Sports & Spinal Injury Clinic, LLC

6634 Lake Otis Pkwy #A, Anchorage, AK 99507
Phone (907) 522-3511; Fax (907) 522-8551

Patient Name: ______________________ ______________________ ______________________
Last First Middle

Name You Prefer to be called: ______________________ SS#: ______________________

Date of Birth: ____/____/____ Gender: M / F Email: ______________________

Mailing Address/City/ST: ______________________ Zip: __________

Home Phone #: __________ Cell Phone #: __________ Work Phone w/ext.: __________

Occupation: Student / Clerical / Laborer / Education / Sales / Other: ______________________

Employer: ______________________ How long?: __________

Employer's Address/City/ST: ______________________ Zip __________

Other Phone #'s: ______________ Marital Status: Single / Married / Divorced / Widowed / Separated

Spouse's Name: ______________ Spouse DOB: __________ Spouse Cell #: __________

Spouse's Employer: ______________________ Phone Wk #: __________

Emergency Contact: ______________ Relation: __________ Phone #: __________

I HEARD ABOUT THIS CLINIC FROM (Name if app): ______________________

Payment Information (Circle one) **Auto • Cash/Check/CC • Health Ins • Personal Injury • Work Comp**

Do you have Medicare? Yes / No Is Medicare your Primary or Secondary? __________

Person ultimately responsible for account (If dependant is patient)

Name: ______________________ SS#: __________ DOB: __________

Mailing Address/City/ST: ______________________ Zip: __________

Home #: __________ Cell #: __________ Relationship to Patient: __________

Employer: ______________________ Work # __________

Primary:

Insured Name: ______________ SS#/ID: __________ DOB: __________

Insurance Co.: ______________ Group #: __________ Plan #: __________

Ins. Address/City/ST: ______________________ Zip: __________

Phone #: __________ Insured's Employer: ______________________

Secondary:

Insured Name: ______________ SS#/ID: __________ DOB: __________

Insurance Co.: ______________ Group #: __________ Plan #: __________

Ins. Address/City/ST: ______________________ Zip: __________

Phone #: __________ Insured's Employer: ______________________

Attorney / Auto/PI Information: (Circle one) This is: **My / Other Person's** Insurance Information

Atty Name: ______________ Work#: __________ Cell #: __________

Mailing Address/City/ST: ______________________ Zip: __________

Ins Co: ______________ Claim #: __________ Phone #: __________

Ins. Address /City / ST / Zip: ______________________

Adjuster Name: ______________ Insured Name (If not self): ______________

I fully understand when the insurance company verifies my benefits it is not a guarantee or authorization to pay on claims submitted. I agree to pay my patient portion, plus any balance insurance does not reimburse for, at each visit or when I receive the outstanding bill. I agree to pay/settle any denied and unpaid claims over and above insurance payments. I further understand all claims submitted by this office are my responsibility and may require my participation to settle regardless of my insurance or assignment of benefits. I also understand that if my bill is not paid within 90 of the date of service and no financial arrangements have been made, a $20 per month charge from the first month will be added to my bill. I agree that this office will file my claim form, and that Health Care Benefits or Medical Reimbursement from a Third Party Payer, if I don't have med-pay with my insurance, will be made directly to **Sports & Spinal Injury Clinic, LLC** otherwise payable to me, unless the account is previously paid in full. I authorize **Sports & Spinal Injury Clinic, LLC** to perform any necessary diagnostic testing, ie. vital signs, range of motion, palpation, muscle strength, postural analysis, basic neurological, orthopedic testing, etc., needed during diagnosis and treatment. I also authorize the release of any information required to process and pay my insurance claims. I understand that pain syndromes can be caused by conditions (such as tumors, etc.) which may be visualized by x-rays, however, I have decided that if the Doctor feels X-rays are not necessary for my condition that I agree also to no x-rays and do not hold anyone associated with the **Sports & Spinal Injury Clinic, LLC** responsible for such pathology. I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status. **I also understand that if I do not show for an appointment or if I give less then 12 hours notice to cancel or reschedule an appointment, that I am responsible for the charges of that appointment.** I have read, understand and agree to these terms.

Signature of Patient (or Guardian) ______________________ Date __________

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Sports & Spinal Injury Clinic, LLC

Reason For Visit Form

Patient Name ____________________ Date ____________

The reason for this visit is/Major complaint(s): 1.____________ 2.____________
3.____________ 4.____________ 5.____________
When did condition begin? 1.________ 2.________ 3.________ 4.________
What caused your condition? 1.________ 2.________ 3.________ 4.________
When does it and which complaint hurts? AM / PM #________ Constant / Intermittent #________
Daily / Weekly / Monthly #________
Describe the quality/character of the pain of each complaint: ____________

____

Does it radiate to another part of your body? If so, where?: ____________
Is condition getting: ☐ Worse? #____ ☐ Better? #____ ☐ Unchanged? #____ ☐ Comes and goes? #____
What helps your condition? 1.________ 2.________ 3.________ 4.________
What aggravates your condition? 1.________ 2.________ 3.________ 4.________
Associated Symptoms (Ex: headache, difficulty breathing, bowel/bladder dysfunction, etc.) ____________

____

Level of physical activities now from 1 to 10? (1 = Sedentary & 10 = Active) ____ Level before? ____
Is this condition interfering with your: ☐ Work ☐ Sleep ☐ Daily routine? If any, how and which one?____

____

Have you been treated by another Physician for <u>this</u> condition? ☐ Yes ☐ No If so, when and where and which one? Name of Hospital and/or Attending doctor? ____________

____

Was he/she a: ☐ D.C. ☐ M.D. ☐ D.O. ☐ D.D.S. ☐ N.D. ☐ Other ____________
How did you get there? ☐ Ambulance ☐ Private transportation Were X-rays taken? ☐ Yes ☐ No
Was medication prescribed? ☐ Yes ☐ No If so, what? ____________
What's been done for which condition?: ____________

____

To evaluate the effect that continuing work will have on your recovery please complete the following: (If applicable)

Have you been able to work since this injury? ☐ Yes ☐ No # of hours in normal work day? ____
Maximum weight you are required to lift? ____ Maximum weight you can lift since injury? ____
Prior to injury were you physically capable of working on an equal basis with others your age? ☐ Yes ☐ No
While in recovery, is there any light duty work you could request? ☐ Yes ☐ No ☐ N/A
Please describe your job/work: ____________

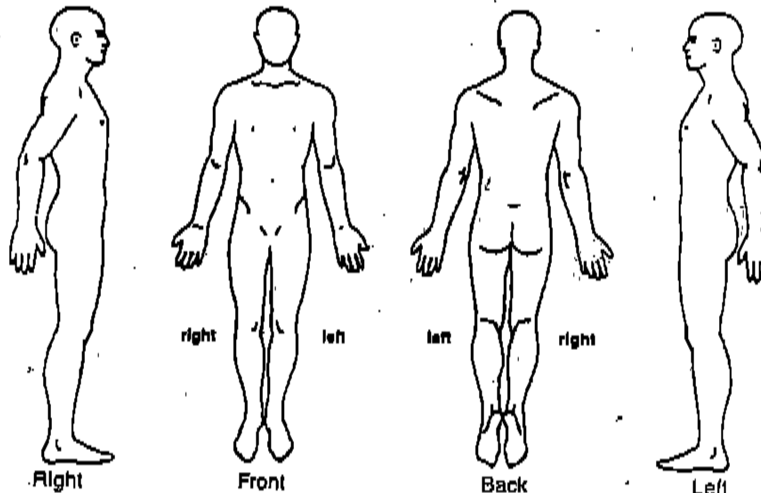
____

Please check any of the following activities that cause pain or discomfort.

- ☐ Bending Forward / Backward
- ☐ Kneeling
- ☐ Lifting
- ☐ Lovemaking
- ☐ Lying on Back / Side / Stomach
- ☐ Pulling / Pushing / Reaching
- ☐ Running / Walking
- ☐ Sitting / Standing
- ☐ Sports
- ☐ Turning Head / Back
- ☐ Twisting
- ☐ Working

Please circle all area(s) of injury or discomfort. Mark all areas with the appropriate symbols.

NN = Numbness
BB = Burning
AA = Aching
SS = Stabbing
PP = Pins & Needles
P = Pinching



Sports & Spinal Injury Clinic
Health History Form

Patient Name ______________________________ Date ________________

Please check any of the following you have or have had.

- ☐ Alcohol / Drug Abuse
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Bones / Joints
- ☐ Artificial Valves
- ☐ Asthma / Difficulty Breathing
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Congenital Heart Defect
- ☐ Diabetes / Tuberculosis
- ☐ Disc Herniation ____________
- ☐ Emphysema / Lung Disorder
- ☐ Fainting / Seizures / Epilepsy
- ☐ Fibromyalgia
- ☐ Frequent Neck Pain
- ☐ Frequent / Severe Headaches
- ☐ Glaucoma
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Heart Surgery / Pacemaker
- ☐ Hepatitis
- ☐ High / Low Blood Pressure
- ☐ HIV+ / Aids
- ☐ Kidney Problems
- ☐ Lower Back Pain
- ☐ Lupus
- ☐ Mitral Valve Prolapse
- ☐ Psychiatric Problems
- ☐ Rheumatic Fever
- ☐ Scoliosis
- ☐ Shingles
- ☐ Sinus Problems
- ☐ Stroke
- ☐ Ulcers / Colitis
- ☐ Venereal Disease
- ☐ Other ______________

Please list any medications (prescriptions and non-prescriptions) you are currently taking.: ____________________

Please list any other serious medical condition(s) you have or ever had: ____________________

Please list anything that you may be allergic to: ____________________

List previous surgeries/treatments with dates: ____________________

List any **past** serious accidents/injuries/illnesses with dates: ____________________

List any fractures/broken bones: ____________________

Family Health History: ____________________

Other complaints: ____________________

Do you smoke/chew tobacco? If so, how much? ______________ How long? ______________
Do you drink alcohol / drugs? If so, how much? ______________ How long? ______________
Do you consume caffeine on a regular basis? ☐ Yes ☐ No / How much? ______________
Describe your dietary habits: ____________________

Are you wearing: ☐ Heel Lifts ☐ Sole Lifts ☐ Inner Soles ☐ Arch Supports
Is your mattress supportive? ☐ Yes ☐ No Do you exercise?: ☐ Rarely ☐ Frequently ☐ Routinely
Do you sleep on your ☐ Back ☐ Left side ☐ Right side ☐ Stomach
What types of exercise do you do? ____________________

Any other relative information: ____________________
Have you ever been treated by a Chiropractor before? ☐ Yes ☐ No

For women: Pregnant? ☐ Yes ☐ No / How long? __________ Nursing? ☐ Yes ☐ No
Birth Control? ☐ Yes ☐ No If so, what? ______________

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