Alpine Spinal Health

Name _____ Hm# _____ Cell # _____

Local Address _____ City _____ State ____ Zip_____

Perm. Address _____ City _____ State ____ Zip_____

Email _____

Sex M F

Age _____

B-Day _____

Social Sec# _____

Marital Status S M D

Spouse _____

Guardian _____

Primary Doctor _____

Address: _____

Dentist _____

Address: _____

_____

Your Employer _____

Phone # _____

Accidents

Were you in an auto accident?_____

Was it work related? _____

Were you at fault? _____

Was anyone else in the car? _____

Do you have an attorney? _____

Attorney's Name_____

Insurance Information

Name of Company _____

Subscriber's Name _____

Policy # _____

Group # _____

Claim # _____

Billing Information:

I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the convenience of credit to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. It is my understanding that my credit may be checked if Alpine Spinal Health extends credit to me and I also hereby authorize the doctor at Alpine Spinal Health and whomever he may designate as his assistants to administer treatment as they so deem necessary and I also authorize the release of any information acquired in the course of my examination or treatment. In the event that full payment for charges incurred in my medical care is not made, I agree to pay all costs of collection, including a 33 1/3 % up to 50% Collection Agency Commision, reasonable attorney's fees and interest at the rate of 18% per annum. I also agree to submit myself to the jurisdiction of the courts of Utah County, UT. I certify that the above information is true and correct.

This assignment will remain in effect until revoked by me in writing. A photocopy of this agreement is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.

Print _____ **Sign** _____ **Date** _____

Consent to treat a minor:

I hereby authorize Alpine Spinal Health and whomever they may designate as their assistants to administer diagnostic and chiropractic care as they deem necessary for _____ for whom I am the parent or legal guardian.

Signature of Parent/Guardian: _____ **Date:**_____

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Detailed Case History

We are so glad you are here today. If you need help with this form or any of our procedures, just ask. It is our pleasure to help you. Please fill this form out as completely as possible.

date

Patient Information

last name | first name | m.i.

Street | city | state | zip

Home phone ( ) | mobile phone ( ) | TEXTING? YES / NO | email address

age | date of birth | social security number | sex Male / Female

marital status | single _____ | married _____ | Spouse Name | Emergency Contact

Primary care doctor/dentist (and location): | How did you hear about our office?

Do you have an attorney? Yes / No | Name of Attorney / Firm

Insurance

Insurance Company Name | Primary Insured Name | Relationship to Patient

Policy Number | Group Number | Claim Number

Employment

employer name | occupation

street | city | state | zip

Health Complaints

Are you here because you were injured at (circle one): Work Auto Accident Slip/Fall

Other_____

What is the ***Primary*** reason for your visit?

Personal History

Mark the following conditions that apply to you now or at any time in the past.

- __Cancer
- __Heart Disease
- __High Blood Pressure
- __Diabetes
- __Epilepsy
- __Arthritis
- __Osteoporosis
- __Dizziness
- __Facial Weakness
- __Headache
- __Limb Weakness
- __Loss of consciousness
- __Loss of memory
- __Numbness
- __Seizures/convulsions
- __Sleep disturbance
- __Slurred speech
- __Stroke
- __Tremors
- __Loss of balance
- WOMEN: Pregnant? Y___N___

Lifestyle Habits

How often do you exercise ___Never ___2x/week ___3x/week ___5x/week

Do you use tobacco? ___Yes ___No Pks/week_____ Alcohol? ___Yes ___No Number drinks/week?_____

How many hours per day do you use a computer? Number of hours spent driving daily?

Family History

Mark the following conditions as they pertain to an immediate family member:

	Mother	Father	Brother	Sister
Cardiovascular Disease	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____
Cancer	_____	_____	_____	_____
Stroke	_____	_____	_____	_____

Injuries

Auto Collisions, Job, Sports, Other Injuries: Please list all history.

type of injury | type of treatment received | date of injury

Hospital / Medicine

Have you ever been hospitalized? ___Yes ___No For What reason? _____

Please list all surgeries you have had. _____

Please list all broken bones or dislocations you have had. _____

Have you ever been knocked unconscious? ___Yes ___No

Do you have any implantable medical device in your body? ___Yes ___No List _____

Please list all **medications** you are currently taking and for what purpose. _____

I understand and agree to the following:

- It is my responsibility to complete the clinic's forms accurately and to notify the doctor if any of my information changes.
- A history, consultation, examination and x-rays are conducted for diagnostic and informational purposes.
- My case may not be accepted for treatment at this clinic.
- If the doctors believe that I may respond to their care, additional service may be recommended and I will be advised of applicable cost.

patient printed name | patient signature | date

Consultation Record

Patient Information

last name | first name

Area of Complaint/Location (R/L side?):

Onset—What Caused it?

Date of onset_____ or Gradual Onset

Referred/Radiating—to where?

Localized:

Quality ° Dull/Achy ° Burning ° Stabbing ° Tingling ° Numbness ° Other_____

Pain at Rest 0 1 2 3 4 5 6 7 8 9 10 Pain with Activity 0 1 2 3 4 5 6 7 8 9 10

Timing: Constant/Come & Go:

Worse in the: Morning / Afternoon / Evening

Makes Better: ° Ice ° Heat ° OTC pain med ° Massage ° Rest ° Other_____

Makes Worse:

Have you seen another provider for this condition? Who/When/Diagnosis/Treatment

Additional Signs and Symptoms associated:

Bowel/Bladder changes? Yes / No If yes, explain

How did you hear about our office? Please circle one:

Google Search Facebook Ad in the Mail A Friend(Name:_____

)

Doctor/Attorney(Name:_____) Insurance Other(Please Specify:_____)

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Social History

date

Occupation

Occupation/Job Title	Hours of work per week	Description of work

Job Classification

° Sedentary (less than 5 lbs) ° Light (between 5-20lbs) ° Moderate (20-50 lbs) ° Heavy (more than 50 lbs)

Lifting Frequency

° Constant (67-100% per day) ° Frequent (33-66% per day) ° Occasional (0-32% per day)

Work Activity Posture (hours/day)

° Bending ___ ° Sitting ___ ° Pulling ___ ° Pushing ___

° Reaching ___ ° Kneeling ___ ° Twisting ___ ° Walking ___

° Climbing ___ ° Standing ___

Repetitive Activities (hours/day)

° Computer Use ___ ° Fine Manipulation ___ ° Phone Use ___

° Grasping ___ ° Machine Control Operation ___ ° Hand tool Use ___

Condition effect on Job Performance

° No Effect ° Moderate (painful /limited ability) ° Severe (no limit on duty)

° Mild (painful but can do) ° Mod/Severe (limited duty) ° Severe (Can't perform duty)

Recreational Activities

Activity

° _____	No effect	Mild Pain	Moderate Pain	Severe Pain
° _____	No effect	Mild Pain	Moderate Pain	Severe Pain
° _____	No effect	Mild Pain	Moderate Pain	Severe Pain
° _____	No effect	Mild Pain	Moderate Pain	Severe Pain

Other Activities Affected

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Activities of Daily Living

date

Activities	Mild Pain (can perform activity)	Moderate Pain (limited)	Severe Pain (unable to perform)
Bending	No effect	Mild Pain	Moderate Pain	Severe Pain
Care-Infirm Family	No effect	Mild Pain	Moderate Pain	Severe Pain
Carrying groceries	No effect	Mild Pain	Moderate Pain	Severe Pain
Sit to Stand	No effect	Mild Pain	Moderate Pain	Severe Pain
Climbing Stairs	No effect	Mild Pain	Moderate Pain	Severe Pain
Driving	No effect	Mild Pain	Moderate Pain	Severe Pain
Extended Computer Use	No effect	Mild Pain	Moderate Pain	Severe Pain
Feeding	No effect	Mild Pain	Moderate Pain	Severe Pain
Household Chores	No effect	Mild Pain	Moderate Pain	Severe Pain
Lifting	No effect	Mild Pain	Moderate Pain	Severe Pain
Child Care	No effect	Mild Pain	Moderate Pain	Severe Pain
Reading/concentration	No effect	Mild Pain	Moderate Pain	Severe Pain
Self care-bathing	No effect	Mild Pain	Moderate Pain	Severe Pain
Self care-dressing	No effect	Mild Pain	Moderate Pain	Severe Pain
Sexual activities	No effect	Mild Pain	Moderate Pain	Severe Pain
Sleep	No effect	Mild Pain	Moderate Pain	Severe Pain
Sitting	No effect	Mild Pain	Moderate Pain	Severe Pain
Standing	No effect	Mild Pain	Moderate Pain	Severe Pain
Walking	No effect	Mild Pain	Moderate Pain	Severe Pain
Yard Work	No effect	Mild Pain	Moderate Pain	Severe Pain
Other_____	No effect	Mild Pain	Moderate Pain	Severe Pain
Other_____	No effect	Mild Pain	Moderate Pain	Severe Pain
Other_____	No effect	Mild Pain	Moderate Pain	Severe Pain

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X-Ray Report

Patient Name	Date of Films	Date of Report

- There is no obvious evidence of pathology, disease or fracture as visualized.

Cervical **Views Taken**_____

- Negative for congenital anomaly fracture or pathology
- Also noted is mild scoliosis (Curvature) (L or R)
- Subluxation complex (Alignment:Rotation) at: C1 C2 C3 C4 C5 C6 C7 T1 T2 T3 T4 T5
- Lordosis (Curvature): hypo or hyper Flattening / Military / Reversal
- Antero/Retrolisthesis (Alignment) at: C1 C2 C3 C4 C5 C6 C7 T1 T2 T3 T4 T5
- DJD/uniform loss of disc height levels: C1/2 C2/3 C3/4 C4/5 C5/6 C6/7 C7/T1
- IVD Syndrome/Possible disc bulged at levels: C1/2 C2/3 C3/4 C4/5 C5/6 C6/7 C7/T1
- Osteoarthritis (irregular surfaces) at levels: C1 C2 C3 C4 C5 C6 C7 T1 T2 T3 T4 T5
- Osteophyte with / without encroachment at: C1 C2 C3 C4 C5 C6 C7 T1 T2 T3 T4 T5
- Ligament Laxity at: C1 C2 C3 C4 C5 C6 C7 T1 T2 T3 T4 T5
- Other_____

Lumbar **Views Taken**_____

- Negative for congenital anomaly fracture or pathology
- Also noted is mild scoliosis (Curvature) (L or R)
- Subluxation complex (Alignment:Rotation) at: T10 T11 T12 L1 L2 L3 L4 L5 S1
- Lordosis (Curvature): hypo or hyper
- Antero/Retrolisthesis (Alignment) at: T10 T11 T12 L1 L2 L3 L4 L5 S1
- DJD/uniform loss of disc height levels: T12/L1 L1/2 L2/3 L3/4 L4/5 L5/S1
- IVD Syndrome/Possible disc bulged at levels: T12/L1 L1/2 L2/3 L3/4 L4/5 L5/S1
- Osteoarthritis at levels: T10 T11 T12 L1 L2 L3 L4 L5 S1
- Osteophyte with / without encroachment at: T10 T11 T12 L1 L2 L3 L4 L5 S1
- Pelvic Unleveling with L/R femur head low.
- Other_____

Thoracic **Views Taken**_____

- Findings_____
-

- Osteoporosis at the level of: _____

Other:

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Welcome to our Office

We are so glad you are here today. If you need help with this form or any of our procedures, just ask. It is our pleasure to help you. Please fill this form out as completely as possible.

Our Privacy Practices

In our office, all health information is considered confidential and we are careful about how we use it. This notice describes how your health information may be used and disclosed and how you can get access to this information.

We may share your health information to:

- Treat you
- Discuss your case with family
- Collect payment
- Do Research
- Run our office
- Include you in care classes
- Inform you about services
- Thank you for referring other patients
- Health & Safety reasons
- Reporting to worker's compensation
- Reporting to law enforcement officials
- Reporting victims of abuse
- Court hearings and filings

You have the right to:

- Request a copy of your health record (an additional fee may be involved)
- Request confidential communications
- Request a list of whom we share your health information with
- Amend you protected health information
- Ask us to limit the information we share
- Advise our management if you believe your privacy rights have been violated

These privacy practices are effective: October 15, 2009
For further information, please contact: Julie@alpinespinalrehab.com

Assignment of benefits

By signing below, I authorize that payment of charges be made directly to the doctor of this clinic. This authorization includes:

-All insurance reimbursement for services rendered including those which may be payable to me under my insurance plan.
-Amounts owed, on my behalf, from proceeds of any settlement related to my case.

Information Release

By signing below, I authorize the release of any necessary information to my insurance companies, pre-paid health plan or account, or government managed health plan or program to request payment of benefits to me or my assignee.

I understand and agree to the following:

- The privacy practices have been satisfactorily explained to me.
- I understand that the purpose of today's visit is to determine if I would likely respond to the doctor's care and that my case may not be accepted for treatment.
- I understand the assignment of benefits portion of this form.
- I understand the information release portion of this form.

patient printed name | patient signature | date

Alpine Spinal Health

Jerry S. Clark

Irrevocable Assignment, Direction and Authority to pay Medical Expenses

Patient Section:

I, _____, hereby irrevocable assign, transfer and set over to the above named clinic, Alpine Spinal Health, a sum equal to their fees for the professional services rendered, and to be rendered to me, or to the person(s) of _____, from any amount due me by virtue of my claim for damages from the incident of _____, 20_____.

I hereby irrevocably authorize and direct any person or company having or receiving money due me on such a claim, including my attorney, to pay said clinic the unpaid balance of their bill for all professional services rendered to me or to the above person(s) before distributing any money to me.

I understand and expressly acknowledge that I am personally responsible an liable for the payment in full of services rendered in the above named clinic. The payment to the clinic is not contingent upon obtaining any funds from any third party who may be responsible for my injuries. Payment may be requested in part or in full at any time and I agree to pay any fees upon request.

DATED this _____ day of _____ 20_____.

x_____

Attorney Section: Acknowledgement and Agreement by Council

Receipt of a copy of the above assignment is hereby acknowledged. I agree that prior to the payments of any monies to _____, after first subtracting from said funds all attorney's fees and costs due and owing me as a direct of my representation of the client on the claim which resulted in the injuries being treated at the above nemed clinic, I shall pay Alpine Spinal Rehabilitation, all outstanding bills for professional services, if any, directly to 3325 North University Avenue, Suite 125, Provo, Utah 84604.

DATED this _____ day of _____ 20_____.

x _____

Alpine Spinal Health

Diagnosis Codes

Name _____ Date _____

	Musculoskeletal System/Spine	
	756.1	Congenital Anomalies
	720.0	Ankylosing Spondylitis
	720.1	Spinal Tendomyfascitis
	722.3	Schmoris Nodes
	737.4	Curvature of the Spine
	729.0	Rheumatism/Fibrositis/Unspecified
	756.1	Spondylolisthesis/Congenital
	738.4	Spondylolisthesis/Aquired
	353.0	Thoracic Outlet Syndrome
	754.2	Spine/Congenital Deformity
	714.0	Rheumatoid Arthritis
	715.0	Degenerative Joint Disease
	715.3	Osteoarthritis/localized
	719.0	Joint enfusion
	728.4	Ligament Laxity/Instability
	728.5	Hypermobility Syndrome
	729.1	Myalgia/Myositis
	733.0	Osteoporosis
	755.3	Congenital Short Leg
	848.3	Sprain/Strain-Rib

	Headache	
	346.0	Migraine
	784.0	Headache
	307.8	Tension Headache

	Trauma Codes	
	844.9	Lower Leg Sprain/Strain
	847.2	Lumbar Sprain/Strain
	847.4	Coccyx Sprain/Strain
	846.9	Hip Sprain/Strain
	847.0	Cervical Sprain/Strain
	846.0	Lumbosacral Sprain/Strain
	848.3	Rib Sprain/Strain
	846.1	Sacroliliac Sprain/Strain
	840.8	Shoulder Sprain/Strain
	847.1	Thoracic Sprain/Strain

	Musculoskeletal System/Ext	
	719.4	Arthragia/Joint Pain
	719.5	Joint Stiffens/Restricted Motion
	719.7	Gait Disability
	728.2	Muscular Disease Atrophy

	Cervical Spine	
	721.0	Spondylosis, Cervical
	722.0	Displacement of Cervical Disc w/o Myelopathy
	722.0	Displacement of Cervical Disc w/ Myelopathy
	722.4	Disc Degeneration, Cervical
	723.0	Spine Stenosis, Cervical
	723.1	Cervicalgia
	723.3	Cervicobrachial Syndrome
	723.4	Radiculitis, Cervical
	723.5	Torticollis
	739.1	Multiple Segmental Joint Dysfunction, Cervical
	756.2	Cervical Rib

	Thoracic Spine	
	721.2	Spondylosis, Thoracic
	722.5	Disc Degeneration, Thoracic
	724.1	Pain, Thoracic
	724.4	Radiculitis, Thoracic
	739.2	Multiple Segmental Joint Dysfunction - Thoracic

	Lumbar/Lumbosacral	
	724.4	Radiculitis, Lumbosa ral
	721.3	Spondylosis, Lumbosacral
	722.1	Displacement of Lumbar Disc w/o Myelopathy
	724.3	Sciatic Neuralgia
	724.5	Backache
	739.4	Multiple Segmental Joint Dysfunction - Sacral
	739.3	Multiple Segmental Joint Dysfunction - Lumbar
	727.5	Disc Degeneration, Lumbar
	722.8	Post Laminectomy Syndrome

	Sacroiliac/Coccyx	
	739.4	Intersegmental Joint Dysfunction - Sacroiliac

	Extremities	
	739.6	Segmental of lower extremities
	718.7	Derangement of ankle & foot

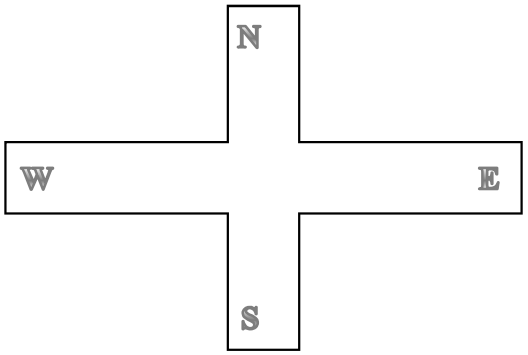
Alpine Spinal Health

Your name

Auto Accident *(only fill out if you will be treated for an auto accident)*

Date of accident:_____ Time of day: □ Daylight □ Dawn □ Dusk □ Dark
You were: □ Driver □ Front Seat Passenger □ Rear Seat Passenger □ Other
Your vehicle: (year, make, model): _____
Your estimated speed at the moment of accident: _____ M.P.H. □ Stopped □ Slowing □ Accelerating
Others in the car? □ Yes □ No Have they been checked for injuries? □ Yes □ No
Other vehicle (year, make, model):_____
Road conditions: □ Dry □ Damp □ Wet □ Snow □ Icy □ Other
Head restraints: □ None □ Integral Type □ Adjustable Type □ Up □ Down □ Don't know
If adjustable, was the position altered by the accident? □ Yes □ No
Was the seat back adjustment altered by the accident? □ Yes □ No Was the seat broken? □ Yes □ No
Were you wearing seat belts? □ Yes □ No □ Don't know □ Shoulder & lap □ Lap only
Did the air bag deploy? □ Yes □ No If yes, were you struck? □ Yes □ No Injuries?
Body position: □ Good □ Forward lean □ Other
Head position: □ Forward □ Looking left □ Looking right □ Looking up □ Looking down
Braced for impact? □ Yes □ No Brakes applied? □ Yes □ No
Were you looking in your mirror? □ Yes □ No If yes, □ Inside rear view □ Outside door mirror
Brief description of accident:

ACCIDENT DIAGRAM



During the Crash:
Did you strike any parts of the vehicle? □ Yes □ No
If yes, describe: _____
Did vehicle stike any object after initial collision?
□ Yes □ No Describe:
Wearing hat or sunglasses? □ Yes □ No
If yes, still on after crash? □ Yes □ No
Did you lose consciousness? □ Yes □ No
If yes, for how long? _____
Estimated property damage to your vehicle: $_____
Estimated damage to other vehicle(s):
□ None □ Minimal □ Moderate □ Major
Were police called to the scene? □ Yes □ No
If yes, was a report made? □ Yes □ No

After the crash:
Did you go to the hospital? □ Yes □ No If no, did you see another doctor? □ Yes □ No
How did you get there? □ Ambulance □ Car If by car, were you driven by: □ Self □ Other _____
What treatment did you receive? □ Exam □ Neck brace □ X-rays □ Medication □ Other _____
Have you lost any days of work? □ Yes □ No If yes, dates: _____
Were you unable to do housework, yard work, etc. due to pain from the accident? □ Yes □ No
Have you been in other accidents? □ Yes □ No If yes, dates: _____

Auto Insurance Information
Company insuring vehicle you occupied: _____ Accident claim #: _____
Claims address: _____ Phone #: _____
Name of person found at fault in the accident: _____
Their auto insurance company: _____ Phone #: _____