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**Patient Information:** Please completely answer the following information

Name:_____ Date: _____

SSN:_____DOB:_____ Name of Spouse:_____

If Minor name of Parent(s) or Guardian:_____Email address_____

Home Phone:_____Cell Phone:_____Work Phone:_____

Address:_____City:_____State:_____Zip:_____

Employer:_____Occupation:_____

EmployerAddress:_____City:_____State:_____Zip:_____

If you are a full time student, school name:_____Grade:_____

Who can we thank for referring you?_____

Who is your Primary Care Physician?_____Address_____

Phone #:_____May we have your permission to update your medical doctor regarding your care at this office?_____

**Person Responsible for Account:** [ ] Patient [ ] Mother/Father [ ] Spouse [ ] Guardian

Name:_____ [ ] Same Address as Patient

Home Phone:_____Cell Phone:_____Work Phone:_____

Address:_____City:_____State:_____Zip:_____

**Emergency Contact NOT Living With You:**

Name:_____Relationship:_____

Address:_____City:_____State:_____Zip:_____

Home Phone:_____Cell Phone:_____Work Phone:_____

**Insurance Information:** Please completely answer the following information

**Primary Insurance**

[ ] Patient [ ] Mother/Father [ ] Spouse

Policyholder Name:_____

SS#:_____DOB:_____

Insurance ID #:_____

Employer:_____

Insurance Company:_____

Group#:_____Phone #_____

**Secondary Insurance**

[ ] Patient [ ] Mother/Father [ ] Spouse

Policyholder Name:_____

SS#:_____DOB:_____

Insurance ID #:_____

Employer:_____

Insurance Company:_____

Group#:_____Phone #:_____

**For Office Use Only**

**[ ] Posted _____ [ ] Insurance Card Received _____**

Patient Name:_____ Date:_____

## Insurance Disclaimer, Payment and Treatment Authorization:

Medical insurance plans have exclusions, these help keep premiums low for your employers. This makes your medical plan a supplemental coverage for your medical needs and not designed to cover your treatment in its entirety. Dr. DeArmon's goal is to identify, recommend and create a treatment plan in your best interest. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I authorize and give consent for payments to be directly made to ProActive Sport and Spine. I understand that I am responsible for all medical costs regardless of my medical coverage. All information provided by me on my patient information and health history are correct to the best of my knowledge. I grant the right to ProActive Sport and Spine to release my medical information to third party payers and/or other health professionals. I understand ProActive Sport and Spine works with the District Attorneys office when fraudulent funds are issued. Service charges may apply to my account in addition to any NSF Check Fee. In the case of default of payment, I promise to pay any legal interest on the balance due, together with collection costs and just attorney fees incurred to collect on my account or future outstanding accounts. I understand that payment is due at the time services are rendered. I am aware of ProActive Sport and Spine's 24 hour cancellation policy. I understand if I cancel an appointment without giving the requested 24 hour notice, my account will be assessed a $25 fee.

## Notice of Privacy Practice Acknowledgement

The following is a summary of the guidelines ProActive Sport and Spine uses to protect your personal healthcare information. Inquire at the front desk if you would like to review our Notice of Privacy Practices which contains a more complete description of the uses and disclosures of your health information. I understand that ProActive Sport and Spine has the right to change their Notice of Privacy Practices from time to time and I may contact ProActive Sport and Spine at any time to obtain a current copy of the notice. I understand that I may request in writing that ProActive Sport and Spine restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

-Obtain payment from third party payers.
-Conduct normal healthcare operations such as quality assessments and physician certifications.
-Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

## Consent for Release of Medical Information

ProActive Sport and Spine will not release your information to anyone except you without your written consent unless such release of information is mandated by law. I grant ProActive Sport and Spine permission to contact me via email and/or leave messages pertaining to my chiropractic care (including calling to remind me of appointments, to inform me of referral appointments) by a recording device or with the following persons (please consider listing spouse, parents, step-parents, grandparents, children, secretary etc). This consent will remain in effect throughout our doctor-patient relationship unless withdrawn in writing by the patient. I am aware that signing this form may cause disclosure of confidential or privileged information to those designated by me. Information can be released to the following individuals:

Name:_____ Name:_____

Name:_____ Name:_____

**Patient Signature:**_____ **Date:**_____

**ProActive Sport & Spine Financial Review**

Deductible, co-payment or co-insurance is due at the time of service. We accept cash, check, VISA, Mastercard and Discover. I understand that these benefits were confirmed by my insurance company and are not a guarantee of payment for the services rendered. According to my policy, claims are considered when they are received by the insurance company and are subject to their terms. I assign Dr. DeArmon proceeds of the insurance policy for the services rendered. I agree that if my insurance company denies the claims, I am responsible for the entire bill, not just my deductible, co-pay or co-insurance.

Signed: _____ Date: _____

# Patient Health Questionnaire

ProActive SPORT & SPINE

*Patient Name* _____ *Date* _____

*1. When did your symptoms start:* _____ *Describe your symptoms and how they began:*

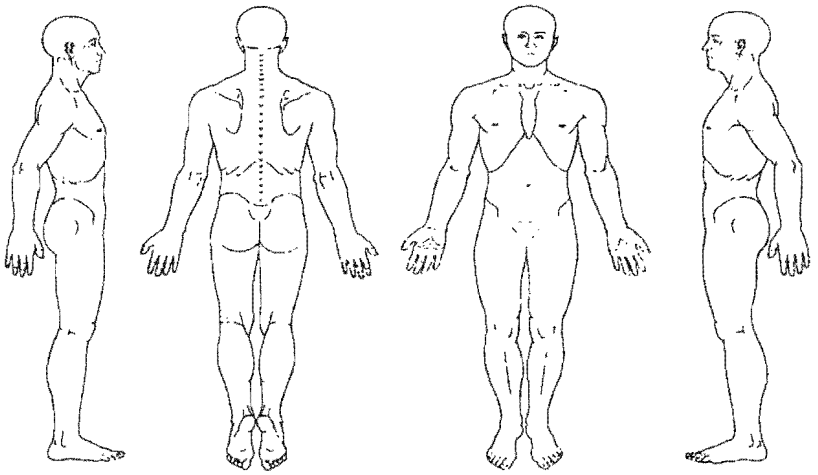
_____

_____

*2. How often do you experience your symptoms?*

- ☐ Constantly (76-100% of the day)
- ☐ Frequently (51-75% of the day)
- ☐ Occasionally (26-50% of the day)
- ☐ Intermittently (0-25% of the day)

*Indicate where you have pain or other symptoms*



*3. What describes the nature of your symptoms?*

- ☐ Sharp ☐ Shooting
- ☐ Dull ache ☐ Burning
- ☐ Numb ☐ Tingling

*4. How are your symptoms changing?*

- ☐ Getting Better
- ☐ Not Changing
- ☐ Getting Worse

*5. How bad are your symptoms at their:*

| | None | | | | | | | | | | Unbearable |
|---|---|---|---|---|---|---|---|---|---|---|---|
| *a. worst:* | ⓪ | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| *b. best:* | ⓪ | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |

*6. How do your symptoms affect your ability to perform daily activities?*

| ⓪ | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
|---|---|---|---|---|---|---|---|---|---|---|
| *No complaints* | | *Mild, forgotten with activity* | | *Moderate, interferes with activity* | | *Limiting, prevents full activity* | | *Intense, preoccupied with seeking relief* | | *Severe, no activity possible* |

*7. What activities make your symptoms worse:* _____

*8. What activities make your symptoms better:* _____

*9. Who have you seen for your symptoms?*

☐ No One ☐ Medical Doctor ☐ Other
☐ Other Chiropractor ☐ Physical Therapist

*a. When and what treatment?* _____

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

☐ Xrays *date:* _____ ☐ CT Scan *date:* _____
☐ MRI *date:* _____ ☐ Other *date:* _____

*10. Have you had similar symptoms in the past?* ☐ Yes ☐ No

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

☐ This Office ☐ Medical Doctor ☐ Other
☐ Other Chiropractor ☐ Physical Therapist

*11. What is your occupation?*

_____

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

☐ Full-time ☐ Self-employed ☐ Off work
☐ Part-time ☐ Unemployed ☐ Other

*12. What do you hope to get from your visit/treatment (select all that apply):*

☐ Reduce symptoms ☐ Explanation of condition/treatment ☐ How to prevent this from occurring again
☐ Resume/increase activity ☐ Learn how to take care of this on my own ☐

*Patient Signature* _____ *Date* _____

## Patient Health Questionnaire - page 2

ProActive SPORT & SPINE

***Patient Name*** _____ ***Date*** _____

***What type of regular exercise do you perform?*** ☐ None ☐ Light ☐ Moderate ☐ Strenuous

***What is your height and weight?*** Height ☐☐☐ (*Feet* *Inches*) Weight ☐☐☐ lbs.

***For each of the conditions listed below, place a check in the Past column if you have had the condition in the past. If you presently have a condition listed below, place a check in the Present column.***

| *Past* | *Present* | |
|---|---|---|
| ☐ | ☐ | Headaches |
| ☐ | ☐ | Neck Pain |
| ☐ | ☐ | Upper Back Pain |
| ☐ | ☐ | Mid Back Pain |
| ☐ | ☐ | Low Back Pain |
| ☐ | ☐ | Shoulder Pain |
| ☐ | ☐ | Elbow/Upper Arm Pain |
| ☐ | ☐ | Wrist Pain |
| ☐ | ☐ | Hand Pain |
| ☐ | ☐ | Hip/Upper Leg Pain |
| ☐ | ☐ | Knee/Lower Leg Pain |
| ☐ | ☐ | Ankle/Foot Pain |
| ☐ | ☐ | Jaw Pain |
| ☐ | ☐ | Joint Swelling/Stiffness |
| ☐ | ☐ | Arthritis |
| ☐ | ☐ | Rheumatoid Arthritis |
| ☐ | ☐ | General Fatigue |
| ☐ | ☐ | Muscular Incoordination |
| ☐ | ☐ | Visual Disturbances |
| ☐ | ☐ | Dizziness |

| *Past* | *Present* | |
|---|---|---|
| ☐ | ☐ | High Blood Pressure |
| ☐ | ☐ | Heart Attack |
| ☐ | ☐ | Chest Pains |
| ☐ | ☐ | Stroke |
| ☐ | ☐ | Angina |
| ☐ | ☐ | Kidney Stones |
| ☐ | ☐ | Kidney Disorders |
| ☐ | ☐ | Bladder Infection |
| ☐ | ☐ | Painful Urination |
| ☐ | ☐ | Loss of Bladder Control |
| ☐ | ☐ | Prostate Problems |
| ☐ | ☐ | Abnormal Weight Gain/Loss |
| ☐ | ☐ | Loss of Appetite |
| ☐ | ☐ | Abdominal Pain |
| ☐ | ☐ | Ulcer |
| ☐ | ☐ | Hepatitis |
| ☐ | ☐ | Liver/Gall Bladder Disorder |
| ☐ | ☐ | Cancer |
| ☐ | ☐ | Tumor |
| ☐ | ☐ | Asthma |
| ☐ | ☐ | Chronic Sinusitis |

| *Past* | *Present* | |
|---|---|---|
| ☐ | ☐ | Diabetes |
| ☐ | ☐ | Excessive Thirst |
| ☐ | ☐ | Frequent Urination |
| ☐ | ☐ | Smoking/Use Tobacco Product |
| ☐ | ☐ | Drug/Alcohol Dependence |
| ☐ | ☐ | Allergies |
| ☐ | ☐ | Depression |
| ☐ | ☐ | Systemic Lupus |
| ☐ | ☐ | Epilepsy |
| ☐ | ☐ | Dermatitis/Eczema/Rash |
| ☐ | ☐ | HIV/AIDS |

***Females Only***

| | | |
|---|---|---|
| ☐ | ☐ | Birth Control Pills |
| ☐ | ☐ | Hormonal Replacement |
| ☐ | ☐ | Pregnancy |
| ☐ | ☐ | |

***Other Health Problems/Issues***

| | |
|---|---|
| ☐ | ☐ |
| ☐ | ☐ |
| ☐ | ☐ |

***Indicate if an immediate family member has had any of the following:***

☐ Rheumatoid Arthritis ☐ Heart Problems ☐ Diabetes ☐ Cancer ☐ Lupus ☐ _____

***List all prescription and over-the-counter medications, and nutritional/herbal supplements you are taking:***

_____ _____ _____

_____ _____ _____

***List all the surgical procedures you have had and times you have been hospitalized:***

_____ _____ _____

_____ _____ _____

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

***Doctor's Additional Comments***

_____

_____

_____

***Doctors Signature*** _____ ***Date***