- ☐ Anemia
- ☐ Alcoholism
- ☐ Gout
- ☐ Tuberculosis
- ☐ Pneumonia
- ☐ Arthritis
- ☐ Cancer
- ☐ Psoriasis
- ☐ Lung Disease
- ☐ Bleeding Disorder
- ☐ Muscle Disease
- ☐ Ulcers
- ☐ Pulmonary Embolism
- ☐ Deep Vein Thrombosis
- ☐ Thyroid Disorder
- ☐ Kidney Disease
- ☐ Heart Disease
- ☐ GERD
- ☐ High Cholesterol
- ☐ Stroke
- ☐ Anxiety
- ☐ Heart Murmur
- ☐ Diabetes
- ☐ Rheumatoid Arthritis
- ☐ Depression
- ☐ Heart Attack
- ☐ Rheumatic Fever
- ☐ Migraines
- ☐ Other:____________________

PAST SURGICAL HISTORY

List any previous surgeries:____

FAMILY HISTORY

Please list any medical illness that the following blood relatives have history of

Grandparents:____

☐ Living ☐ Deceased

Father:____

☐ Living ☐ Deceased

Mother:____

☐ Living ☐ Deceased

Brother/Sister:____

☐ Living ☐ Deceased

SOCIAL HISTORY

Marital Status:

☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow

Number of Children:__________________________

Ages:________________________

Do you smoke: Y ☐ **N** ☐

How much:________________________

How long:_________________________

Previous smoker: Y ☐ **N** ☐

When did you quit:____________________________

Do you drink: Y ☐ **N** ☐

How many drinks per week:__________________________________

Do you use recreational drugs: Y ☐ **N** ☐

If yes, what type:____

REVIEW OF SYSTEMS

Please check all that apply

Constitutional

☐ Fever ☐ Chills ☐ Fatigue ☐ Night Sweats
☐ Unexplained weight loss/gain ☐ None

Skin

☐ Rashes ☐ Nail Changes ☐ Easy Bruising ☐ Color Changes
☐ Jaundice ☐ Infections ☐ None

Eyes/Ears/Nose/Throat

☐ Vision Changes ☐ Hearing Loss ☐ Dizziness/Vertigo
☐ Ringing in the ear ☐ Hoarseness ☐ Difficulty Swallowing
☐ Discharge/Drainage ☐ None

Cardiovascular

☐ Chest Pain ☐ Palpations ☐ Leg Swelling ☐ None

Respiratory

☐ Coughing up blood ☐ Wheezing ☐ Shortness of Breath
☐ Cough ☐ Sputum ☐ Production
☐ Recent Infection ☐ None

Gastrointestinal

☐ Abdominal pain ☐ Vomiting with Blood ☐ Nausea
☐ Blood in Stool ☐ Constipation ☐ Diarrhea ☐ None

Genitourinary

☐ Painful Urination ☐ Blood in urine ☐ Venereal Disease
☐ Difficulty urinating ☐ Sexual problems ☐ Menstrual Problems
☐ Pregnant ☐ Menopausal ☐ None

Musculoskeletal

☐ Joint swelling ☐ Stiffness ☐ Cramping
☐ Infection ☐ None

Endocrine

☐ Changes in urination ☐ Changes in heat or cold tolerance
☐ Changes in appetite/thirst/sweating ☐ None

Psychiatric

☐ Depression ☐ Anxiety ☐ Suicidal Thought
☐ Mood Changes ☐ None

______________________________ ______________________________

Patient Signature **Physician Signature**

______________________________ ______________________________

Date **Date**

Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by Bates Chiropractic or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk.

Requesting a Restriction on the Use or Disclosure of Your Information

Your may request a restriction on the use or disclosure of your Protected Health Information.
This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change Privacy Practice

This office reserves the right to modify the privacy practices outlined in the Notice.

Signature

I have reviewed this consent form and give my permission to this office to use and disclose my health information in accordance with it.

____
Name of Patient (Print)

____
Signature of Patient Date

____
Signature of Patient Representative

____
Relationship of Patient Representative to Patient

____
Office Representative Date

OFFICE POLICY ON FEES AND INSURANCE CLAIMS

If, by mutual agreement, we are filing your insurance, we need to inform you that you are entering a relationship with the doctor in which the doctor agrees to treat the patient and the patient agrees to pay the doctor's fee for that treatment. The insurance company has no relationship with the doctor. If we contact your insurance company and are informed that insurance benefits are available for the treatment recommended, we will file your claim for you. We are responsible only to file your claim and answer any medical questions they may have.

Insurance companies give estimates and benefits over the telephone, but these are only estimates and are not always accurate nor a guarantee of payment. You will be responsible for your yearly deductible, co-payment and/or co-insurance and the portion of the charges your insurance carrier does not cover or lists as a "non covered" expense. If your insurance company does not pay within sixty (60) days, your bill is due and payable immediately.

____ ________________

Name (please print) Date

____

Signature of Responsible Party

ASSIGNMENT AND RESPONSIBILITY

I hereby assign to Dr. Bates all of my rights, title and interest to my medical reimbursement benefits under my insurance policy with my insurance company. I further permit a copy of this authorization to be used in place of the original. **I understand that I am financially responsible for all charges whether or not paid by my insurance carrier.** If the insurance company does not pay within sixty (60) days, I understand the balance is due immediately and agree to pay in full.

________________________________ ________________

Signature of Responsible Party Date

OUT OF NETWORK

I understand if Dr. Bates is not preferred providers for my insurance company and that out of network benefits will apply. This may include, but not limited to, such things as a deductible, higher deductible and/or higher co-pay, reduced benefits.

________________________________ ________________

Signature of Responsible Party Date

NON-INSURANCE PATIENTS

I understand that I will be responsible for all services rendered and will pay at the time of service in full.

________________________________ ________________

Signature of Responsible Party Date

ACKNOWLEDGEMENT FORM

I acknowledge that Bates Chiropractic and Sports Therapy “Notice of Privacy Practices” has been provided to me.

I understand I have a right to review Bates Chiropractic Notice of Privacy Practices prior to signing this document. Bates Chiropractic Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of bills or in the performance of health care operations of Bates Chiropractic, The Notice of Privacy Practices for Bates Chiropractic website at www.bateschirosport.com. This Notice of Privacy Practices also describes my rights and Bates Chiropractic duties with respect to my protected health information.

Bates Chiropractic reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing Bates Chiropractic website, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

____

Signature of Patient or Personal Representative   Date

____

Name of Patient or Personal Representative (Print)

____

Description of Personal Representative’s Authority

____

Name of Privacy Officer

CANCELLATION/NO SHOW POLICY AGREEMENT

Bates Chiropractic and Sports Therapy is committed to providing all of our patients exceptional care. When a patient doesn’t show after confirming or cancels without giving enough notice, they prevent another patient from being seen.

Please call us at (318) 220-8753 or text us at (318) 379-4229 within 24 hours notice on the day prior to your scheduled appointment to notify us of any changes or cancellations. ***To cancel a Monday appointment, please call or text us by 12:00pm on Friday.*** If prior notification is not given, you will be charged **$25.00** for the missed appointment.

Please sign below to consent to theses terms.

___________________________________   __________

Signature of patient or Responsible party   Date

CONSENT FOR TREATMENT

Health care provider are required to advise patients of the nature of the treatment to be provided, the risks, and the benefits of the treatment, and any alternatives to the treatment.

There are some risks that may be associated with treatment, in particular you should note:

a. While rare, some patients have experienced rib fractures or muscle and ligament sprain/strains following treatment.

b. There have been rare reported cases of disc injuries following cervical and lumbar spinal adjustment although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal or soft tissue manipulation or treatment.

c. There have been reported cases of injury to a vertebral artery following osseous spinal manipulation. Vertebral artery injuries have been known to cause a stroke, sometimes with serious neurological impairment, an may, on rare occasion, result in paralysis or death. The possibility of such injuries resulting from cervical spine manipulation is extremely remote.

Osseous and soft tissue manipulation ha been the subject of government reports and multi-disciplinary studies conducted over many years and have demonstrated it to be highly effective treatment of spinal conditions including general pain and loss of mobility, headaches, and other related symptoms. Musculoskeletal care contributes to your overall well being. ***The risk of injuries or compilations from treatment is substantially lower than that associate with many medical or other treatments, medications, and procedures given for the same symptoms.***

I acknowledge I have discussed the following with my healthcare provider:

a. The condition that the treatment is to address

b. The nature of the treatment.

c. The risk and benefits of that treatment; and

d. Any alternatives to that treatment.

I have had the opportunity to ask questions and receive answers regarding the treatment.

I consent to the treatment offered or recommended to me by my healthcare provider, including osseous and soft tissue manipulation. I intend this consent to apply to all present and future care with **Bates Chiropractic & Sports Therapy.**

Dated this ____________ Day of ________________ 20____________.

_______________________________ _______________________________

Signature Patient Name (Legal Guardian) Signature of Witness

_______________________________ _______________________________

Print Name Print Name

Bates Chiropractic & Sports Therapy
7591 Fern Ave Suite 1502
Shreveport, LA 71105
www.bateschirosport.com

**Changes in Medical Insurance Carriers
Beginning September 19, 2017**

Listed below is the only insurance I will be accepting after September 19, 2017. If your insurance company is listed below payment procedure will remain the same. If you have any other medical insurance, listed below are the prices for the services.

INUSRANCE ACCEPTED:
Blue Cross Blue Shield

OTHER INSURANCES:
New Patient: $100-153
Follow Up Visit: $50-$85

Please sign and date this form stating you are aware and understand the changes that are being made regarding medical insurance carriers and payment amounts.

____
Date

____
Print Name

____
Witness Name

____
Signature

____
Witness Signature