nextlevel
SPINE & SPORTS INJURY CENTER

2605 Nicholson Rd, Suite 3120
Sewickley, PA 15143
Nextlevelspineandsports.com

Patient Intake Form

Patient information contained within this form is considered strictly confidential.

Your responses are important to help us better understand the health issues you face and ensure the delivery of the best possible treatment.

Name:_____ **Date:**_____
Insurance: _____
Address: _____
_____
Date of Birth:_____
Marital Status: ☐ single ☐ married
Home Phone: _____ **Cell:** _____
Email: _____
Occupation: _____**Employer:**_____

Mark (c) for current problems. Check and indicate the age when you were diagnosed.

- ☐ Allergies
- ☐ Arthritis
- ☐ Asthma
- ☐ Autoimmune disease
- ☐ Bleeding disorders
- ☐ Cancer/Tumor
- ☐ Cardiovascular disease
- ☐ Chest pain
- ☐ COPD/Emphysema
- ☐ Depression
- ☐ Diabetes
- ☐ Difficulty breathing
- ☐ Dizziness
- ☐ Emotional/Mental disorders
- ☐ Epilepsy/Seizures
- ☐ Fatigue
- ☐ Fever
- ☐ Gallbladder disease
- ☐ Gastrointestinal disorders
- ☐ Gout
- ☐ Headache
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Irregular heart beat
- ☐ Kidney disorders
- ☐ Urinary disorders
- ☐ Unintentional weight loss/gain
- ☐ Loss of balance
- ☐ Loss of smell or taste
- ☐ Lung disorders
- ☐ Menstrual irregularities
- ☐ Migraines
- ☐ Numbness/tingling
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Prostate disorders
- ☐ Previous surgery
- ☐ Pregnancy (___ weeks)
- ☐ Recent vision/hearing changes
- ☐ Shortness of breath
- ☐ Skin disorders
- ☐ Sleep disturbances
- ☐ Smoking
- ☐ Stroke (__/__/__)
- ☐ Swelling
- ☐ Thyroid disorders
- ☐ Ulcers
- ☐ Weakness
- ☐ Other

Family History: *For blood relatives and indicate which relative(s)*

- ☐ Arthritis
- ☐ Autoimmune conditions
- ☐ Cancer
- ☐ Diabetes
- ☐ Heart disease
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Stroke

Past Health History: *if yes, explain briefly below*

- ☐ Hospitalization in the last 5 years
- ☐ Broken bones
- ☐ Joint replacements
- ☐ Strains/Sprains
- ☐ Surgeries

_____ _____
_____ _____
_____ _____

Please list any medications or dietary supplements you are currently taking and why:

_____
_____
_____

Patient Intake Form (page 2)

Give a brief detailed description of what specific issue caused you to seek care:

_____

_____

_____

What seemed to be the initial cause? _____

How long have you had this condition? _____ Is it worsening? □ yes □ no

Does anything make the condition better (certain activity, other)?_____

Does anything worsen the condition (particular movements, other)?_____

Have you received prior treatment (physical therapist, medical doctor, other)?_____

If so, what was the treatment and what were your results?_____

_____

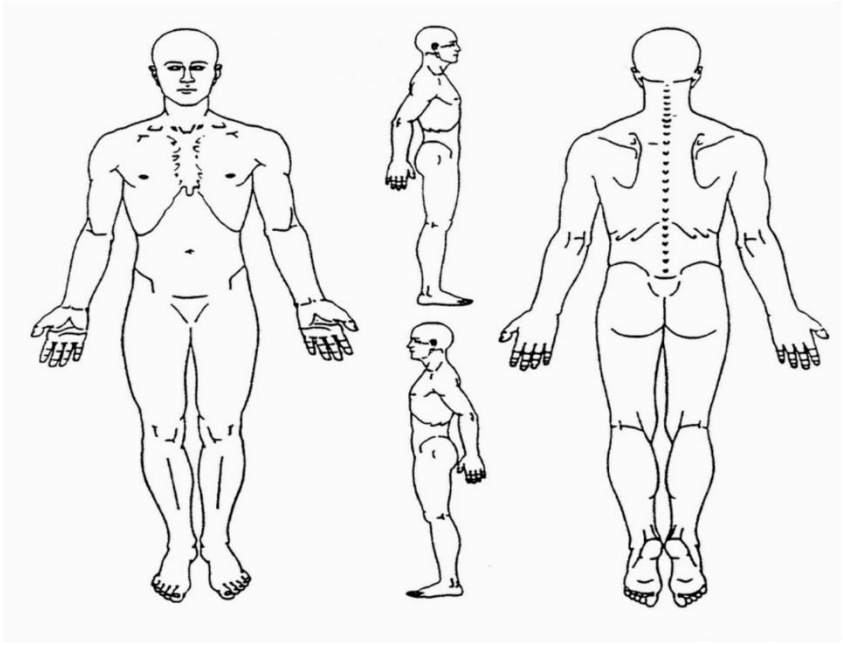
Have you had previous diagnostic testing? □ X-Ray □ CT □ MRI □ other_____

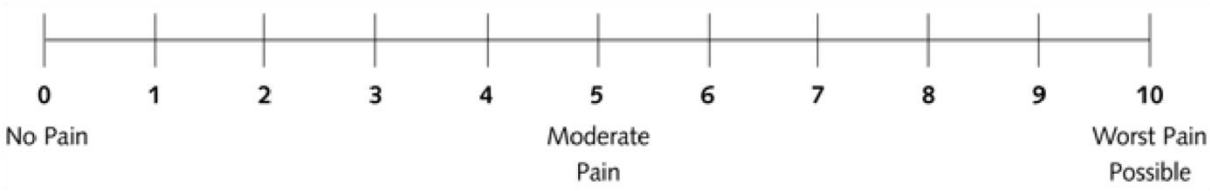
When/Where? _____

What is your goal for seeking care today? _____

_____

Mark the area(s) of complaint indicating what you have been experiencing: P= pain; T = tightness; N = numbness or tingling; W = weakness





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CANCELLATION POLICY

We understand that unplanned issues can come up and you may need to cancel an appointment. If that happens, we respectfully ask for scheduled appointments to be cancelled by 5:00 pm of the day preceding your appointment. Most days, we have cancellation list of patients that would like be seen and with proper notice of a cancellation; we would be able to accommodate them. When we receive late cancellations or no-shows, the appointments go unused while Dr. Scott and Dr. Palmieri often come in early and stay late to accommodate acute/urgent cases. While we have always had a cancellation policy in place, circumstances have caused us to enforce a policy of charging for late cancellations.

Effective as of April 1, 2016, Next Level Spine and Sports Injury Center will be instituting the following No-Show/Late Cancellation Policy.

• You may cancel your appointment without charge any time before the close of business (5pm) on the business day preceding your appointment. (ex: You may cancel your Tuesday appointment before 5pm on Monday with no penalty).
• Same day cancellations and late cancellations will be charged a $35 late cancellation fee.

- **This cancellation fee must be paid prior to scheduling your next appointment**

While we hope this will not be necessary, patients who repeatedly violate the No-Show/Late Cancellation Policy will be sent written notification that he/she has violated the policy and these instances will be handled on an individual basis.

Thank you for being a valued patient and for your understanding and cooperation as we institute this policy. This policy will enable us to open otherwise unused appointments to better serve the needs of all patients

Patient Signature_____ Date_____

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Informed Consent Form

I_____, do hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/adjustments involving movement of the joints and soft tissues. Physical therapy and exercises may also be used. Although spinal and extremity manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows:

Soreness/Bruising: I am aware that like exercise it is common to experience muscle soreness and occasionally bruising in the first few treatments.

Dizziness: Temporary symptoms like dizziness and nausea can occur but are relatively rare. Fractures/Joint Injury: I further understand that in isolated cases underlying physical defects, deformities or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disc, or other abnormality is detected, this office will proceed with extra caution.

Stroke: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage including stroke is reported to occur once in a million to once in ten million treatments. Once in a million is about the same chance as getting hit by lightning. Once in ten million is about the same chance as a normal dose of aspirin or Tylenol causing death.

Physical Medicine Modalities: Other therapies used in this office include instrument assisted soft tissue mobilization, active release technique (myofascial release), electrical stimulation, Piezowave, kinesio-taping, normatec recovery boots, game-ready ice compression, and corrective exercises. Possible side effects of these treatments include muscle soreness, bruising, redness, petechia, joint pain, and skin irritation.

TREATMENT RESULTS I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits. I realize that the practice of medicine, including chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures. I agree to the performance of these procedures by my doctor and such other persons of the doctor’s choosing.

ALTERNATIVE TREATMENTS AVAILABLE Reasonable alternatives to these procedures have been explained to me including rest, home applications of therapy, prescription or over-the-counter medications, exercises and possible surgery. Medications: Medication can be used to reduce pain or inflammation. I am aware that long-term use or overuse of medication is

always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks. Rest/Exercise: It has

been explained to me that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat or other home therapy. Prolonged bed rest contributes to weakened bones and joint stiffness. Surgery: Surgery may be necessary for joint instability or serious disc rupture. Surgical risks may include unsuccessful outcome, complications, pain or reaction to anesthesia, and prolonged recovery. Non-treatment: I understand the potential risks of refusing or neglecting care may include increased pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy. I have read or had read to me the above explanation of chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction PRIOR TO

MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely. To attest to my consent to these procedures, I hereby affix my signature to this authorization for treatment.

Signature of Patient _____

Date:_____

Patient Name: _____

Phone Number:_____

Insurance Verification

Insurance Company:_____

Member ID Number:_____

Member Name:_____

Date of Birth:_____

Primary Insured Name:_____

Primary Insured Date of Birth:_____

Payer ID (United Insurance Only):_____

Group Number (United Only):_____

ARE YOU PARTICIPATING WITH MEDICARE? YES NO

IS YOUR INSURANCE PLAN PARTICIPATING WITH PNC BANK?

YES NO