Enterprise Therapy Center

SERVING YOU SINCE 2002

Name: _____ **SSN:** _____ **Date:** _____

Leisure activities, including exercise routines: _____

Occupation, including activities that comprise your workday: _____

Age: _____ **Height:** _____ **Weight:** _____

Are you on a work restriction from your doctor? YES NO **Are you latex sensitive?** YES NO

Do you smoke? YES NO **Do you have a pacemaker?** YES NO

FOR WOMEN: Are you currently pregnant or think you might be pregnant? YES NO

ALLERGIES: List any medication(s) you are allergic to _____

Have you RECENTLY noted any of the following (check all that apply)?

- ❍ Fatigue
- ❍ Fever/chills/sweats
- ❍ Nausea/vomiting
- ❍ Weight loss/gain
- ❍ Difficulty maintaining balance while walking
- ❍ Falls
- ❍ Numbness or tingling
- ❍ Muscle weakness
- ❍ Dizziness/lightheadedness
- ❍ Heartburn/indigestion
- ❍ Difficulty swallowing
- ❍ Changes in bowel or bladder function
- ❍ Constipation
- ❍ Diarrhea
- ❍ Shortness of breath
- ❍ Fainting
- ❍ Cough
- ❍ Headaches

Have you RECENTLY been diagnosed with any of the following conditions (check all that apply)?

- ❍ Cancer
- ❍ Heart problems
- ❍ Chest pain/angina
- ❍ Circulation problems
- ❍ Blood clots
- ❍ Stroke
- ❍ Anemia
- ❍ Bone or joint infection
- ❍ Chemical dependency (i.e., alcoholism)
- ❍ Depression
- ❍ Lung problems
- ❍ Tuberculosis
- ❍ Asthma
- ❍ Rheumatoid arthritis
- ❍ Other arthritic condition
- ❍ Bladder/urinary tract infection
- ❍ Kidney problem/infection
- ❍ Sexually transmitted disease/HIV
- ❍ Pelvic inflammatory disease
- ❍ Thyroid problems
- ❍ Diabetes
- ❍ Osteoporosis
- ❍ Multiple sclerosis
- ❍ Epilepsy
- ❍ Eye problem/infection
- ❍ Ulcers
- ❍ Liver problems
- ❍ Hepatitis
- ❍ pneumonia

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- ❍ pneumonia

During the past month have you been feeling down, depressed or hopeless? YES NO

During the past month have you been bothered by having little interest or pleasure in doing things? YES NO

Is this something in which you would like help? YES YES, BUT NOT TODAY NO

Do you ever feel unsafe at home or has anyone hit or tried to injure you in any way? YES NO

Please list any medications you are currently taking (INCLUDING pills, injections, and/or skin patches):

1. _____ **2.** _____ **3.** _____

4. _____ **5.** _____ **6.** _____

Have you ever taken steroid medications for any medical conditions? YES NO

Have you ever taken blood thinning or anticoagulant medications for any medical conditions? YES NO

Please list any surgeries or other conditions for which you have been hospitalized, including dates:

1. _____ **2.** _____ **3.** _____

Enterprise Therapy Center

NAME _____

What date (roughly) did your present symptoms start? _____

What do you think caused your symptoms? _____

My symptoms are currently: ___ **Getting Better** ___ **Getting Worse** ___ **Staying about the same**

I should not do physical activities that might make my pain worse: ___ **Disagree** ___ **Unsure** ___ **Agree**

Treatment received so far for this problem (chiropractic, injections, etc.) _____

Please list special tests performed for this problem (x-ray, MRI, labs, etc.) _____

Have you ever had this problem before? ___ **Yes** ___**No** **When** _____ **Treatment received** _____

How long did it take for you to feel better? _____

BODY CHART:

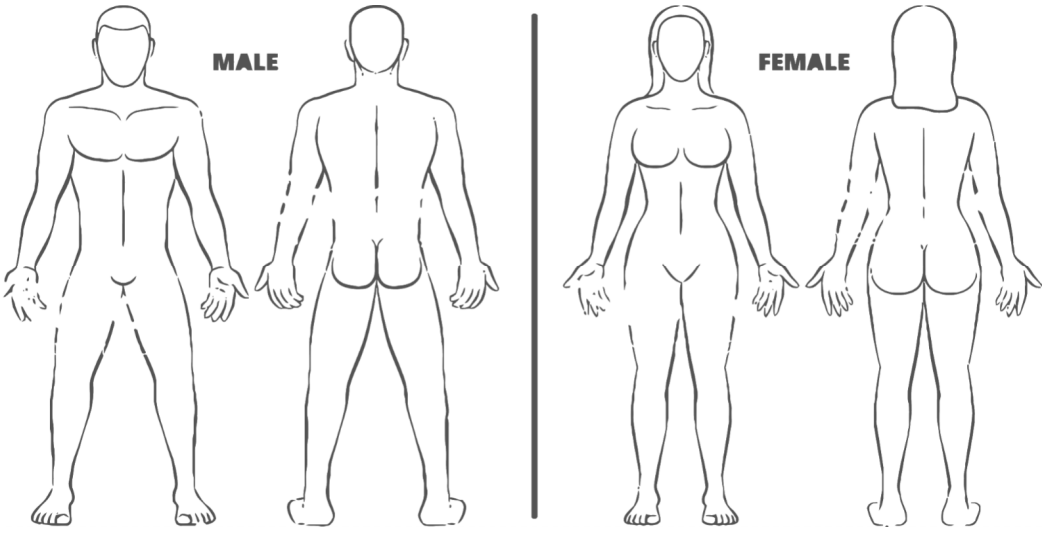
Please mark the areas where you feel symptoms on the chart to the right with the following symbols to describe your symptoms:

↓ **Shooting/sharp pain**

○ **Dull/aching pain**

||| **Numbness**

= **Tingling**



My symptoms currently: ___ **Come and go** ___ **Are Constant** ___ **Are constant, but change with activity**

Aggravating Factors: Identify up to 3 important positions or activities that make your symptoms worse:

1. _____ 2. _____ 3. _____

Easing Factors: Identify up to 3 important positions or activities that make your symptoms better:

1. _____ 2. _____ 3. _____

How are you currently able to sleep at night due to your symptoms?

___ No problem sleeping ___ Difficulty falling asleep ___ Awaked by pain ___ Sleep only with medication

When are your symptoms worse? ___ Morning ___ Afternoon ___ Evening ___ Night ___ After Exercise

When are your symptoms best? ___ Morning ___ Afternoon ___ Evening ___ Night ___ After Exercise

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Using the 0 to 10 scale, with 0 being "no pain" and 10 being the "worst pain imaginable" please describe: (circle one)

Your current level of pain with completing this survey: 0 1 2 3 4 5 6 7 8 9 10

The best your pain has been during the past 24 hours: 0 1 2 3 4 5 6 7 8 9 10

The worst your pain has been during the past 24 hours: 0 1 2 3 4 5 6 7 8 9 10

CONSENT FOR CARE AND TREATMENT

I, the undersigned, do hereby agree and give my consent for Enterprise Therapy Center to furnish medical care and treatment to _____ which is considered necessary and proper in the diagnosing or treating of my (their) physical condition.

Signature _____ Date _____

Patient / Guardian

BENEFIT ASSIGNMENT / RELEASE OF INFORMATION

I, the undersigned, hereby assign all medical benefits, i.e.: Medicare, private insurance, major medical benefits, Worker's Compensation and any other health plans to which I am entitled to. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize Enterprise Therapy Center to release all medical information and records necessary to secure payment for services rendered.

Signature _____ Date _____

Patient / Guardian

FINANCIAL POLICY STATEMENT

It is our policy to bill your insurance carrier or other provider of medical benefits as a courtesy to you, although you are responsible for the entire bill when the services are rendered. Required co-payments and estimated co-insurances are to be made as services are rendered and arrangements are to be made for payment of all amount not covered by your medical benefits or estimated co-insurances as soon as those amounts are known. If your medical benefits are not paid within sixty (60) days, the balance will be due in full from you.

All co-insurance percentages paid at time of service are estimated. Your actual liability may be more. You are responsible for any difference between the estimated and actual co-insurance due.

If any payments of medical benefits are made directly to you for services rendered by Enterprise Therapy Center, you must promptly remit such payment directly to Enterprise Therapy Center.

If you are a Worker's Compensation patient the above policy does not apply to you. Be advised, however, that you may be responsible for your charges if your Worker's Compensation claim is successfully controverted.

If you fail to make timely payment for any amount for which you are responsible, you will be responsible for all costs of collection, including court costs, collection agency fees and/or a reasonable attorney fee.

I have read the above information and/or it has been explained to me and I accept the terms and conditions of the above and will be responsible for the payment of my account.

Signature _____ Date _____

Patient / Guardian

Confidential Medical Information

Please state current problem(s): _____

_____

Are you currently being treated by:

Another Therapist	**____ Yes**	**____ No**	**Or within the last 12 months**	**____ Yes**	**____ No**
Chiropractor / Osteopath	**____ Yes**	**____ No**	**Or within the last 12 months**	**____ Yes**	**____ No**
Home Health Agency	**____ Yes**	**____ No**	**Or within the last 12 months**	**____ Yes**	**____ No**

Major surgeries since birth: _____

Allergies: _____

List current medications: _____

Check it you currently have or previously have had any of the following:

- ❍ **Arthritis**
- ❍ **Asthma**
- ❍ **Cancer**
- ❍ **Circulation Problems**
- ❍ **Diabetes**
- ❍ **Heart Problems**

Specify: _____

_____

_____

- ❍ **High Blood Pressure**
- ❍ **Gout**
- ❍ **Seizures**
- ❍ **Stroke**
- ❍ **Ulcers**
- ❍ **Other Illnesses**

Specify: _____

_____

_____

The above information is true and accurate to the best of my knowledge. I hereby authorize the release of any medical information necessary for processing insurance claims and payment of medical benefits for myself or the party who accept assignment of benefits.

Signature _____ **Date** _____

Patient Privacy Policy & Procedure Statement

Dear Patient:

Enterprise Therapy Center maintains compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPPA) privacy regulations passed into law on December 20, 2000.

We obtain your voluntary consent to provide treatment, release medical records to the appropriate entities and those who you designate to provide health care treatment, payment, and daily operations of the facility.

Our clinical and front office staff use patient information to ensure quality care and appropriate billing for services.

You may correct, amend, access, and request a copy of your medical record and access history by signing a letter for release of your medical information. The cost for copies of medical records is in accordance with state law.

We protect all patient information within the guidelines provided by federal, state, and local government.

If you have any grievance pertaining to the privacy of medical records or wish to inquire further about how our facility manages patient information, please contact our Privacy Officer at 334-393-7500.

Enterprise Therapy Center reserves the right to amend, change, and/or revise our privacy policy at any time in accordance with federal, state, and local rules, regulation, and guidelines.

Thank you for choosing our health care facility.

Signature _____ Date _____

Parent / Guardian