(Formerly AFCN Physical Medicine)
A member of the Arkansas Family Care Network, P.A.

If you have a problem with vision, hearing, speech or communication, please let our front desk personnel know.

Payment is expected at the time of service, unless prior arrangements have been made. A copy of your insurance card and photo ID will be required for our records.

PATIENT INFORMATION

FIRST NAME: _____MI: _____LAST NAME: _____

ADDRESS: _____CITY: _____

STATE: _____ZIP: _____HOME PHONE: _____CELL PHONE: _____

DOB: _____SEX: _____SSN: _____

MARITAL STATUS: S M W D EMAIL ADDRESS: _____

EMPLOYER: _____WORK #: _____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____
Relationship between patient and insurance policy holder (circle one): Self Spouse Parent/Guardian

SECONDARY INSURANCE: _____
Relationship between patient and insured policy holder (circle one): Self Spouse Parent/Guardian

Have you seen any other Physical Therapist or Chiropractor in the past year? _____
If so, Who and when? _____

Are you being seen for an accident or injury that is a result of a Motor Vehicle Accident or an accident at work?
Please circle one: YES NO If yes, please provide the name and phone number of the insurance company who will be paying for your care: _____

Who referred you to our clinic? _____

Do you currently smoke or use tobacco products? YES NO
How many packs/pouches do you use per day? _____
How many years have you used tobacco? _____

Do you drink alcoholic beverages? YES NO If yes, how many drinks per week? _____

What is your job or occupation? _____

What does your work involve? _____

_____

Leisure/Activities: _____

_____

To ensure you receive a complete and thorough examination, please provide the following background information. If you do not understand a question, leave it blank and your provider will discuss further.

Please check any of the following whose care you are **currently under or recently seen:**

_____Medical Doctor _____Psychiatrist/Psychologist _____Dentist

_____Physical Therapist _____Chiropractor _____Other

If you have seen any of the above in the past 3 months, please describe what reason (illness, medical condition, physical, etc.): _____

_____

When was the date (approximately) of your last complete physical (wellness) examination? _____

Is there any information from your last physical examination that you think we should know about? If not, leave blank.

_____

The following are questions to gather some information about why you are coming to our clinic. If you are not sure, leave it blank and your provider will discuss further during your evaluation.

Please briefly describe the problem that you would like us to look at today: _____

_____

_____

When and how did you start having this problem? _____

Is the problem getting **worse, better,** or **staying about the same?** _____

Is the problem **constant** or **come and go?** _____

Are there any activities that make your complaints worsen? YES NO If yes, please explain: _____

_____

Is there a certain time of the day that your symptoms are worse? YES NO If yes, when? _____

Is there anything that has made your problem feel better (heat, laying down, etc.) _____

Is the problem keeping you awake at night? _____

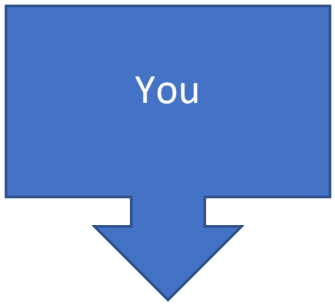
Have you had this problem before? YES NO If yes, when? _____

Did you have any treatment? YES NO If yes, did it help? _____

Have you had any type of tests for this problem? YES NO Please list any tests that have been performed in the past year (MRI, CT, X-rays, lab, nerve test, etc.) _____

_____

*The next questions relate to any illnesses that **you, your parent, or siblings** might have had. If you do not know or the questions does not apply, just leave it blank.*

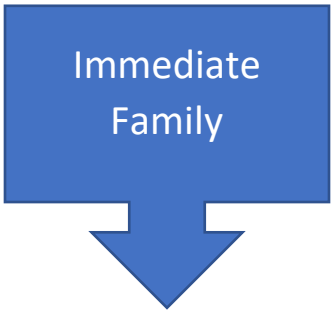


Cancer? YES NO

If yes, provide the date and type of cancer: _____

_____

Diabetes?	YES	NO
High Blood Pressure?	YES	NO
Heart Disease/Attack?	YES	NO
If yes, date? _____		
Angina/Chest pain?	YES	NO
Stroke?	YES	NO
High Cholesterol?	YES	NO
Osteoporosis?	YES	NO
Osteoarthritis?	YES	NO
Rheumatoid Arthritis?	YES	NO
Lupus?	YES	NO
Thyroid Problems?	YES	NO
Hepatitis/Liver dx?	YES	NO
Kidney Disease?	YES	NO
Asthma?	YES	NO
Migraine headaches?	YES	NO
Depression?	YES	NO
Anxiety/Panic attacks?	YES	NO
Psoriasis?	YES	NO
Tuberculosis?	YES	NO
Multiple Sclerosis?	YES	NO
Parkinson's Disease?	YES	NO
Fibromyalgia?	YES	NO
HIV/AIDS?	YES	NO
Sexually Trans. Dx?	YES	NO
Rheumatic Fever?	YES	NO
Seizures?	YES	NO
Organ Transplant?	YES	NO
Joint Transplant?	YES	NO
Pacemaker?	YES	NO



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Migraine headaches?	YES	NO
Depression?	YES	NO
Anxiety/Panic attacks?	YES	NO
Psoriasis?	YES	NO
Tuberculosis?	YES	NO
Multiple Sclerosis?	YES	NO
Parkinson's Disease?	YES	NO
Fibromyalgia	YES	NO

Do you have any allergies? YES NO If yes, what are you allergic to? _____

Are you allergic to Latex? YES NO

Do you take blood thinners? YES NO

Are you fearful of needles? YES NO

Do you have a medical implant? YES NO If yes, what? _____

For Women Only

Are you currently pregnant? YES NO

Is there a possibility you could be pregnant? YES NO

History of Endometriosis? YES NO

Do you use oral contraceptives? YES NO

Are you post-menopausal? YES NO

Do you use hormone replacement therapy? YES NO

For Men Only

Do you have prostate problems? YES NO

Surgeries

If you have had any surgeries, please describe them and the approximate date they occurred: _____

_____

_____

_____

Have you been hospitalized in the last 3 months? YES NO If yes, what for? _____

_____

In the past 3 months have you **had** or are you **currently** experiencing?

Trouble Sleeping?	YES	NO
Nausea/Vomiting?	YES	NO
Fever/Chills/Sweats?	YES	NO
Unexplained weight loss/gain?	YES	NO
Numbness/Tingling?	YES	NO
Weakness?	YES	NO
Changes in bowel or bladder infection?	YES	NO
Dizziness/Shortness of breath?	YES	NO
Insomnia?	YES	NO
Upper Respiratory Infection?	YES	NO
Urinary Tract Infection?	YES	NO
Changes in fingernails?	YES	NO

List your current medications both prescription and over the counter (pills, injections, patches, ointments, vitamins or herbs) : _____

_____

_____

_____

_____

FOR OFFICE USE ONLY

SIGNATURE OF PROVIDER: _____DATE: _____

Kyle Kifer, DC Bekah Fisher, PT, DPT Annie Cavenar, PT, DPT

Numerical Pain Scale

0 = No Pain 10 = Worst Pain

1. Please rate your level of pain **at this moment** on the following scale (circle one):
   0 1 2 3 4 5 6 7 8 9 10

2. Please rate your **worst** level of pain in the **last 48 hours** on the following scale (circle one):
   0 1 2 3 4 5 6 7 8 9 10

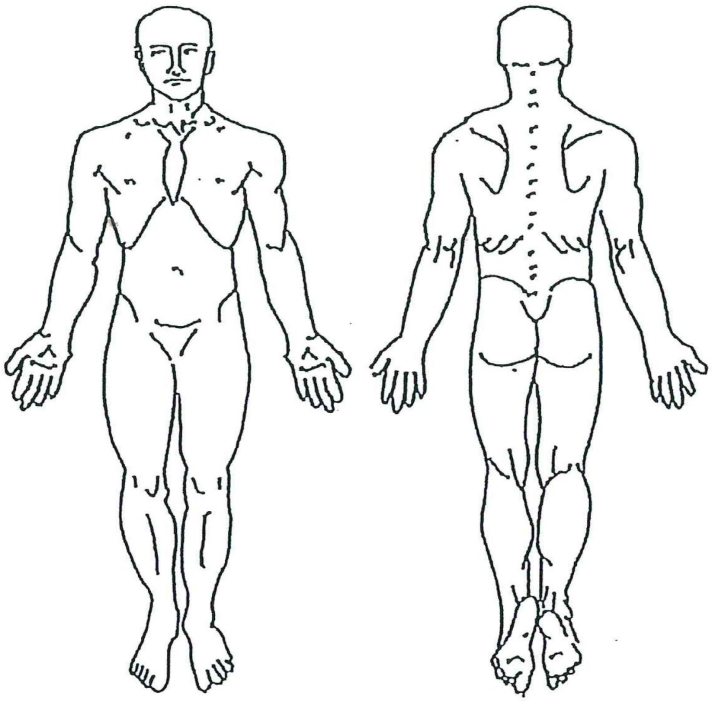
3. Please rate your **least** level of pain the in **last 48 hours** on the following scale (circle one):
   0 1 2 3 4 5 6 7 8 9 10

Score: #1 ____ + #2 _____ + #3 _____ = _____ (low intensity = <5; High intensity = >5)

Pain Drawing

Please use the diagram below to indicate where you have been feeling symptoms. Use the following key to indicate the types of symptoms.

Key: Pins/Needles = 0000 Burning = XXXX Stabbing = //// Aching = ZZZZ



*A decrease of at least 2 points represents a clinically meaningful important difference. Minimal clinically important chronic musculoskeletal pain intensity measured on a numerical rating scale.

Arkansas Family Care Network

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have received or have been offered a copy of the Arkansas Family Care Network Policy of Privacy Practices. The notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the notice may be changed at any time and that I may obtain a revised copy of the notice at the clinic location where I received health care services.

All services rendered are the financial responsibility of the patient and not the insurance company. Our office will bill your insurance company as a courtesy. Your financial responsibility is to ensure that the Arkansas Family Care Network is paid for services rendered. This includes liability covered injuries, as bills will not be postponed in anticipation of legal settlement. Information will be provided to you to file your own insurance and supplied to your attorney upon your request.

I hereby authorize the health care providers of Elite Functional Rehab to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to the provider all payments for medical services rendered to my dependents or myself. I understand that this authorization will remain in effect as long as my dependents or I remain a patient.

Informed consent to treatment: The term "informed consent" means that the potential risks, benefits, and alternatives of treatment have been explained to me. The provider offers a wide range of services and I understand that I will receive information at the initial visit concerning the treatment and options available for my condition.

Potential risks: I may experience in increase in my current level of pain or discomfort, or an aggravation of my existing injury or condition. The discomfort is usually temporary; if it does not subside in a reasonable time period, I agree to contact my provider.

Potential benefits: I may experience an improvement in my symptoms and an increase in my ability to perform daily activities. I may experience increased strength, awareness, flexibility and endurance in my movements. I may experience decreased pain and discomfort. I should gain a greater knowledge about managing my condition and the resources available to me.

Alternatives: If I do not wish to participate in the therapy program, I will discuss my medical, surgical or pharmacological alternatives with my therapy provider, as well as my physician or primary provider.

I, _____, hereby consent to allow the following person(s) access to information on my account that would otherwise be considered protected health information: _____

_____

I acknowledge that I fully understand the above statements and that all provided information relative to my health is accurate to the best of my knowledge.

Signature of patient or guardian: _____Date: _____

Appointment Reminders and No-Show Consent Form

Due to the increased amount of time in making appointment reminder calls, Elite Functional Rehab offers the ability to send text messages or email reminders for appointments booked with our office.

This service should not be solely relied upon, as the responsibility of remembering, and attending or cancelling appointments still rests with you, but we hope this will make things easier.

There will be a charge for appointments **missed** or **not cancelled by 5pm** on the day prior to the appointment. **The first occurrence is $10, second occurrence $15 and all subsequent occurrences $20.** This will need to be paid prior to the next appointment.

Messages are generated by an NHS secure server; however, they are transmitted over a public network to a personal phone or computer. **The practice will never transmit any information that would enable an individual patient to be identified, or to transmit specific medical information.**

*By signing this form, I **CONSENT** to Elite Functional Rehab contacting me by text message or email for the purpose of information and appointment reminders.* ***I will ensure that I keep the practice informed on my current phone number or email addresses at all times.***

My signature also confirms that I have received and understand the appointment cancellation or no-show policy.

I prefer to receive reminders by (circle one): TEXT EMAIL NO REMINDERS

Patient Name: _____Date of Birth: _____

Mobile Phone number: _____Cell Phone Carrier: _____

Email Address: _____

Signature: _____Date: _____