PSMC
PERFORMANCE SPORTS
MEDICAL CENTER

Patient Information		
First Name:	Middle Initial:	Last Name:
Date of Birth:	Social Security Number:	Gender: Male: ☐ Female: ☐
Street Address:	Email Address:	
City:	State:	Zip Code:
Home Phone:	Work Phone:	Cell Phone:
Emergency Contact:	Phone Number:	Relationship:

Consent to Treat:

I hereby request and consent to the performance of chiropractic adjustments and any other chiropractic procedures, including various modes of physical therapy, soft tissue therapy and diagnostic testing (doctor will thoroughly discuss and inform patient beforehand) on myself (or on the patient named below, for whom I am legally responsible) by the Doctor of Chiropractic or the staff of Performance Sports Medical Center.

I have had an opportunity to discuss with the Doctor of Chiropractic or the staff of Performance Sports Medical Center, the nature and the purpose of chiropractic adjustments and other 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 sprain/strains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise appropriate judgement during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

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.

If Patient is under the age of 18, please fill out parent or guardian's information

Parent or Guardian First Name:	Middle Initial:	Last Name:

Patient's Signature (or guardians signature): _____Date:_____

ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS
AS WELL AS AN APPOINTMENT AND/OR DESIGNATION AS MY PERSONAL REPRESENTATIVE
AND AN ERISA/PPACA REPRESENTATIVE AND BENEFICIARY

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay **PERFORMANCE SPORTS MEDICAL CENTER** as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided. I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that ***have been*** **or** ***will be*** rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under. I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same. I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment, appointment, and designation will remain in effect unless revoked by me in writing. *It is my intent that the effective date of this document shall relate back to include all services, supplies, test, treatments, or medications that have been previously provided by Healthcare Provider.* A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

Signed this _____ day of _____, 20 ____.

X_____
(patient signature)

X_____
(signature of Guardian if applicable)

X_____
(please print patient name)

Thank you for choosing **Performance Sports Medical Center**. In our clinic we carefully examine all the systems in your body so that we may gather all the information necessary to best address your healthcare and wellness needs. Please bear with all the paperwork we present you with. Please never assume that any question is irrelevant or unimportant to your case, everything asked here is highly relevant and extremely important! We need you to carefully and honestly answer every question so that we may piece together the best approach to managing your case.

Health History

Patient Name: _____DOB: _____Date:_____

Chief Complaint: _____

History of Present illness:

Location: _____ (Where is the pain/problem?)

Quality: _____ (Example: normal vs abnormal color, activity, etc..)

Severity: _____ (How severe is the pain/problem on a scale of 1-10 with 10 being the most severe?)

Duration: _____ (How long have you had this pain/ problem? When did it start?)

Timing: _____ (Does the pain/problem occur at a specific time?)

Context: _____ (Where were you at the onset of this pain/problem?)

Associated Signs/Symptoms _____ (What other associated problems have you been having?)

Modifying Factors _____ (What makes the pain/problem worse or better? Have you had previous episodes?)

Past Medical History

(Have you ever had the following: (circle "yes" or "no"/ leave blank if you are uncertain.)

Measles……	NO YES	Anemia……..NO	YES	Back Trouble……..NO	YES	Hepatitis……..NO	YES
Mumps……	NO YES	Bladder Infection…….NO	YES	High Blood Pressure……NO	YES	Ulcer……NO	YES
Chicken Pox……	NO YES	Epilepsy……NO	YES	Low Blood Pressure…….NO	YES	Kidney Disease……NO	YES
Whooping Cough…	NO YES	Migraine Headaches. NO	YES	Hemorrhoids……NO	YES	Thyroid Disease……NO	YES
Scarlet Fever……	NO YES	Tuberculosis……..NO	YES	Date of Last Chest X-Ray_____		Bleeding Tendency…….NO	YES
Diphtheria……	NO YES	Diabetes……..NO	YES	Asthma……..NO	YES	Any Other Disease…….NO	YES
Small pox……	NO YES	Cancer……NO	YES	Hives of Eczema……NO	YES	(Please List):	
Pneumonia……	NO YES	Polio……NO	YES	AIDS & HIV……NO	YES		
Rheumatic Fever…	NO YES	Glaucoma……NO	YES	Infectious Mono……NO	YES	_____	
Arthritis……	NO YES	Hernia……NO	YES	Bronchitis……..NO	YES		
Venereal Disease…	NO YES	Blood or Plasma Transfusion……..NO	YES	Mitral Valve Prolepses….NO	YES	_____	
				Stroke……NO	YES		

Previous Hospitalizations/Surgeries/Serious Illnesses When? Hospital, City, State

_____ _____ _____

_____ _____ _____

_____ _____ _____

Medication: (include nonprescription)

_____

_____

Have you ever taken Fen-Phen/Redux? NO YES

Are you taking any medications (prescription or over the counter) for acid indigestion?

O yes O no if yes what type: _____

Patient Social History:

Marital Status	Single: _____	Married: _____	Separated: _____	Divorced: _____	Widowed: _____
Use of Alcohol	Never: _____	Rarely: _____	Moderate: _____	Daily: _____	
Use of Tobacco	Never: _____	Rarely: _____	Moderate: _____	Daily: _____	
Use of Drugs	Never: _____	Type/Frequency: _____			
Excessive Exposure At home or at work to:	Fumes: _____	Dust: _____	Solvents: _____	Airborne Particles: _____	Noise: _____

CLINICIAN SIGNATURE: _____ **DATE REVIEWED:**_____

PATIENT NAME: _____ **DATE:**_____

Name:_____ DOB _____ Date:_____

Family Medical History:

	Age	Disease	If Deceased, Cause Of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Spouse:	_____	_____	_____
Children:	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Indicate which of the below you have experienced in the last 1-2 months
1=Never; 2=Rarely; 3=Occasionally; 4=Frequently; 5=Constantly

Eyes/Ears/Nose/Throat/Respiratory		**Muscular/Skeletal**	
Asthma	1 2 3 4 5	Muscle Aches	1 2 3 4 5
Stuffy Nose	1 2 3 4 5	Fibromyalgia	1 2 3 4 5
Hay Fever	1 2 3 4 5	Arthritis	1 2 3 4 5
Sore throat	1 2 3 4 5	Joint Pain	1 2 3 4 5
Chronic Cough	1 2 3 4 5	Low Back Pain	1 2 3 4 5
Chest Congestion	1 2 3 4 5	Neck Pain	1 2 3 4 5
Frequent Sneezing	1 2 3 4 5	Wrist/Hand Pain	1 2 3 4 5
Itchy/Watery Eyes	1 2 3 4 5	Elbow Pain	1 2 3 4 5
Drainage	1 2 3 4 5	Shoulder Pain	1 2 3 4 5
Earache or Ear Infection	1 2 3 4 5	Hip Pain	1 2 3 4 5
Itching	1 2 3 4 5	Knee Pain	1 2 3 4 5
Hoarseness	1 2 3 4 5	Ankle/Foot Pain	1 2 3 4 5
Shortness of Breath	1 2 3 4 5	Pain b/t shoulder blades	1 2 3 4 5
Wheezing	1 2 3 4 5		

Neurological		**General**	
Headaches	1 2 3 4 5	Fatigue	1 2 3 4 5
Migraines	1 2 3 4 5	Malaise	1 2 3 4 5
Dizziness	1 2 3 4 5	Weakness, tiredness	1 2 3 4 5
Numbness	1 2 3 4 5	Lightheadedness	1 2 3 4 5
Tingling	1 2 3 4 5	Irritability	1 2 3 4 5
Pins/needles in hands or feet	1 2 3 4 5	Constipation	1 2 3 4 5
		Diarrhea	1 2 3 4 5
		Feeling foggy	1 2 3 4 5
		Forgetfulness	1 2 3 4 5

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

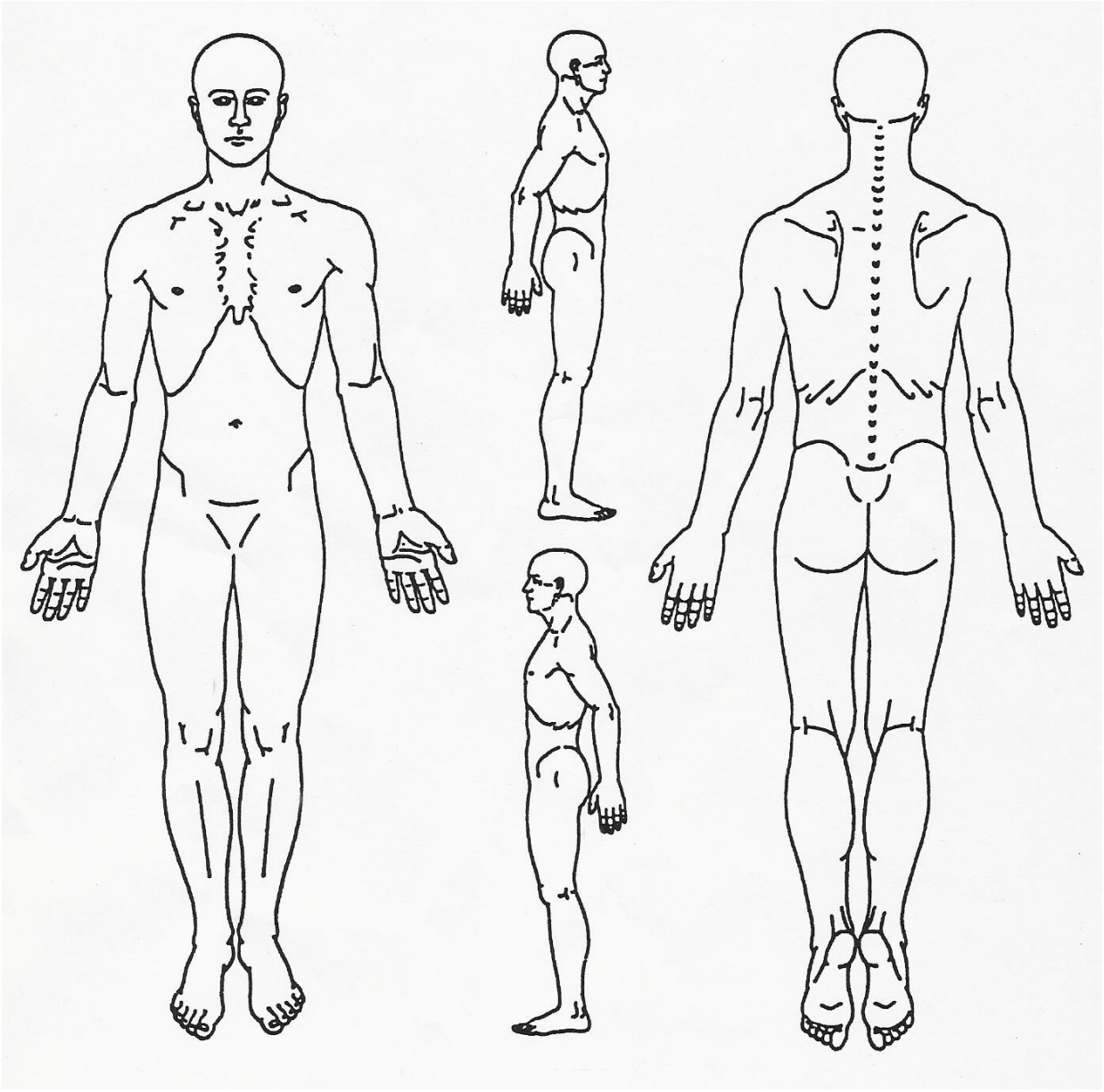
_____

Signature of the Patient, Parent or Guardian Date

Doctor's Review

_____

Signature of Doctor Date



HIPPA (Health Insurance Portability and Accountability Act)

PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

1. The practice's Privacy Notice has been provided to me prior to my signing this consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. The practice explained to me that the Privacy Notice will be available to me in the future at my request. The practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.
2. The practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
3. I understand that, and consent to, the following appointment reminders that will be used by the practice: a) a postcard mailed to me at the address provided to me at the address provided by me; and b) telephoning my home and leaving a message on my answering machine or with the individual answering the phone.
4. The Practice may use and/or disclose my PHI (which includes information about my health condition and the treatment provided to me) in order for the practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.
5. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, the restriction is binding on the Practice.
6. I understand that this Consent is valid for seven years. I further understand that I have to right to revoke this Consent, in writing, at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.
7. I understand that if I revoke this consent at any time, the practice has the right to refuse to treat me.
8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.

Patient Signature (or guardian's signature): _____

Consent to Intramuscular Manual Therapy aka Functional Dry Needling (FDN)

IMT/FDN involves placing a small needle into the muscle at the trigger point which is typically in an area which the muscle is tight and may be tender with the intent of causing the muscle to contract and then release, improving the flexibility of the muscle and therefor decreasing the symptoms. The performing therapist will not stimulate any distal or auricular points during the dry needling treatment.

IMT/FDN is a valuable treatment for musculoskeletal related pain such as soft tissue and joint pain, as well as to increase muscle performance. Like any treatment there are possible complications. While these are rare in occurrence, it is recommended you read through the possible risks prior to giving consent to treatment.

Risks of the Procedure:

Though unlikely, there are risks associated with this treatment. The most serious risk associated with FDN is accidental puncture of a lung (pneumothorax). If this were to occur, it may likely only require a chest x-ray and no further treatment as it can resolve on its own. The symptoms of pain and shortness of breath may last for several days to a week. A more severe lung puncture can require hospitalization and re-inflation of the lung. This is a rare complication and in skilled hands should not be a concern. If you feel any related symptoms, immediately contact your IMT/FDN provider. If a pnuemo is suspected you should seek medical attention from your physician or if necessary, go to the emergency room.

Other risks may include bruising, infection and nerve injury. Please notify your provider if you have any conditions that can be transferred by blood, require blood anticoagulants or any other conditions that may have an adverse effect to needle punctures. Bruising is a common occurrence and should not be of concern unless you are taking a blood thinner. As the needles are very small and do not have a cutting edge, the likelihood of any significant tissue trauma from IMT/FDN in unlikely.

*Do you have any known disease or infection that can be transmitted through bodily fluids?_____

Patients Signature (or guardian's signature): _____

PERFORMANCE SPORTS MEDICAL CENTER

NEUROLOGICAL AND VASCULAR PATIENT QUESTIONNAIRE

NAME:_____ DATE:_____

For any YES answer, please notify the Doctor.

1. Do you suffer from neck pain with pain in your shoulder, arms or hands? NO YES
   Comment:_____
2. Do you have weakness, numbness or burning in your shoulder, arms or hands? NO YES
   Comment:_____
3. Do your hands or arms fall asleep regularly? NO YES
   Comment:_____
4. Do you have reduced feeling (sensation) or swelling in your hands or arms? NO YES
   Comment:_____
5. Do you suffer from a loss of handgrip strength? NO YES
   Comment:_____
6. Do you suffer from back pain with pain in your buttocks, legs or feet? NO YES
   Comment:_____
7. Do you have weakness, numbness or burning in your buttocks, legs or feet? NO YES
   Comment: _____
8. Do your legs or feet fall asleep regularly? NO YES
   Comment:_____
9. Do you have reduced feeling (sensation) or swellings in your legs, feet? NO YES
   Comment:_____
10. Do you suffer from cold hands or feet? NO YES
    Comment:_____
11. Do you suffer from headaches, dizziness or memory loss? NO YES
    Comment:_____
12. Do you have difficulty maintaining your balance? NO YES
    Comment:_____
13. Do you suffer from vertigo or blurred vision? NO YES
    Comment:_____
14. Do you suffer from a reduced hearing capacity? NO YES
    Comment:_____
15. Do you suffer from ringing in your ears? NO YES
    Comment:_____
16. Do you have bladder or bowel control problems on a regular basis? NO YES
    Comment:_____