

# UTAH SPINE & SPORT

## CHIROPRACTIC, ACUPUNCTURE AND REHAB CENTER

(Utah Spine & Sport is a DBA of The Health & Wellness Institute of Utah, LLC. If billing your insurance, either name may show up on your statements.)

Dear Patient, please complete this questionnaire. Your answers will help us determine if you qualify for care in our clinic. Thank You!

### PATIENT INFORMATION:

Name \_\_\_\_\_ Gender  M  F Date \_\_\_\_\_  
Birth Date \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Marital Status  S  M  D  W

Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone (cell) \_\_\_\_\_ (home) \_\_\_\_\_

Email\* \_\_\_\_\_ (\*your email will NEVER be sold or shared)

To which of the above would you like appointment reminders sent? (please pick 1 of the 2 options below)

Email or  Cell Phone (via Text Message): Who is your Cell phone carrier (i.e. t-mobile, AT&T, etc?): \_\_\_\_\_

How soon before each visit should we send it?  30 minutes  1 Hour  3 Hours  1 Day  2 Days  1 Week  Other \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

How did you hear about us?  Referred by \_\_\_\_\_  Google  Yahoo  Facebook  Twitter  Other \_\_\_\_\_

What was your primary interest that brought you in today?  Chiropractic  Acupuncture  Sports/Golf Care  Weight Loss

Muscle Testing(AK)  Rehab  Other: \_\_\_\_\_

### INSURANCE INFORMATION: Do you have health insurance? Y N (if No, skip to "Reason for Visit")

\*\*Please Note: Many insurances only pay for spinal adjustments and do not cover some of the other services we provide.

You are responsible for any deductibles, co-pays and non-covered charges.\*\*

Insurance Company Name \_\_\_\_\_ Telephone: \_\_\_\_\_

Group #: \_\_\_\_\_ Insured's Name: \_\_\_\_\_

Insured's SS#: \_\_\_\_\_ Insured's DOB: \_\_\_\_\_ Relation: \_\_\_\_\_

\* If an auto accident, please provide:

Insurance Company Name \_\_\_\_\_ Contact Person \_\_\_\_\_

Phone: \_\_\_\_\_ Claim # \_\_\_\_\_ Date of Accident \_\_\_\_\_

### Reason For Visit: What type of treatment are you looking for?

the most minimal amount of care to "get rid of the symptoms" of my problem.

resolve my symptoms and then go on to "fix the cause" of my problem.

fix my problem and then go on to "maintain optimal Health and Wellness"

What is your Primary Health Complaint? Please include the Date it started and Grade it on a scale of 1 to 10.

Primary Complaint:

Date it Started:

(1=No complaint, 10=worst)

1) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ 1 2 3 4 5 6 7 8 9 10

Is the condition interfering with your:  Work  Sleep  Daily Routine  Recreation  Other \_\_\_\_\_

What makes your condition better? \_\_\_\_\_ What makes it worse? \_\_\_\_\_

Is it progressively getting?  Better  Worse  Staying the Same Is it?  Constant  Intermittent

Have you had any of the following in the last 2 months:  Allergies  Surgeries  Medications  Supplements

Please explain \_\_\_\_\_

Please indicate which of the conditions below you have experienced lately?

- |                                                           |                                                  |                                                |                                                      |
|-----------------------------------------------------------|--------------------------------------------------|------------------------------------------------|------------------------------------------------------|
| <input type="checkbox"/> Acid Reflux                      | <input type="checkbox"/> Decreased Sex Drive     | <input type="checkbox"/> Kidney Problems       | <input type="checkbox"/> Sore Muscles                |
| <input type="checkbox"/> Anemia                           | <input type="checkbox"/> Depression              | <input type="checkbox"/> Knee Pain             | <input type="checkbox"/> Sports Injury               |
| <input type="checkbox"/> Ankle / Foot Pain                | <input type="checkbox"/> Dislocated Joints       | <input type="checkbox"/> Menstrual Problems    | <input type="checkbox"/> Swollen Joints              |
| <input type="checkbox"/> Arthritis                        | <input type="checkbox"/> Ear Infection/Earache   | <input type="checkbox"/> Nausea/Vomiting       | <input type="checkbox"/> Tingling in Hands / Feet    |
| <input type="checkbox"/> Asthma                           | <input type="checkbox"/> Elbow / Hand Pain       | <input type="checkbox"/> Neck Pain             | <input type="checkbox"/> Tired/Fatigued              |
| <input type="checkbox"/> Back Pain (Mid-Upper-Lower ?)    | <input type="checkbox"/> Facial Pain             | <input type="checkbox"/> Numbness              | <input type="checkbox"/> Walking Problems            |
| <input type="checkbox"/> Bladder Problems                 | <input type="checkbox"/> Headaches/Migraines     | <input type="checkbox"/> Paralysis             | <input type="checkbox"/> Weak Muscles                |
| <input type="checkbox"/> Bone fracture                    | <input type="checkbox"/> Heart Problems          | <input type="checkbox"/> Poor Circulation      | <input type="checkbox"/> Crave Salts/Sweets          |
| <input type="checkbox"/> Carpel Tunnel                    | <input type="checkbox"/> High Blood Pressure     | <input type="checkbox"/> Reproductive Problems | <input type="checkbox"/> Symptoms ↑ with stress      |
| <input type="checkbox"/> Chest Pain                       | <input type="checkbox"/> Hip Pain                | <input type="checkbox"/> Serious Injury        | <input type="checkbox"/> Symp ↑ with Seasonal Change |
| <input type="checkbox"/> Concussion                       | <input type="checkbox"/> Indigestion / Heartburn | <input type="checkbox"/> Sinus Problems        | <input type="checkbox"/> Unexplained Weight Gain     |
| <input type="checkbox"/> Constipation                     | <input type="checkbox"/> Insomnia                | <input type="checkbox"/> Shoulder Pain         | <input type="checkbox"/> Dizziness Upon Standing     |
| <input type="checkbox"/> Cramping (muscle or menstrual ?) | <input type="checkbox"/> Joint Stiffness         | <input type="checkbox"/> Other: _____          |                                                      |

Which of the above conditions do you seek treatment for in our office? \_\_\_\_\_

**FAMILY HISTORY:** Please let us know if YOU or any of your FAMILY have or have had any of the following:

- Stroke     HIV/AIDS     Vaccine Reaction     Infertility     Cancer     Heart Disease     Tumor(s)  
 Aortic Aneurism     Diverticulitis/IBS     Seizures     Diabetes     Hepatitis     Other \_\_\_\_\_

Please Explain \_\_\_\_\_

[Females only]: Date of last menstrual period \_\_\_\_\_ Pregnant Y N Maybe    Nursing Y N

**CHIROPRACTIC INFORMED CONSENT TO TREAT:**

- I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that payment is due at the time services are rendered.
- I authorize the provider to release any information required to process insurance claims and assign all insurance benefits directly to the provider.
- I have read and understand how my patient health information will be used and I agree to these policies.
- 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 understand and accept that other chiropractic procedures may include clinical acupuncture, therapeutic exercises, cold laser treatment and other modes of therapy and give my consent to receive such treatments if indicated, realizing each may carry risks.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office of clinic personnel the nature and purpose of chiropractic adjustments and procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

PATIENT SIGNATURE <b>X</b> (Or Patient Representative)	(Date)
(Indicate relationship if signing for patient)	

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers or preceptorship interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit.

Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and if not revoked will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment) patient should initial here. \_\_\_\_\_. Effective as the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

Signature lines for Patient and Office, including fields for signature, date, and relationship to patient.

Please return to the secretary, Thank you!