HISTORY OF PRESENT CONDTION (RETURNING PATIENTS)

Name: _____DOB:_____Date:_____

Address: _____

Insurance Name: _____

The following are questions to gather some information about why you are coming back to our clinic. If you do not know the answer it is fine to leave blank; you can talk about it during your evaluation.

Is this work or accident related? YES NO If yes, what date were you injured? _____

Please briefly describe the problem that you would like for 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 tend to ***come and go***? _____

What kind of activities make your complaint(s) worsen? _____

Is there a certain time of day that your symptoms are worse? _____

What have you noticed that makes your problem feel better? _____

Is the problem keeping you awake at night? _____

Have you ever had this problem before? If so, did you have treatment or did it go away? _____

_____

Have you had any type of test performed for this problem? Tests may include X-rays, lab, MRI, CT, nerve test…

_____

If yes, when and where were they performed? _____

_____

Has anything changed in your medical history since your last visit? YES NO If yes, please describe:

_____

_____

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

_____

_____

Do you have 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 **pacemaker** or other type of **implant, including replacement?** _____

_____

FOR WOMEN ONLY

Are you currently pregnant? YES NO

Is there a possibility you could be pregnant? YES NO

History of Endometriosis? YES NO

Are you post-menopausal? YES NO

Do you use hormone replacement therapy? YES NO

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

_____

If you have had any surgeries, please describe when and 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 or gain?	YES	NO
Numbness/Tingling?	YES	NO
Weakness?	YES	NO
Changes in appetite?	YES	NO
Difficulty Swallowing?	YES	NO
Changes in bowel or bladder function?	YES	NO
Blood in stool?	YES	NO
Dizziness?	YES	NO
Shortness of Breath?	YES	NO
Insomnia?	YES	NO
Upper Respiratory Infection?	YES	NO
Urinary Tract Infection?	YES	NO
Changes in Fingernails?	YES	NO

FOR PROVIDER USE ONLY

Signature of Provider: _____Date: _____

Kyle Kifer, DC

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

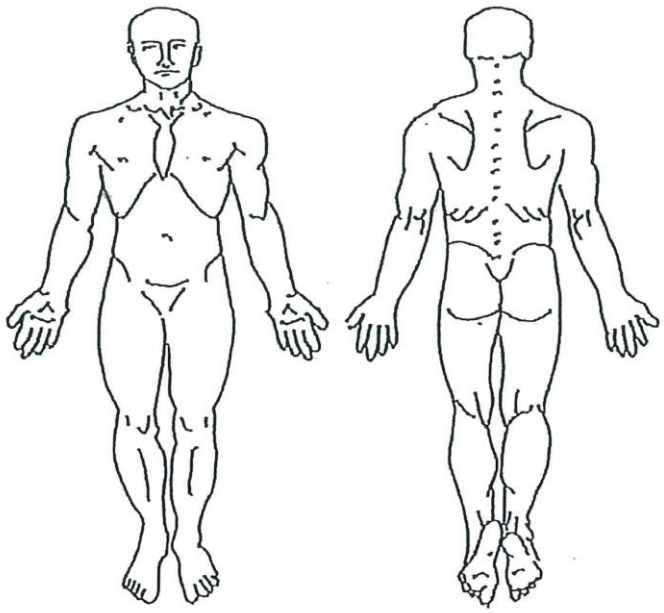
3. Please rate your **least** level of pain the in **last 48 hours** on the following scale (circle one):
   0 1 2 3 4 5 6 7 8 9 10

Score: #1 ____ + #2 _____ + #3 _____ = _____/ 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 $25, second occurrence $30 and all subsequent occurrences $50.** 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: _____