PN:_____ MRN:_____

Medical History Intake

Family/Personal History

Patient Name:_____ DOB:_____ Age:_____
Employer:_____ Phone #:_____
Employer Address:_____
Emergency Contact/Relationship:_____ Phone #:_____
Family Physician:_____ Surgery: Yes / No If yes, date of surgery:_____
Are you currently taking any prescription or non-prescription medication: Yes / No
List all medication you are currently taking:_____
Are you allergic to: Medications Latex Adhesive
List all allergies:_____
Do you have a family history of: Cancer High Cholesterol Diabetes Heart Attack High Blood Pressure

Personal History

Do you have or ever had? Yes

Cancer:_____----☐
Shortness of Breath----☐
Chest Pain (Angina)----☐
Night Sweats----☐
Pain that wakes you from sleep----☐
Weight Loss----☐
High Blood Pressure----☐
Coronary Artery Disease----☐
Heart Attack----☐
Blood Clot----☐
Stroke or TIA----☐
Do you have a pacemaker----☐
Irregular Heartbeat----☐
Anemia----☐
Ulcer/Stomach problems----☐
High Cholesterol----☐

Diabetes----☐
Vision/Hearing Problems----☐
Thyroid Disease----☐
Fatigue ----☐
Depression----☐
Emotional/Psychological Dx---☐
Bowel/Bladder Problems----☐
Numbness/Tingling----☐
Joint Replacement----☐
Pins or Metal Implants----☐
Foot/Ankle Injury/Surgery----☐
Knee Injury/Surgery----☐
Neck Injury/Surgery----☐
Hepatitis----☐
Varicose Veins----☐

Shoulder Injury/Surgery----☐
Osteoporosis----☐
Osteopenia----☐
Epilepsy/Seizure----☐
Gout----☐
Weakness----☐
Do you smoke---- ☐
Are you pregnant ---- ☐
Recently given birth----☐
Chemical dependency----☐
Eating disorder----☐
Anxiety/Panic attacks----☐
Asthma/Breathing problem-☐
Pneumonia----☐
HIV/AIDS----☐

Have you fallen in the past year?	Yes	No
Did you sustain an injury from the fall?	Yes	No
Have you had two or more falls in the past year?	Yes	No

Patient Signature:_____ Date_____

PN:_____ MRN:_____

Patient Health Questionnaire - PHQ

ACN Group, Inc. - Form PHQ-202

ACN Group, Inc. Use Only rev 7/18/05

Patient Name_____ **Date** _____

1. Describe your symptoms _____

_____

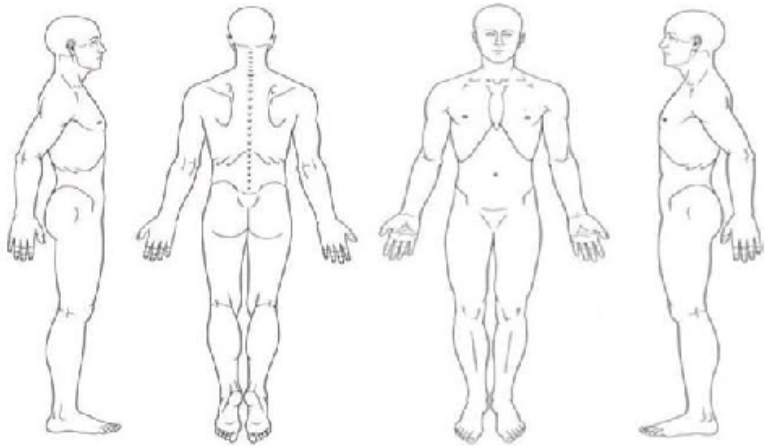
a. When did your symptoms start? _____

b. How did your symptoms begin? _____

2. How often do you experience your symptoms?

① Constantly (76-100% of the day)
② Frequently (51-75% of the day)
③ Occasionally (26-50% of the day)
④ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?

① Sharp ④ Shooting
② Dull ache ⑤ Burning
③ Numb ⑥ Tingling

4. How are your symptoms changing?

① Getting Better
② Not Changing
③ Getting Worse

5. During the past 4 weeks:

a. Indicate the average intensity of your symptoms

None ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Unbearable

b. How much has pain interfered with your normal work (including both work outside the home, and housework)

① Not at all ② A little bit ③ Moderately ④ Quite a bit ⑤ Extremely

6. During the past 4 weeks how much of the time has your condition interfered with your social activities?
(like visiting with friends, relatives, etc)

① All of the time ② Most of the time ③ Some of the time ④ A little of the time ⑤ None of the time

7. In general would you say your overall health right now is...

① Excellent ② Very Good ③ Good ④ Fair ⑤ Poor

---

8. Who have you seen for your symptoms?

① No One ③ Medical Doctor ⑤ Other
② Chiropractor ④ Physical Therapist

a. What treatment did you receive and when? _____

b. What tests have you had for your symptoms and when were they performed?

① Xrays *date:* _____ ③ CT Scan *date:* _____
② MRI *date:* _____ ④ Other *date:* _____

9. Have you had similar symptoms in the past? ① Yes ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

① This Office ③ Medical Doctor ⑤ Other
② Chiropractor ④ Physical Therapist

10. What is your occupation?

① Professional/Executive ④ Laborer ⑦ Retired
② White Collar/Secretarial ⑤ Homemaker ⑧ Other
③ Tradesperson ⑥ FT Student

_____

a. If you are not retired, a homemaker, or a student, what is your current work status?

① Full-time ③ Self-employed ⑤ Off work
② Part-time ④ Unemployed ⑥ Other

Patient Signature_____ **Date** _____

PN:_____ MRN:_____

Rocky Mountain Spine and Sport
Cancellation/No Show Policy
and
Notice of Privacy Practices

The Staff at *Rocky Mountain Spine and Sport* work hard to provide quality care and to give each patient the time required for their condition. We offer early morning and evening hours for those whose schedules do not allow treatment during the day.

As our business grows, it becomes increasingly important that we continue to offer treatment time slots that are as convenient as possible to our patients. **It is equally important that if you wish to cancel or reschedule an appointment that we receive at least *24 hours* notice so that we can call and schedule patients from our waiting list.** We do realize that scheduling conflicts and emergency situations occasionally arise and we will do our best to excuse these special circumstances.

A ***$50 Cancellation/No Show Fee*** will be charged to you directly. These fees ***cannot*** be billed to insurance.

A voice message on our phone is an acceptable means of communicating a cancellation.

Thank you in advance for your consideration.

I have read and understand *Rocky Mountain Spine and Sports* Cancellation and No Show policy.

_____ _____
Patient/Responsible Party Signature **Date**

Notice of Privacy Practices

I hereby acknowledge that I have read and received Rocky Mountain Spine and Sport, LLC's Notice of Privacy Practices.

_____
Printed Name of Patient

_____ _____
Signature of Patient or Guardian Date

PN:_____ MRN:_____

Communication Preferences

Patient Name: _____ Date: _____

Date of Birth: _____ (If patient is 18 or under, must supply Parent/Guardian Info)

Guardian/Parent Name: _____

In caring for our patients, it may be necessary for our practice to contact you by automated calls to leave a message or text. When you are not available to speak to directly, we like to leave messages when possible. In order to protect your privacy, it is our policy to not leave specific information on an answering machine/voice mail system, unless we have permission to do so.

Please check applicable way for us to reach you/leave messages for you.

[ ] **YES**, call me on this phone number and leave a voice mail: _____

[ ] **YES**, text me on this mobile phone number *:_____(mobile phone)

[ ] **YES**, email me at this email address: _____

[ ] **NO,** I do not give consent for you to leave a voice message or text me with appointment reminders.

If you have any questions please call us at the clinic.

* Data and Messaging Rates May Apply

See Notices/Policy Section for full Communications Disclaimer.

By signing below, you are expressly consenting to receive text, email, and/or phone messages regarding appointment reminders, confirmations, surveys, and other communications specific to your or your child's care.

Patient/Guardian Signature: _____ Date: _____

Insurance Explanation

If you have a Deductible that you have not met, we will collect $45.00 at the time of your visit. This amount is applied to your bill and goes toward you deductible. YOU WILL GET A BILL for the remainder once your insurance has processed the claim. It can take up to an average of 60 days for insurance to process claims. You can expect anywhere from +/-100 to +/-250 a visit. If your Deductible is met, then the Coinsurance/Out of Pocket information below will apply.

If you have an Out of Pocket that you have not met, we will collect a portion of your responsibility / Co-insurance at the time of your visit. For example: if your insurance covers 80% and your Co-insurance/ responsibility is 20%, we will take $20.00 and this is applied to your bill and goes toward your Out of Pocket. YOU WILL GET A BILL for the remainder once insurance has processed the claim.

If you have true Co-Pay, you pay the Co-Pay at the time of your visit. We have seen some insurances that do not cover all of the charges for the Initial Evaluation. You may get a bill for this.

The most common treatment/ CPT codes we use are:

97162 - Initial Evaluation
97110 - Therapeutic Exercise
97112 - Neuromuscular Re-Education
97140 - Manual Therapy
97530 - Therapeutic Activities
97535 - Self Care, Self Management Training

Patient Name Date