

### TREATMENT APPLICATION

This treatment application is the first step in assisting the doctor in determining if you are a candidate for our non-surgical procedures, therapies and specialized treatment technology. Please answer the following questions honestly and to the best of your knowledge.

#### CONFIDENTIAL PATIENT INFORMATION

Thank you for the opportunity to serve you. If you have any questions, do not hesitate to ask. We will be happy to help.

Name \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_ S/S#\_\_\_\_-\_\_\_\_-\_\_\_\_  
 First MI Last  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Email \_\_\_\_\_  
 Sex:  Female  Male Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Status:  Minor  Married  Single  Divorced  Widowed  Separated  
 Occupation \_\_\_\_\_ Please Explain Duties of Your Work \_\_\_\_\_  
 Spouse/ Parent's Name \_\_\_\_\_ Phone \_\_\_\_\_  
 How were you referred to our office? \_\_\_\_\_  
 Person to contact in case of an emergency \_\_\_\_\_ Phone \_\_\_\_\_  
 Who is your Primary Care Physician? \_\_\_\_\_ Phone \_\_\_\_\_

#### HEALTH HISTORY

What type of regular exercise do you perform? (circle) None Light Moderate Strenuous Height: \_\_\_\_ft. \_\_\_\_in. Weight: \_\_\_\_\_lbs.

Do you currently have or have you previously had any of the following symptoms or conditions:

Past	Present	Past	Present	Past	Present
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches		Tension		Ringing/ Buzzing in Ears	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neck Pain		Irritability and Stress		Loss of Memory	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neck Stiffness		Mood Swings		Loss of Smell	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mid Back Pain		Sleeping Problems		Loss of Taste	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low Back Pain		Fatigue		Upset Stomach	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain In Arm and/or Legs		Depression		Constipation	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Burning on the Feet		Chest Pain		Diarrhea	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pins and Needles in Arms		Shortness of Breath		Urinary Problems	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pins and Needles in Legs		Cold Sweats		Heartburn	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Numbness in Fingers		Fever		Ulcers	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Numbness in Toes		Fainting		Allergies	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cold Hands and/or Feet		Dizziness		Menstrual Pain	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin Sensitivity To Touch		Loss of Balance		Menstrual Irregularity	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nervousness		Light Sensitivity w/Eyes		Hot flashes	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin Disorders		Loss of Vision		Intimacy/Sex-related Disorders	
<input type="checkbox"/>	<input type="checkbox"/>				
Other _____					

Have YOU or A FAMILY MEMBER ever been diagnosed with any of the following conditions:

<input type="radio"/>	<input type="checkbox"/>	AIDS/HIV/Hepatitis C	<input type="radio"/>	<input type="checkbox"/>	Heart Disease	<input type="radio"/>	<input type="checkbox"/>	Thyroid Disorders
<input type="radio"/>	<input type="checkbox"/>	Cancer	<input type="radio"/>	<input type="checkbox"/>	Diabetes	<input type="radio"/>	<input type="checkbox"/>	Respiratory/COPD
<input type="radio"/>	<input type="checkbox"/>	High Blood Pressure	<input type="radio"/>	<input type="checkbox"/>	Stroke	<input type="radio"/>	<input type="checkbox"/>	Other Medical

Conditions Not Listed \_\_\_\_\_

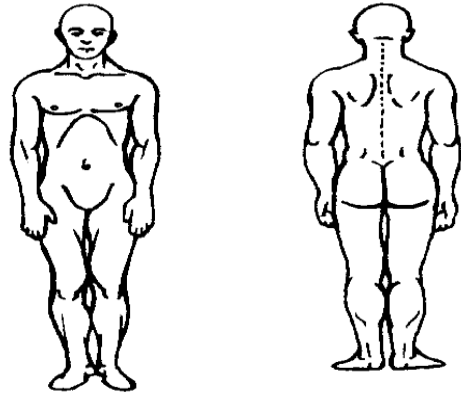
**PLEASE LIST YOUR CURRENT PROBLEMS OR COMPLAINTS: (chief complaint or present illness)**

1) \_\_\_\_\_ 2) \_\_\_\_\_ 3) \_\_\_\_\_ 4) \_\_\_\_\_

What % of the day do these symptoms bother you? 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

**PLEASE MARK YOUR AREAS OF COMPLAINT ON THE BODY DIAGRAM USING THE FOLLOWING KEY:**

- Dull = D
- Aching = A
- Stiffness = S
- Burning = B
- Tingling = T
- Numbness = N
- Sharp = ^^^^^
- Shooting = →
- Other \_\_\_\_\_ = \*\*\*



Please circle the appropriate number(s) for the intensity of your pain and the appropriate letter(s) for the frequency of the pain.

**O = Occasional** (0-25% of the time)  
**F = Frequent** (51-75%)

**I = Intermittent** (26-50%)  
**C = Constant** (76-100%)

**Area of Pain and Intensity of Pain**

	Normal	Minimal	Slight				Moderate				Severe				Frequency					
			1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
Neck		1	2	3	4	5	6	7	8	9	10		O	I	F	C				
Middle Back		1	2	3	4	5	6	7	8	9	10		O	I	F	C				
Lower Back		1	2	3	4	5	6	7	8	9	10		O	I	F	C				
Hips L R		1	2	3	4	5	6	7	8	9	10		O	I	F	C				
Shoulders L R		1	2	3	4	5	6	7	8	9	10		O	I	F	C				
Arms L R		1	2	3	4	5	6	7	8	9	10		O	I	F	C				
Hands L R		1	2	3	4	5	6	7	8	9	10		O	I	F	C				
Legs L R		1	2	3	4	5	6	7	8	9	10		O	I	F	C				
Feet L R		1	2	3	4	5	6	7	8	9	10		O	I	F	C				
Other:		1	2	3	4	5	6	7	8	9	10		O	I	F	C				
Other:		1	2	3	4	5	6	7	8	9	10		O	I	F	C				

Is it worse in the morning or as the day progresses? \_\_\_\_\_

Does anything relieve your pain? \_\_\_\_\_

What activities/movements are guaranteed to make it worse? \_\_\_\_\_

What positions are difficult?  Sitting  Standing  Walking  Bending  Lying Down

Other \_\_\_\_\_

Describe on the scale how the pain has affected your work (both inside and outside the home, and housework)

0 none 1 2 3 4 5 moderate 6 7 8 9 10 extremely

In General, how would you rate your overall health right now? Excellent Very Good Good Fair Poor

Please describe any other activities/hobbies that are restricted due to these symptoms? \_\_\_\_\_

When did you first notice these symptoms? \_\_\_\_\_ Is the condition getting worse?  No  Yes

Have you had this problem before?  No  Yes, When? \_\_\_\_\_

Have you had an injury or fall?  No  Yes, Describe \_\_\_\_\_

What other doctors and kinds of treatments have you received? \_\_\_\_\_

Did any of these treatments work? If so which one(s)? For how long? \_\_\_\_\_

Have you had Lab tests, X-rays/MRI's for this condition?  No  Yes Where? \_\_\_\_\_ When? \_\_\_\_\_

List ALL medications that you are taking even if it's not for condition listed above: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

List surgeries and dates:

\_\_\_\_\_

Please check any of the following that may apply to you:

- Abdominal Aortic Aneurism     Severe Bleeding or Anticoagulant Therapy     Pacemaker/Defibrillator
- Severe Bone Loss     Acute Infections     Benign Bone Tumors     Fractures or Dislocations
- Vascular Insufficiencies     Surgical Hardware/Metal Implants     Pain Control Devices
- Cholesterol Medications

For Women Only: Is there a possibility that you may be pregnant?  No  Yes

No treatments will be rendered until we understand completely whether your condition is a good fit for our treatments and you are comfortable with our clinical approach.

If you are accepted as a patient we will clearly help you understand your responsibility for services rendered. In cases where someone has insurance benefits...you are responsible for deductibles and copays that your insurance requires as well as any services not covered under your policy. For those without insurance or limited coverage, that is not a problem. We have easy and affordable payment options for you to get the care that you need.

Once we have enough information to determine whether or not you can be helped in our clinic we will spend all the time necessary to help you understand your condition and what options there are to help you get better, as well as those treatments or therapies that may be available to you even outside our facility.

Thank You

\_\_\_\_\_

**Healthcare & Privacy Laws Require Us To Have Written Consent In The Following Areas**

**Authorization to Release Information**

*If I am accepted as a patient*, I authorize this healthcare facility to release all information related to the care I receive, to my primary care physician, insurance company, third party payor, attorney, or their designee, as may be necessary for the coordination of care, payment of my bill, determining benefits, or for quality review.

**Privacy and Confidentiality**

I understand that this healthcare facility is making extensive effort to protect my personal privacy and information. I understand that there are some treatments and procedures that are not in a private setting such as, therapy tables and exercise rehabilitation. If I am uncomfortable with that setting then I will notify the staff and they will try to accommodate me as much as possible. I also give permission for the office to leave messages regarding future appointments and information related to my care. Federal and State laws (HIPPA) requires all healthcare facilities to adhere to their policies regarding the release and disclosure of medical records. Records and x-rays are the property of this facility. Copies of records may be received only by authorization of the patient or guardian, request must be in writing and payment of those copies follow the usual/customary costs. 7-10 business days is required to process this request. I have received a copy of the privacy protection policy.

**Authorization for Examination, Diagnostic Testing and Treatment**

*If, after consultation and deemed appropriate*, I authorize the performance of examination, laboratory, diagnostic tests, procedures and treatment deemed necessary by personnel in this office regarding my care. Necessary procedures will be discussed with the doctor on a case basis. I give the office staff permission to use their best clinical judgment regarding what is necessary to handle my case. I understand that occasionally it may be necessary for another doctor/therapist to treat me.

I understand that as with all medical procedures and treatments there are risks such as fracture, stroke, and the possibility that there will be no or little benefit for my particular condition. There is no guarantee of a cure. I understand that the doctor will explain the risk-benefits, prognosis of my condition and refer to another provider if needed. I understand that it may not be possible for every risk factor to be explained to me, I expect the doctor to use his best judgment in the management of my care. I also understand that the intent of this facility is to facilitate healthy body function primarily to musculoskeletal conditions and some individuals may need a medical provider to diagnosis and treat a certain disease. If medicines are prescribed then risks will be explained. Medicines can only be administered by the medical doctor on staff.

**Assignment of Benefits**

I assign to Dr. Brian McCain and all affiliates of Adams County Spine and Accident Center, Inc. all benefits payable to me for my care. If I ask this facility to handle my insurance claims for me, I authorize this healthcare facility be paid directly by the insurance company or other third party payer. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as the original. Insurance company contracts are between the company and the insured individual(s).

**Guarantee of Payment**

I guarantee payment of all charges incurred for evaluation and treatment in accordance with the rates and terms of this healthcare facility. I understand that this agreement will start once I am accepted as a patient and my care plan and responsibilities are discussed.

**Payment for all services is required on the same day and may be paid by, cash, check, VISA, Mastercard, Discover, or AMEX unless other arrangements have been made.** If we are submitting claims for your insurance to pay, then your co-insurance and payment toward your annual deductible is also required at the time of service.

**Payment plans and discounts are available; please ask if you are interested.**

We are happy to file claims for you if appropriate. However, disputes regarding coverage, benefits, payments, etc. are strictly between the patient and the insurance company. Most insurance claims involve delay before we receive payment. Please keep in mind that we can't guarantee payment from the insurance company, your insurance is your responsibility and we may need your help to collect your claims for you. Ultimately, you are responsible for payment of any services.

I certify that I understand the above office policies and agree to abide by the same.

\_\_\_\_\_  
Signature of patient or responsible party

\_\_\_\_\_  
date

\_\_\_\_\_  
If under 18 years old, relationship to patient