BAY STATE PHYSICAL THERAPY

MCR CHIROPRACTIC

Personal Injury Intake Form

Patient Information

Date: _____ Date of Birth: ___/___/_____

Name: _____ Social Security: _____-___-_____

Address: _____

Street City State Zip

Email Address:_____

Home Phone: _____ Cell Phone: _____

Gender: _____ Height: _____" Weight: _____ lbs

Marital Status: _____Number of Children: _____

Employer: _____ Occupation: _____Work Phone: _____

Employer Address: _____

Street City State Zip

Attorney: _____ Phone:_____

Emergency Contact: _____ Relation: _____

Emergency Contact Phone Number: _____

If under 18 years, name of Parent or Guardian: _____

PCP Name: _____ Phone: _____

How did you hear about our office ? □ Website □ Gym member □ Walk in □ Yellow pages □ Friend/Former patient_____ □ Doctor_____ □Other_____

Accident Information

Date: _____ Time: _____ AM PM Was it reported? □ YES □ NO

Town accident occurred in:_____ Street:_____

Please explain in detail how the accident occurred:_____

_____

Please list symptoms felt immediately after the accident: _____

_____

Were you in a work vehicle at the time of the accident? □ YES □ NO

Were you the □ DRIVER □ FRONT SEAT PASSENGER □ BACK SEAT PASSENGER?

Were you wearing a seat belt? □ SHOULDER HARNESS □ LAP HARNESS

Where were you taken after the accident? _____

If hospital, how were you taken? □ AMBULANCE □ PRIVATE VEHICLE □ OTHER

Were X-Rays done? □ YES □ NO An MRI? □ YES □ NO CAT scan? □ YES □ NO

Have you seen any other doctor(s) since the accident? □ YES Name _____ □NO

Have you missed any work since the accident? □ YES □ NO Date(s) _____

Did you ever experience similar symptoms prior to the accident? □ YES □ NO

Has your condition □ IMPROVED□ WORSENED or □ STAYED SAME since the accident?

Please share any other information that might be important to your diagnosis and treatment:_____

Patient Signature (Parent/Guardian or Minor):_Date:

Acknowledgement of Office Policies

The following are Bay State Physical Therapy and MCR Chiropractics policies governing appointment scheduling, payment terms, and information releases. ***Please read carefully*** *and be sure to ask questions you might have before signing the document.*

Appointment Scheduling: We at Bay State Physical Therapy and MCR Chiropractic are glad to accept insurance assignment on your behalf in handling your personal injury or worker's compensation claim. However, in order to help ensure that your insurance company pays for the care you receive here, it is important that you adhere to the recommended care program. We require a 24 hour cancellation notice for all appointments. If you miss three (3) or more appointments without 24 hour notice, you may be dismissed from care and your file may be closed.

Consent for Treatment: I, the undersigned, give Bay State Physical Therapy and/or MCR Chiropractic my permission to evaluate and treat my injury. I further understand that in the course of recommended treatment, condition may worsen on rare occasions. I further understand that no guarantee or promise has been made to me concerning the results of treatment. I further understand that the gym and/or pool areas are common areas accessed by patients, gym members and guests and as a result there may be incidental contact with personal health information.

Assignment of Payment: I hereby authorize my insurance company and/or my attorney to pay direct to Bay State Physical Therapy and/or MCR Chiropractic any monies due on my account for professional services rendered.

Acknowledgment and Understanding: It is further understood that I, the undersigned, agree to pay the full amount of the charges should my condition be such that it is not covered by my policy, or if, for any reason, the insurance company and/or my attorney refused to pay my balance at this office.

Private Health Insurance: I understand that I am responsible for whatever fees my insurance company does not pay on my claim. (Typically, this includes deductibles and/or co-payments).

Authorization to Release Information: I have read and fully understand Bay State Physical Therapy and/or MCR Chiropractic's Notice of Information Practices. I understand that Bay State Physical Therapy and/or MCR Chiropractic may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payments, understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operation if I notify the practice. I also understand that Bay State Physical Therapy and/or MCR Chiropractic will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

Patient Requests for Records: I instruct the release of all medical, hospital, or surgical records pertinent to my case, including but not limited to exams, special test, x-rays, or lab results to this office.

Ownership: I understand that MCR Chiropractic, Bay State Physical Therapy, Optimal Weight Loss, and Massage Works! Are all owned and operated by the same entity. I understand I have the option to seek any/all of the same services these clinics provide elsewhere.

I certify that I have read and understand all appointment and office policies listed above.

Patient Signature: _____ **Date:** _____
Name (Please Print): _____ **DOB:** _____
Witness Signature: _____ **Date:** _____
Name (Please Print): _____

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Designate Individuals Authorization Form

I hereby authorize one or all of the designated parties listed below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Please give the name(s) of the individual(s) who you will allow to receive any part(s) of your health record.

Authorized Designees:

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

_____ DOB:_____

Patient Name

_____ **Date:** _____

Patient Signature

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Medical History Form

Name: _____ DOB: ___/___/_____ Today's Date: ___/___/_____

Occupation: _____ Gender:_____ PCP: _____

Referring Physician (MD):_____ Next appointment w/ referring MD: ___/___/____

Please answer the following questions:

What injury or condition brings you here today? _____

When did you first notice your condition (date of onset)? _____

How did this injury occur? _____

Is your condition due to a motor vehicle accident? ☐ Yes ☐ No If yes, date of accident? _____

Have you had any falls in the past 12 months? ☐ Yes ☐ No If yes, how many times? _____

Did the fall(s) result in injury? ☐ Yes ☐ No If yes, please describe: _____

Please describe above: _____

Are you seeing (or have you been seen by) any other specialists for your current condition (e.g.: doctor, psychologist, chiropractor, physical therapist, etc.)? Please list: _____

Have you been treated by another physical therapist/chiropractor in the past for this or any other condition?

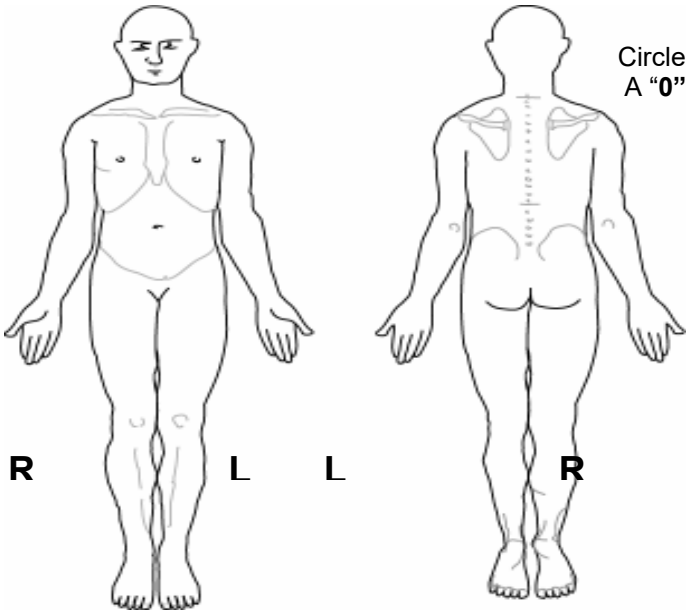
☐ Yes ☐ No

If Yes, by whom/when? _____

What tests have you had for this condition? ☐ X-ray ☐ MRI ☐ CT scan ☐ Other: _____

Please mark where you have symptoms on the picture below.

Sharp Pain: ////// Achy Pain: ^^^^^ Burning Pain: XXXXX Numbness: 0000



Circle the number corresponding with the intensity of your symptoms.
A "**0" = No Pain** where as a **"10" = most severe pain imaginable**.

Location:_____ 0 1 2 3 4 5 6 7 8 9 10

Location:_____ 0 1 2 3 4 5 6 7 8 9 10

Location:_____ 0 1 2 3 4 5 6 7 8 9 10

Location:_____ 0 1 2 3 4 5 6 7 8 9 10

Since this condition began your symptoms have: ☐ decreased ☐ not changed ☐ increased

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Your symptoms are worse in the: ☐morning ☐afternoon ☐night ☐same all day

What are your goals for treatment? _____

Please list past surgeries/conditions/hospitalizations:

_____ ___/___/_____

_____ ___/___/_____

Please list all medications, dosage, frequency and route (or you may attach a separate list):

Name: _____Dosage: _____ Frequency: _____Route: _____

Name: _____Dosage: _____ Frequency: _____Route: _____

Name: _____Dosage: _____ Frequency: _____Route: _____

Have you ever been diagnosed and/or treated for any of the following conditions (circle all that apply):

CONSTITUTIONAL
Weight Loss
Fatigue
Fever

EYES
Glasses/Contacts
Eye Pain
Double Vision
Cataracts

CARDIOVASCULAR
Murmur
Chest Pain
Palpitations
Fainting/Spells
Short of Breath
Difficulty Lying Flat
Swelling in Ankles
Pacemaker/Defibrillator

ENDOCRINE
Loss of Hair
Heat Intolerance
Cold Intolerance
Diabetes Type I or II

ALLERGIC
Hives/Eczema
Hay Fever

PSYCHIATRIC
Anxiety
Depression
Mood Swings
Difficulty Sleeping

RESPIRATORY
Cough
Coughing Blood
Wheezing
Chills

GASTROINTEST
Heartburn/Reflux
Nausea/Vomiting
Constipation
Change Bowel Mvts
Diarrhea
Jaundice
Abdominal Pain
Black/Bloody Bowel Mvts

GENITOURINARY
Burning/Frequency
Nighttime
Blood in Urine
Erectile Dysfunction
Bladder Leakage
Abnormal Leakage

HEMATOLOGY/LYMPH
Bruise Easily
Gums Bleed Easily
Enlarged Glands

MUSCLE/BONE
Joint Pain/Swelling
Stiffness
Muscle Pain
Bone Pain

SKIN
Rashes/Sores
Lesions
Itching/Burning

NEUROLOGICAL
Loss of Strength
Numbness
Headaches
Tremors
Memory Loss

CANCER
Date of diagnosis: _____
Location: _____
Status: _____

FEMALES ONLY
Age Onset of Periods_____
Periods Regular? Yes/No
Age Onset of Menopause_____
Number of Pregnancies_____

Please list any allergies that you have (For example: medications, latex, food, bee stings): _____

Is there any additional information? _____

The above information is true to the best of my knowledge.

Signature: _____ DOB: ___/___/_____ Date: ___/___/_____

Acknowledgement of Privacy Policy (HIPAA)

We are very concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with the *Health Insurance Portability and Accountability Act* of 1996 (HIPAA), we are required to supply you with a copy of our privacy policies and procedures. We encourage you to read this document carefully, for it outlines the use and limitations of the disclosure of your health information and your rights as a patient. If you ever have any questions or concerns regarding the use or dissemination of your personal health information, we would be happy to address them.

I acknowledge that I have received a copy of Bay State Physical Therapy and/or MCR Chiropractic's *Notice of Privacy Practices for Protected Health Information.*

_____ _____

Patient Name Printed Date

_____ _____

Patient Signature or Authorized Representative Date of Birth

_____

Authorized Representative Name Printed and Relation to Patient

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Cancellation Policy

At Bay State Physical Therapy and/or MCR Chiropractic, we are committed to giving the highest quality of care. Part of that includes our recognition of your busy schedule and your desire to achieve positive results in the shortest time possible. We pride ourselves on starting your treatment at your scheduled time and giving you appointments that work with your busy schedule. We respect your time and ask for your cooperation by maintaining your appointments in order to maximize your rehabilitation potential.

If you are unable to make your appointment, we ask that you reschedule your appointment within the same week rather than canceling. If you need to cancel your appointment and cannot reschedule within the same week, we ask that you provide us with a minimum of 24-hour notice so that we may offer your appointment time to another patient awaiting treatment. If you miss three (3) or more appointments without 24-hour notice, you may be discharged from physical therapy and your physician will be notified.

If you do not provide at least 24-hour notice you will be assessed a $50 fee for your missed physical therapy appointment(s) and $35 for your missed chiropractic appointment(s).

Please note that this charge cannot be billed to insurance and must be paid on or before the next scheduled appointment. By signing below, you acknowledge that you have read and understand our cancelation policy.

Signature (Parent/Guardian of Minor): _____ **Date:** __/___/___