W E L C O M E

Date: ______________________

Patient Information

Name: ____
Last First MI

Email address: ____

Mailing Address: ______________________________ City:__________ State_ _____ Zip_____

Phone # (H)______________________ (W) ____________________ (Carrier) ____________

Can we call you at work? ❑ Yes ❑ No

Date of Birth: ______________ Sex: ❑ Male ❑ Female **SS#:** ________________

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑ Minor

Race ❑ Caucasian ❑ African American ❑ Asian ❑ Native American ❑ Latin American ❑ Other ____

Ethnicity ❑ Hispanic ❑ Latino ❑ Non-Hispanic / Non-Latino

Occupation: ____________________________ Employer: ______________________________

Employer Address: ______________________________________ Phone: ________________

How did you hear about our practice? ____

Emergency contact: Name: ________________ Relation: ____________ Phone #: ________________

Phone #: (H) __________________ (W) __________________

Accident Information

Is this visit due to an accident? ❑ Yes ❑ No If yes, what type? ❑ Auto ❑ Work ❑ Other __________

Has it been reported? ❑ Yes ❑ No If yes, to whom? ______________________________

Insurance Information

Policy Holder Name: ____________________________________ D.O.B. :______________________

Relationship to patient (if other than self): ______________________ Phone # ______________________

Do you have health insurance? ❑ Yes ❑ No Name of Carrier: ____________________________

Do you have secondary insurance? ❑ Yes ❑ No Name of Carrier: ____________________________

PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR INSURANCE CARD(S)

SIGNATURE (X) ______________________________________ **DATE** ____________________

1510 S. Main Street, Boerne, TX 78006 830-816-4357

**ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS
AS WELL AS AN
APPOINTMENT AND/OR DESIGNATION AS AN ERISA/PPACA REPRESENTATIVE AND A BENEFICIARY**

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay ______________________ as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided.

I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, and/or medications that *have been* or *will be* rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under.

I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same.

I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA plan, PPACA plan, or insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our representative, ERISA representative, or PPACA representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals to obtain benefits and/or payments that are due to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan or insurer. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment and/or designation will remain in effect unless revoked in writing. A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

Signed this ______ day of _________________ 20 ____.

X____________________________
(patient signature)

X _____________________________
(please print patient name)

X______________________________
(signature of Guardian if applicable)

Informed Consent to Care

A patient coming to the doctor gives him/her permission and authority to care for them in accordance with appropriate test, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare case, underlying physical defects, deformities or pathologies may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the physician. This office does not perform breast, pelvic, prostate, rectal, or full skin evaluations. These examinations should be performed by your family physician, GYN, and dermatologist to exclude cancers, abnormal skin lesions that should undergo biopsy/removal or other treatments. This clinic does not claim to cure any condition (such as high blood pressure, diabetes, high cholesterol) other than those addressed in your physical medicine care plan. We also do not prescribe or refill ANY controlled substances. All prescriptions should be refilled by your original prescriber and any new prescriptions should be issued by your primary care provider.

The patient assumes all responsibility/liability if the patient does not report on health forms any past medical history, illnesses, medicines, or allergies.

I agree to settle any claim or dispute I may against or with any of these persons or entities, whether related to the prescribed care or otherwise, will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

Sign here: X________________________________I have read and understand the above consent form.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have reviewed the Notice of Privacy Practices of _______________________.
(Please initial one of the following options and sign below.)

__________ I wish to receive a paper copy of Privacy Notice.

__________ I do not request a copy of the Privacy Notice at this time. I acknowledge that I can request a copy at any time and the Privacy Notice is posted in the office. If I should have a problem or question in regard to my rights, I may speak with the Privacy Officer about my concerns.

This serves a notice that as part of our efforts to deliver the most consistent healthcare we can to every patient, we use an electronic healthcare system that enables us to retrieve up to 13 months of prescription history through your insurance carrier.

I acknowledge that it is the policy of this office to leave reminder messages on my answering machine or with another person in my home. I may make a request of an alternative means of communication (within reason) in writing.

X____ __________________________
Signature of Patient/Guardian Date
X____ __________________________
Witness (Office Staff) Date

HILL COUNTRY PHYSICAL MEDICINE 830.816.4357

Review of Symptoms

Name: ____ Date: ________________________

YES	NO	**Neurological**
______	______	Migraines
______	______	Headaches
______	______	Slurring of Speech
______	______	Ringing in Ear
______	______	**Ear/Nose/Throat**
______	______	Altered Taste/Smell
______	______	Night Blindness
______	______	Sore Throat
______	______	Gingivitis
______	______	Nose Bleeds
______	______	**Cardiovascular**
______	______	Chest Pain
______	______	Palpitations/ Racing Heart Beat
______	______	Swelling in Hands/Feet
______	______	Anemia
______	______	**Respiratory**
______	______	Recurrent Respiratory Infections
______	______	Asthma
______	______	Chest Congestion
______	______	Wheezing
______	______	Frequent Sneezing
______	______	**GI**
______	______	Stomach Pains or Cramping
______	______	Constipation
______	______	Reflux or Heartburn
______	______	Bloating
______	______	Gas
______	______	Nausea or Vomiting
______	______	**Musculoskeletal**
______	______	Joint Pain
______	______	Arthritis
______	______	Chronic Pain
______	______	Muscle Aches

YES	NO	**Skin**
______	______	Eczema
______	______	Dermatitis
______	______	Excessive Sweating
______	______	Rashes
______	______	Brittle Nails
______	______	Hair Loss
______	______	Easy Bruising
______	______	Increased Bleeding
______	______	Numbness/Tingling
______	______	**Genitourinary**
______	______	Uterine Fibroids
______	______	Ovarian Cyst
______	______	Cancer (Breast, Ovarian, Prostate, Uterine)
______	______	Prostate Problems
______	______	**Emotional/Mental**
______	______	Depression
______	______	Anxiety
______	______	Mood Swings
______	______	Irritability
______	______	Memory Loss
______	______	Confusion
______	______	**Energy**
______	______	Fatigue
______	______	Hyperactivity
______	______	Restlessness
______	______	Insomnia
______	______	Decreased Libido
______	______	Stress
______	______	**Weight**
______	______	Decreased Appetite
______	______	Weight Gain
______	______	Inability to Lose Weight
______	______	Food Cravings
______	______	Binge Eating
______	______	Water Retention

Please check ALL options you have previously tried to assist in above symptoms:

_____ Over the counter medications
_____ Prescriptions
_____ Dietary Changes
_____ Exercise
_____ Consult with specialist
_____ Supplements
_____ Alternative medication/treatments therapies

Have you ever had any type of food sensitivity or vitamin/mineral testing done? Yes or No

If yes, What? ________________________________ When? ____________________

HILL COUNTRY PHYSICAL MEDICINE 830.816.4357

INITIAL INTAKE EXAMINATION

NAME:____________________________DOB:______________ Age:___________ Date of Exam:____________

Health History

Vitals: Ht:_____ Wt:_____ BP:___________P:_____

SP02:_____ BMI:-_______

What is main reason for seeking treatment?____VAS: (0-10)_______

What, if anything has made the problem worse? ❑driving ❑walking ❑ working ❑bending ❑sports ❑sleeping

What, if anything, has made the problem better? ❑rest ❑ice ❑ heat ❑elevation ❑NSAIDS ❑pain meds

History of Present Injury/Illness:

❑ Neck Pain/Stiffness	❑ Pins/Needles in Arms	❑ Light Bothers Eyes	❑ Sudden Weight Loss	❑ Nausea
❑ Back Pain/Stiffness	❑ Pins/Needles in Legs	❑ Depression	❑ Loss of Taste	❑ Cold Feet
❑ Arm/Hand Pain	❑ Fatigue	❑ Nervousness	❑ Loss of Memory	❑ Chest Pain
❑ Leg/Knee Pain	❑ Sleeping Difficulties	❑ Tension	❑ Jaw Problems	❑ Fever
❑ Headaches	❑ Loss of Smell	❑ Cold Sweats	❑ Constipation	❑ Fainting
❑ Dizziness	❑ Allergies	❑ Stomach Problems	❑ Shortness of Breath	
❑ Asthma	❑ Blurred Vision	❑ Night Pain	❑ Bowel/Bladder Changes	

____

____

____

____

Medical History:

❑ Hypertenstion	❑ Heart Disease	❑ Migraines	❑ Liver Disease	❑ Rheumatoid Arthritis
❑ Diabetes	❑ Pinched nerve	❑ Cancer	❑ Kidney Disease	❑ Fibromyalgia
❑ High cholesterol	❑ Herniated disc	❑ Ulcers	❑ Osteoporosis	❑ Thyroid problems
❑ Pacemaker	❑ Stroke	❑ Arthritis	❑ Bleeding Disorders	

____

____

Are you currently under drug and/or medical care? ❑ Yes ❑ No Who is your primary care Dr? ______________________

Please all medications: (**Be sure to include dosage and frequency**)____

____

Supplements (vitamins/herbs/minerals): ____

Allergies: ____

Surgeries and/or hospitalizations (**type & date**): ____

____

Approximate Date of last Flu vaccine:__________ ***WOMEN ONLY:*** Date of LMP:_______ ***Any possibility of pregnancy: YES or NO***

Is there a family history of any of the following conditions? (Indicate family member including parents, grandparents & siblings)

❑ Heart Disease ___________________ ❑ Diabetes ___________________

❑ Cancer ___________________ ❑ Arthritis ___________________ ❑ Other ______________________________

Intake of following: Cigarettes ___ packs/day Alcohol ______drinks/week Caffeine __________ cups/day

Exercise frequency: ❑Never ❑Daily ❑ Weekly ❑Walks ❑Runs ❑Swims

Occupation:__________________ Does work mostly involve : ❑ Sitting ❑ Standing ❑ Light Labor ❑ Heavy Labor

- Reviewed with patient by: __________

NEUROLOGICAL/ MRI/ VASCULAR PATIENT QUESTIONNAIRE

NAME ____ **DATE** __________

For any YES answer, please include details.

1. Do you suffer from neck pain with pain in your shoulder, arms or hands? NO YES
Comment: ____

2. Do you have weakness, numbness or burning in your shoulder, arms or hands? NO YES
Comment: ____

3. Do your hands or arms fall asleep regularly? NO YES
Comment: ____

4. Do you have reduced feeling (sensation) or swelling in your hands or arms? NO YES
Comment: ____

5. Do you suffer from a loss of handgrip strength? NO YES
Comment: ____

6. Do you suffer from back pain with pain in your buttocks, legs or feet? NO YES
Comment: ____

7. Do you have weakness, numbness or burning in your buttocks, legs or feet? NO YES
Comment: ____

8. Do our legs or feet fall asleep regularly? NO YES
Comment: ____

9. Do you have reduced feeling (sensation) or swelling in your legs, feet? NO YES
Comment: ____

10. Do you suffer from cold hands or feet? NO YES
Comment: ____

11. Do have frequent falls or find that you trip over your feet while walking? NO YES
Comment: ____

12. Do you suffer from headaches? If yes, how often, how severe, what has been tried? NO YES
Comment: ____

13. Medicines previously tried, dosage, duration and outcome.
☐Advil ☐Aleve ☐Tylenol ☐Steroids ☐Prescriptions for a period of ☐0-3mos, ☐3-6mos, ☐6-12 mos ☐12+mos

14. Have you tried any Physical Therapy or Chiropractic treatments before? NO YES
If yes: When? For how long? What kind?
____

15. Have you had an MRI? NO YES
If yes: When? Who ordered it? What was it ordered for?
____

16. Have you used any splint or braces or other prescribed treatment by an MD? NO YES
If yes: When? What kind? Who ordered it?
____

HILL COUNTRY PHYSICAL MEDICINE 830.816.4357

Health Questionnaire

Name: ___________________________DOB: ________ Home Phone #: ________________ Work Phone #: ___________

Address: ___________________________________City: _________________________ State ____Zip: ________

Occupation: ___________________________# Hours/Week Currently Working:____________________________

E-mail Address: ___________________________Cell Phone #: _________________________Cell Carrier______________

Check off any of the following symptoms you have experienced in the past 6 months:

- ☐ Low Back Pain
- ☐ Pain between Shoulder Blades
- ☐ Neck Pain
- ☐ Tension/Headaches
- ☐ Fibromyalgia
- ☐ Tension Across Top of Shoulders
- ☐ Numbness/Tingling in Arms/Hands
- ☐ Numbness/Tingling in Legs/Feet
- ☐ Pain in the legs
- ☐ Pain in the feet
- ☐ Tired/Fatigued
- ☐ Difficulty Sleeping
- ☐ Allergies
- ☐ Digestive Problems
- ☐ Carpal Tunnel

OTHER (explain) ____

Which of the above is the worst? ____

How long have you had it? ____

How often does it occur? ____

What does it feel like ?(describe) ____

What have you done that has helped this problem? ____

What activities would you like to do if this was not a problem? ____

Does this cause you to be:

- ☐ Moody
- ☐ Irritable
- ☐ Interrupt sleep
- ☐ Restricted in your daily activities

Does this affect your work:

- ☐ Decision making
- ☐ Poor attitude
- ☐ Decreased productivity
- ☐ Exhausted at the end of the day
- ☐ Unable to work long hours

Does this affect your life:

- ☐ Lose patience with spouse/children
- ☐ Restricted household duties
- ☐ Hinders ability to exercise or sports
- ☐ Interferes with ability to do hobbies or other activities

What have you tried to help relieve/get rid of this problem and how much did it help? (circle appropriately)

- ◆ Medications…Helped: Little Some Much
- ◆ Physical Therapy…Helped: Little Some Much
- ◆ Chiropractic…Helped: Little Some Much
- ◆ Exercise…Helped: Little Some Much
- ◆ Nutrition…Helped: Little Some Much
- ◆ Stretching…Helped: Little Some Much

OTHER ____

Location Date: Apt:

I consent to receiving a health screening. I realize that I am not receiving a diagnosis, treatment or prognosis for any condition that I may be experiencing. I acknowledge that I am receiving a demonstration only and agree to hold harmless the therapist and/or clinic from any damage resulting from this demonstration.

Signature: ____ **Date:** _____/_____/_____

How did you hear about us? ____