



**10. What makes your problem worse?**

- Nothing  Walking  Standing  Sitting  
 Moving around/exercise  Lying down  Inactivity

**11. What prior treatments have you received for this present condition?**

- Medical  Surgical  Physical therapy  
 Acupuncture  Other \_\_\_\_\_

Did the treatment help?  Yes  No

**12. Are you currently taking any medications?**

- Yes  No

If yes, please describe. \_\_\_\_\_

**13. Were you previously treated for an earlier occurrence of this same condition?**

- Yes  No

If yes, by whom?

- MD  Chiropractor  Physical therapist  Other \_\_\_\_\_

What were the approximate dates, type of treatment and the results? \_\_\_\_\_

**14. What is your physical activity at work?**

- Mostly sitting  Light manual labor  
 Moderate manual labor  Heavy manual labor

**15. What general physical activity do you do?**

- No regular exercise  Light exercise  Strenuous exercise

Describe \_\_\_\_\_

**16. What is your present general stress level?**

- No stress  Minimal stress  Moderate stress  Greatly stressed

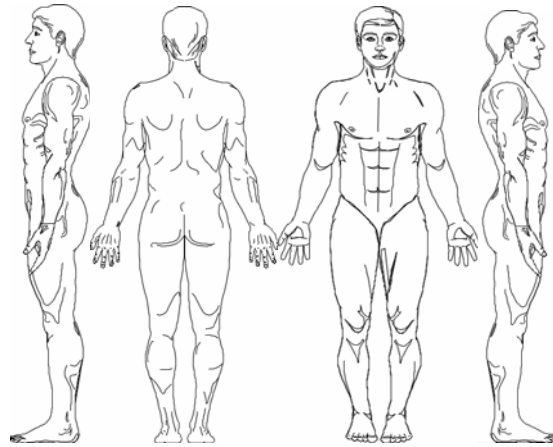
**17. Is your problem affecting your ability to work or do other routine daily activities?**

- No effect  
 Need some assistance with daily activities  
 Cannot function without assistance  
 Have some limited physical restrictions, but can function  
 Cannot work  
 Totally disabled

Name \_\_\_\_\_

Date \_\_\_\_\_

Please mark an X on the figures below where you have pain, numbness or tingling.



Below is a listing of symptoms, conditions or habits. Please check the box indicating whether this applies to past or present.

- | Past                     | Present   |
|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> Neck pain                    |
| <input type="checkbox"/> | <input type="checkbox"/> Shoulder pain                |
| <input type="checkbox"/> | <input type="checkbox"/> Arm/elbow pain               |
| <input type="checkbox"/> | <input type="checkbox"/> Hand pain                    |
| <input type="checkbox"/> | <input type="checkbox"/> Upper back pain              |
| <input type="checkbox"/> | <input type="checkbox"/> Lower back pain              |
| <input type="checkbox"/> | <input type="checkbox"/> Pain in upper leg or hip     |
| <input type="checkbox"/> | <input type="checkbox"/> Pain in lower leg or knee    |
| <input type="checkbox"/> | <input type="checkbox"/> Pain in ankle or foot        |
| <input type="checkbox"/> | <input type="checkbox"/> Jaw pain                     |
| <input type="checkbox"/> | <input type="checkbox"/> Swelling/stiffness of joints |
| <input type="checkbox"/> | <input type="checkbox"/> Headaches                    |
| <input type="checkbox"/> | <input type="checkbox"/> Dizziness                    |
| <input type="checkbox"/> | <input type="checkbox"/> Fainting spells              |
| <input type="checkbox"/> | <input type="checkbox"/> Convulsions                  |
| <input type="checkbox"/> | <input type="checkbox"/> General prolonged fatigue    |
| <input type="checkbox"/> | <input type="checkbox"/> Condition of uterus/ovaries  |

- | Past                     | Present   |
|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> High blood pressure        |
| <input type="checkbox"/> | <input type="checkbox"/> Heart condition            |
| <input type="checkbox"/> | <input type="checkbox"/> Respiratory condition      |
| <input type="checkbox"/> | <input type="checkbox"/> Digestive problems         |
| <input type="checkbox"/> | <input type="checkbox"/> Kidney/bladder problem     |
| <input type="checkbox"/> | <input type="checkbox"/> Menstrual problems         |
| <input type="checkbox"/> | <input type="checkbox"/> Breast soreness/lump       |
| <input type="checkbox"/> | <input type="checkbox"/> Sinus conditions           |
| <input type="checkbox"/> | <input type="checkbox"/> Allergies/asthma           |
| <input type="checkbox"/> | <input type="checkbox"/> Cancer                     |
| <input type="checkbox"/> | <input type="checkbox"/> Stroke                     |
| <input type="checkbox"/> | <input type="checkbox"/> Excessive weight loss/gain |
| <input type="checkbox"/> | <input type="checkbox"/> Skin condition             |
| <input type="checkbox"/> | <input type="checkbox"/> Arthritis                  |
| <input type="checkbox"/> | <input type="checkbox"/> Diabetes                   |
| <input type="checkbox"/> | <input type="checkbox"/> Prostate condition         |

- | Past                     | Present  |
|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> Tobacco use                             |
| <input type="checkbox"/> | <input type="checkbox"/> Alcohol use                             |
| <input type="checkbox"/> | <input type="checkbox"/> Caffeine (coffee, tea, soft drinks)     |
| <input type="checkbox"/> | <input type="checkbox"/> Pregnancy                               |
| <input type="checkbox"/> | <input type="checkbox"/> Surgical Procedures. Please list: _____ |

- | Occasional               | Moderate                 | Heavy                    |
|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

\_\_\_\_\_

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

FINANCIAL AGREEMENT

Dear Patient:

We will attempt to provide you with information necessary to determine the type of care you will require and the financial information you may need to determine how you wish to handle your financial obligation to our office.

We wish to make it very clear that your health is the sole responsibility of you, the patient, or your guardian.

These policies apply only to the services actually performed and in no way obligates the patient to continue the course of treatment recommended. If care is discontinued, the balance due for care received up to that date is due in full within 30 days of discontinuance of care.

I have elected to use the following payment method to finance my care at the Advanced Performance and Rehabilitation Center:

\_\_\_\_\_ 1. CASH – Payment is due at the time of service.

\_\_\_\_\_ 2. MEDICARE – The Advanced Performance and Rehabilitation Center will complete all necessary Medicare forms on my behalf. I may be responsible for a co-payment after Medicare has paid the office.

\_\_\_\_\_ 3. PERSONAL INJURY – Although my insurance or lawsuit may eventually pay the Advanced Performance and Rehabilitation Center in full for service rendered, I will pay this office for any payments not made.

\_\_\_\_\_ 4. INSURANCE POLICY COVERAGE – I understand I am totally responsible for charges I may incur in this office. I will initially pay for my yearly deductible and the co-payment agreed upon at the time of each visit. It is my responsibility to know my insurance plan and to know if a referral is needed before the start of my care. If my insurance fails to pay its share, I will pay the balance in full.

NOTE: The Advanced Performance and Rehabilitation Center will refund any overpayments made to us upon completion of care.

**THERE IS A \$50.00 ADDITIONAL CHARGE FOR ANY EMERGENCY VISITS OR OFFICE VISITS OUTSIDE OUR NORMAL OFFICE HOURS.**

PATIENT’S SIGNATURE \_\_\_\_\_ Date

WITNESS \_\_\_\_\_