SOUTHEAST
SPORTS + REHABILITATION
445 South Blackstock Road Suite A
Spartanburg, SC 29301
Phone: (864) 804-6395
www.sesportschiro.com
Tyler Jack, DC, FMT, SFMA, FAKTR

Patient Name: _____ **Date:** _____

Address_____City_____ State _____ Zip Code _____

Home Phone _____Work Phone_____ Cell Phone _____

Date of Birth_____ Age_____ Social Security #_____

Email Address: _____
What sex were you assigned at birth on your original birth certificate? Male Female Choose not to disclose
Marital Status: Married Single Divorced Widowed
Occupation_____
Employer_____
Have you ever received Chiropractic Care? Yes No If yes, when? _____
Name of most recent Chiropractor: _____
Referred by: _____

1. **Reasons for seeking chiropractic care:**

Primary reason:
_____

Secondary reason(s):
_____

Are these complaints related to a Worker's Compensation Claim or Motor Vehicle Accident? □ Yes (Circle which) □ No

2. **Previous interventions, treatments, medications, surgery, or care you've sought for your complaint(s):**
_____
_____
_____

3. **Past Health History:**

   A. **Please indicate if you have a history of any of the following:**
   □ Anticoagulant use □ Heart problems/high blood pressure/chest pain □ Bleeding problems
   □ Lung problems/shortness of breath □ Cancer □ Diabetes □ Psychiatric disorders
   □ Bipolar disorder □ Major depression □ Schizophrenia □ Stroke/TIA's □ Other _____
   □ None of the above

   B. **Previous Injury/Trauma/Motor Vehicle Accidents:**
   _____

   Have you ever broken any bones? Which and When?
   _____

   C. **Allergies:** _____

Patient Name: _____ **Date:** _____

D. Medications: (Please list ALL prescription medications, nutritional supplements you are currently taking):

Medication/Supplement	Year Began	Dose	Frequency	Reason for Taking

Are you taking these medications according to prescribed instructions? □ Yes □ No
Have you had prolonged or regular use of NSAID's (Advil, Aleve, etc.) Motrin, Aspirin? □ Yes □ No
Have you had prolonged or regular use of Tylenol? □ Yes □ No

E. Surgeries: (Please lis all surgeries performed)

Date	Type	Hospital/Surgeon	Complications

F. Females/ Pregnancies and outcomes:
Pregnancies/Date of Delivery Outcome
_____
_____
_____

4. Family Health History:
Do you have a family history of? (Please indicate all that apply)
□ Cancer □ Strokes/TIA's □ Headaches □ Cardiac disease □ Neurological diseases
□ Adopted/Unknown □ Cardiac disease below age 40 □ Psychiatric disease □ Diabetes
□ Other _____ □ **None of the above**
Deaths in immediate family: _____
Cause of parents or siblings death Age at death
_____
_____
_____

5. Social and Occupational History:
A. Job description:
_____
B. Work schedule:
_____
C. Recreational activities (exercise routine/type, hobbies, etc. and how often):
_____
D. Lifestyle:
Alcohol use? □ Yes □ No, If yes □ Daily □ Weekly □ Occasionally □ How much?_____ Type?_____
Tobacco use? □ Yes □ No, If yes □ Daily □ Weekly □ Occasionally □ How much?_____ Type?_____
Diet: How many meals do you eat per day? _____ How many times do you snack per day? _____
Do you drink caffeinated beverages? _____ if yes how many per day?_____
How many cups of water do you drink daily? _____
Sleep: How many hours per night? _____
How many times do you wake up per night? _____ Are you able to fall back to sleep? □ Yes □ No

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Review of Systems

- Have you had any of the following **pulmonary (lung-related)** issues?
  □ Asthma/difficulty breathing □ COPD □ Emphysema □ Other _____
  □ **None of the above**
- Have you had any of the following **cardiovascular (heart-related)** issues or procedures?
  □ Heart surgeries □ Congestive heart failure □ Murmurs or valvular disease □ Heart attacks/MIs □ Pacemaker
  □ Heart disease/problems □ Hypertension □ Angina/chest pain □ Irregular heartbeat □ Other _____
  □ **None of the above**
- Have you had any of the following **neurological (nerve-related)** issues?
  □ Visual changes/loss of vision □ One-sided weakness of face or body □ History of seizures □ Tremors
  □ Loss of sense of smell □ One-sided decreased feeling in the face or body □ Headaches □ Memory loss □ Vertigo □ Strokes/TIAs □ Other _____
  □ **None of the above**
- Have you had any of the following **endocrine (glandular/hormonal)** related issues or procedures?
  □ Thyroid disease □ Hormone replacement therapy □ Injectable steroid replacements □ Diabetes
  □ Other _____ □ **None of the above**
- Have you had any of the following **renal (kidney-related)** issues or procedures?
  □ Renal calculi/stones □ Hematuria (blood in the urine) □ Incontinence (can't control) □ Bladder Infections
  □ Difficulty urinating □ Kidney disease □ Dialysis □ Other _____
  □ **None of the above**
- Have you had any of the following **gastroenterological (stomach-related)** issues?
  □ Nausea □ Difficulty swallowing □ Ulcerative disease □ Frequent abdominal pain □ Hiatal hernia
  □ Constipation □ Pancreatic disease □ Irritable bowel/colitis □ Hepatitis or liver disease
  □ Bloody or black tarry stools □ Vomiting blood □ Bowel incontinence □ Gastroesophageal reflux/heartburn
  □ Other _____
  □ **None of the above**
- Have you had any of the following **hematological (blood-related)** issues?
  □ Anemia □ Regular anti-inflammatory use (Motrin/Ibuprofen/Naproxen/Naprosyn/Aleve) □ HIV positive
  □ Abnormal bleeding/bruising □ Sickle-cell anemia □ Enlarged lymph nodes □ Hemophilia
  □ Hypercoagulation or deep venous thrombosis/history of blood clots □ Anticoagulant therapy
  □ Regular aspirin use □ Other _____
  □ **None of the above**
- Have you had any of the following **dermatological (skin-related)** issues?
  □ Significant burns □ Significant rashes □ Skin grafts □ Psoriatic disorders □ Other _____
  □ **None of the above**
- Have you had any of the following **musculoskeletal (bone/muscle-related)** issues?
  □ Rheumatoid arthritis □ Gout □ Osteoarthritis □ Broken bones □ Spinal fracture □ Spinal surgery
  □ Joint surgery □ Arthritis (unknown type) □ Scoliosis □ Metal implants □ Other _____
  □ **None of the above**
- Have you had any of the following **psychological** issues?
  □ Psychiatric diagnosis □ Depression □ Suicidal ideations □ Bipolar disorder □ Homicidal ideations
  □ Schizophrenia □ Psychiatric hospitalizations □ Other _____
  □ **None of the above**
- Is there anything else in your past medical history that you feel is important to your care here? (i.e. auto-immune, illnesses)
  _____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes. If my insurance will be billed, I authorize payment of medical benefits to **Southeast Sports Chiropractic, LLC/ Tyler Jack, DC** for services performed.

Patient or Guardian Signature _____ Date_____

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HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

Use and Disclosures of Protected Health Information:
Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing, and fund raising activities, and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

_____ _____
Signature of Patient or Guardian Date

_____
Printed Name

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SOUTHEAST
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OFFICE POLICY/FINANCIAL AGREEMENT

We are honored that you have chosen us for your healthcare needs and we are committed to the successful treatment of your condition. This will require a comprehensive diagnostic exam on your first visit and a treatment plan that will include physiotherapy. Additionally, today's health care system requires that we reach a clear understanding to meet your needs effectively and prevent confusion.

- We will verify your benefits, file and track your insurance payments as contracted.
- You are responsible for the full payment of any fees the insurance company will not cover or remain as a result of incorrect verification information received by our office.
- Appointments are scheduled to give optimal time and individual attention.
  If you need to reschedule an appointment, **please give a 24-hour notice**.
  If you do not, you will impact other patients' ability to be seen during that time and **will be charged a $25 missed appointment fee.**
- Patients that develop a pattern of **missed appointments** or **failure to follow treatment plans** are released from care and referred to another provider who may be better suited to fit the patient's schedule and needs.

INSURANCE/THIRD-PARTY COVERAGE

We will supply you with information regarding deductibles, co-payments, covered charges, secondary insurance and usual and customary charges, but keep in mind that all insurance carriers have a disclaimer that states "the stated benefits are not a guarantee of payment." We accept and file group health insurance, Workers Compensation, managed care plans, Medicare and Automobile Liability Insurance. However, services rendered are the ultimate responsibility of the patient receiving care.

FLEX CARDS/HSA CARDS

It is possible to pay for co-pays, coinsurance, supplies or nutritional supplements with your insurance flex or HAS cards. However, if they deny these charges, it will be your responsibility to reimburse the administrator of this card, not the responsibility of Southeast Sports & Rehabilitation.

OTHER FORMS OF PAYMENT

Patients that do not have insurance or third-party coverage are responsible for full payment at the time of service. We accept cash, personal checks, most major credit cards and Care Credit. If you require special financial arrangements for your care, please ask we never want finances to be a barrier to you receiving the care you need.

INSURANCE AND CHIROPRACTIC

Most of us are used to using our health insurance each and every time we got to the doctor, when it comes to chiropractic, this works a little differently.

Insurance carriers will only cover chiropractic services that are related to an "active complaint". This can be due to an accident, injury or fall or simply one of those "I don't know what I did but I hurt" type of situations.

Insurance companies **DO NOT COVER care that fails to meet medical necessity.** Medical necessity is care that is deemed appropriate for conditions and that those conditions should improve with care over a period of treatment. In order to track your care we may need to see you on a regular basis for a period of time. Treatment plans need to be in place to justify medical necessity.

My signature below indicates that I have read and understood the Southeast Sports & Rehabilitation Office/Financial Policy:

_____ _____

Patient or Guardian Signature Date

_____ _____

Office Staff Witness Date

Patient Name: _____ **Date:** _____

NEW PATIENT HISTORY FORM

Please start with your Primary Symptom for which you are seeking care.
Each symptom needs to be described individually (i.e. Headache, Neck pain, low back pain, etc.)

Primary Symptom/Chief Complaint _____

- On a scale from 1-10, with 10 being the worst**, please circle the number that best describes the symptom MOST of the time:** 1 2 3 4 5 6 7 8 9 10
- What **percentage of the time you are awake** do you experience the above symptom at the above intensity:
  10 20 30 40 50 60 70 80 90 100
- Date symptoms began? _____
  - How did the symptom begin? Suddenly Gradually Unknown (circle one)
  - How did the symptom begin (i.e. fall, repetitive use, yard work, etc.)?_____

- What makes the symptom **worse?** (**circle all that apply**):
  Sitting Standing Walking Bending Lifting Sleeping Sneezing
  Coughing Straining Reaching Twisting Looking Up Looking Down Movement
  Rest Lying supine Lying prone Driving Typing House Chores Exercise
  Stair Stepping
  Other (please describe in detail): _____

- What makes the symptom **better?** (**circle all that apply**):
  Sitting Standing Lying Knees Bent Support Movement
  Heat Ice Topical Analgesic Ibuprofen Medication Rest
  Stretching Exercise Adjustments
  Other (please describe in detail): _____

- Describe the **quality** of the symptom (**circle all that apply**):
  Dull Aching Sharp Throbbing Burning Deep Stabbing
  Cramping Numbness Tingling Radiating Stiffness
  Other (please describe in detail): _____

- Does the symptom **radiate** to another part of your body (circle one): yes no
  If yes, **where does the symptom radiate**? (ex: pain starts in low back, travels down buttock into thigh, and calf)
  - Head: _____
  - Right/Left/Both: Shoulder, Upper Arm, Forearm, Arm to Hand, Fingers (specific)_____
  - Right/Left/Both: Buttock, Thigh, Leg, Leg below Knee, Leg to foot, Toes (specific)_____
    Other (describe in detail) _____

- Is the symptom worse at certain times of the day or night? (circle one)
  Morning Afternoon Evening Night Unaffected by time of day
- What is a goal for your treatment or something that you cannot perform due to symptoms?
  _____
- Anything else you can tell us about this symptom? (i.e. other treatment, imaging studies, associated symptoms)
  _____

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Secondary Symptom _____

- On a scale from 1-10, with 10 being the worst**, please circle the number that best describes the symptom MOST of the time:** 1 2 3 4 5 6 7 8 9 10
- What **percentage of the time you are awake** do you experience the above symptom at the above intensity:
  10 20 30 40 50 60 70 80 90 100
- Date symptoms began? _____
  - How did the symptom begin? Suddenly Gradually Unknown (circle one)
  - How did the symptom begin (i.e. fall, repetitive use, yard work, etc.)?_____

- What makes the symptom **worse?** (**circle all that apply**):
  Sitting Standing Walking Bending Lifting Sleeping Sneezing
  Coughing Straining Reaching Twisting Looking Up Looking Down Movement
  Rest Lying supine Lying prone Driving Typing House Chores Exercise
  Stair Stepping
  Other (please describe in detail): _____

- What makes the symptom **better?** (**circle all that apply**):
  Sitting Standing Lying Knees Bent Support Movement
  Heat Ice Topical Analgesic Ibuprofen Medication Rest
  Stretching Exercise Adjustments
  Other (please describe in detail): _____

- Describe the **quality** of the symptom (**circle all that apply**):
  Dull Aching Sharp Throbbing Burning Deep Stabbing
  Cramping Numbness Tingling Radiating Stiffness
  Other (please describe in detail): _____

- Does the symptom **radiate** to another part of your body (circle one): yes no
  If yes, **where does the symptom radiate**? (ex: pain starts in low back, travels down buttock into thigh, and calf)
  - Head: _____
  - Right/Left/Both: Shoulder, Upper Arm, Forearm, Arm to Hand, Fingers (specific)_____
  - Right/Left/Both: Buttock, Thigh, Leg, Leg below Knee, Leg to foot, Toes (specific)_____
    Other (describe in detail) _____

- Is the symptom worse at certain times of the day or night? (circle one)
  Morning Afternoon Evening Night Unaffected by time of day
- What is a goal for your treatment or something that you cannot perform due to symptoms?
  _____
- Anything else you can tell us about this symptom? (i.e. other treatment, imaging studies, associated symptoms)
  _____

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Tertiary Symptom _____

- On a scale from 1-10, with 10 being the worst**, please circle the number that best describes the symptom MOST of the time:** 1 2 3 4 5 6 7 8 9 10
- What **percentage of the time you are awake** do you experience the above symptom at the above intensity:
  10 20 30 40 50 60 70 80 90 100
- Date symptoms began? _____
  - How did the symptom begin? Suddenly Gradually Unknown (circle one)
  - How did the symptom begin (i.e. fall, repetitive use, yard work, etc.)?_____

- What makes the symptom **worse?** (**circle all that apply**):
  Sitting Standing Walking Bending Lifting Sleeping Sneezing
  Coughing Straining Reaching Twisting Looking Up Looking Down Movement
  Rest Lying supine Lying prone Driving Typing House Chores Exercise
  Stair Stepping
  Other (please describe in detail): _____

- What makes the symptom **better?** (**circle all that apply**):
  Sitting Standing Lying Knees Bent Support Movement
  Heat Ice Topical Analgesic Ibuprofen Medication Rest
  Stretching Exercise Adjustments
  Other (please describe in detail): _____

- Describe the **quality** of the symptom (**circle all that apply**):
  Dull Aching Sharp Throbbing Burning Deep Stabbing
  Cramping Numbness Tingling Radiating Stiffness
  Other (please describe in detail): _____

- Does the symptom **radiate** to another part of your body (circle one): yes no
  If yes, **where does the symptom radiate**? (ex: pain starts in low back, travels down buttock into thigh, and calf)
  - Head: _____
  - Right/Left/Both: Shoulder, Upper Arm, Forearm, Arm to Hand, Fingers (specific)_____
  - Right/Left/Both: Buttock, Thigh, Leg, Leg below Knee, Leg to foot, Toes (specific)_____
    Other (describe in detail) _____

- Is the symptom worse at certain times of the day or night? (circle one)
  Morning Afternoon Evening Night Unaffected by time of day
- What is a goal for your treatment or something that you cannot perform due to symptoms?
  _____
- Anything else you can tell us about this symptom? (i.e. other treatment, imaging studies, associated symptoms)
  _____

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