## Cornerstone Rehab and Spine LLC

# Patient information record

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| Patient Name | | | | | | | | | | | | | | DOB: | | | | | | | | | | SS# | | |
| Address: | | | | | | | | | | | | | | City: | | | | | State: | | | | | | Zip: | |
| Home # | | | Cell # | | | | | | | | | | | | Work # | | | | | | | | | | | |
| Your Employer | | | | | | | | | | | Occupation | | | | | | | | | | | | | | | |
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| Email Address: | | | | | | | | | | | Emergency Contact: | | | | | | | | | | | | | | | |
| Relationship to contact: | | | | Contact # | | | | | | | | | | | |  | | | | | | | | | | |
| How did you hear about us? | | | | | | | | | | | | | | | | | | | | | | | | | | |
| If you are under 18 years of Age: | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Parent/Guardian Name | | | | | | | | | | Phone: | | | | | | | | | | | | | | | | |
| Student at: | | | | | | | | | | | Grade Level | | | | | | | | | | | | | | | |
| Sports Played/ Other Activities: | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Authorization to Treat:** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| This is to certify that Cornerstone Rehab and Spine LLC have been authorized to render treatment and testing to: | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Parent/Guardian Signature:** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Date:** | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **VERIFICATION OF NON-PREGNACNY (Women only)** | | | | | | |  | | | | |  | | | | | | | |  | | | | | |  |
| This is to certify that, to the best of my knowledge, I am not pregnant and you have my permission to perform therapeutic Ultrasound and Electrical Stimulation. I have been advised that therapeutic Ultrasound and Electrical Stimulation can be hazardous to an unborn child. Date of last menstrual period:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Signature:** | | | | | **Date:** | | | | | | | | | | | | **Guardian Initials:** | | | | | | | | | |
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| ATTORNEY INFORMATION: | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Attorney NAME: | | | | | | | | Phone: | | | | | | | | | | | | | | | | | | |
| Address: | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Letter of Protection on file: | | | | | | | | Requested: | | | | | | | | | | | | | Received: | | | | | |
| Fax Number: | | | | | | | | | Contact: | | | | | | | | | | | | | | | | | |
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| I understand and agree that health policies are an arrangement between an insurance carrier and myself. I understand that this office will prepare any necessary reports and forms to assist me in making collections from an insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that I am personally responsible for payment. I authorize this office to release any medical information relating to my treatment to any insurance companies, which may be responsible for paying benefits for treatment rendered to me. I also agree and assign benefits payable to Cornerstone Rehab and Spine LLC for all services rendered to me. | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Signature:** | | | | | Date: | | | | | | | | | | | | Parent/Guardian Initials: | | | | | | | | | |
| (turn over) | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Medical History and Information** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| What is the problem that brings you to see us? | | | | | | | | | | | | | | | | | | | | | | | | | | |
| How did it happen? | | | | | | | | | | | | | | | | | | | | | | | | | | |
| How long has it been going on? | | | | | | | | | | | | Have you had similar problems before? YES or NO | | | | | | | | | | | | | | |
| What aggravates the condition: | | | | | | | | | | | | | What makes it feel better? | | | | | | | | | | | | | |
| Is the condition getting worse? YES or NO | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Are the symptoms you’re experiencing? | Constant? | | | | | | | | | | | | Come and go? | | | | | | | | | | Interfering w work? | | | |
| Interfering with sleep? | | | | | | | | | | | | | Interfering w daily routine? | | | | | | | | | | | | | |
| Other? | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Are there other healthcare providers you have seen for this condition? YES or NO? If yes, please list below. | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Provider Name** | | | | | | **Type of Provider** | | | | | | | | | | | | **Last Visit Date** | | | | | | | | |
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| Are you currently taking medications/pain medications? YES or NO (please list them to include dosage and frequency) | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Known Allergies:** | | | | | | | | | | | | | **Adverse Reactions of Medications?** | | | | | | | | | | | | | |
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| Have you had any major surgical procedures within the last 60 days? **YES**  or **NO**  **Please List:**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| List prior surgeries/ Hospitalizations and dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Medical History** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Conditions:** | | **Yes/ Comments/ Who?** | | | | | | | | | | | **Conditions:** | | | | | | | | | | **Yes/Comments/Who?** | | | |
| Heart Trouble | |  | | | | | | | | | | | Digestive Disorders | | | | | | | | | |  | | | |
| Asthma/Respiratory | |  | | | | | | | | | | | Sinus Troubles | | | | | | | | | |  | | | |
| Dizziness | |  | | | | | | | | | | | Diabetes | | | | | | | | | |  | | | |
| Hernia | |  | | | | | | | | | | | Cancer | | | | | | | | | |  | | | |
| Arthritis/Joint | |  | | | | | | | | | | | Nervousness | | | | | | | | | |  | | | |
| Backaches/Back Pain | |  | | | | | | | | | | | Numbness | | | | | | | | | |  | | | |
| Headaches | |  | | | | | | | | | | | Pregnancy | | | | | | | | | |  | | | |
| **Please list any other conditions which are not listed:** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Informed Consent** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| In consideration of accepting evaluation and treatment, I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, give the doctor permission to care and treat my condition through assessment, testing, diagnostic, impressions, therapeutic modalities, spinal manipulations, and conclusions based on the findings. I understand that it is my responsibility to make known any and all information about myself not excluding symptoms, injury mechanism, history, pathological defects, illness, or deformities that would not come to the attention of the doctor. I understand that all conditions respond differently to treatment and that occasionally, results are less than expected. I do understand that in the event my condition is not responsive that I may be referred to another health care specialist that works with our doctors to evaluate my health are regimen, Furthermore, I grant permission to use my records, photographs, and/or videotapes for any legitimate research purposes. | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Parent/Guardian Initials:\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **MAJOR MEDICAL INFORMATION:** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Benefits Available Y/N: | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ID#: | | | | | | | | | | Max Payout: $ | | | | | | | | | | | | | | | | |
| Subrogation Clause: | | | | | | | | | | Group#: | | | | | | | | | | | | | | | | |
| Medical Verification Completed/Attached: | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | Date: | | | | | | | | | | | | Int: | | | | |
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| NOTES: | | | | | | | | | | | | | | | | | | | | | | | | | | |
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