CORE|HEALTH|&|WELLNESS|CENTER

New PI Patient Intake

Please completely fill out all applicable information

Date · _____

Pt Name · _____, _____ _____
Last First Mid

SS# · _____ DOB · _____

Address · _____ _____
Street Apt

_____
City State Zip

Phone · Home _____ · Work _____
Employer /Occupation · _____
Marital Status · M / S / D / W / SEP Spouses' Name · _____

Primary Insurance Name · _____

Primary Insurance Address · _____ _____
Street Apt

_____ _____ _____
City St Zip

Phone · W _____ Policy # · _____
· Fax _____ Claim # · _____

3rd Party Insurance Name · _____

3rd Party Insurance Address · _____ _____
Street Apt

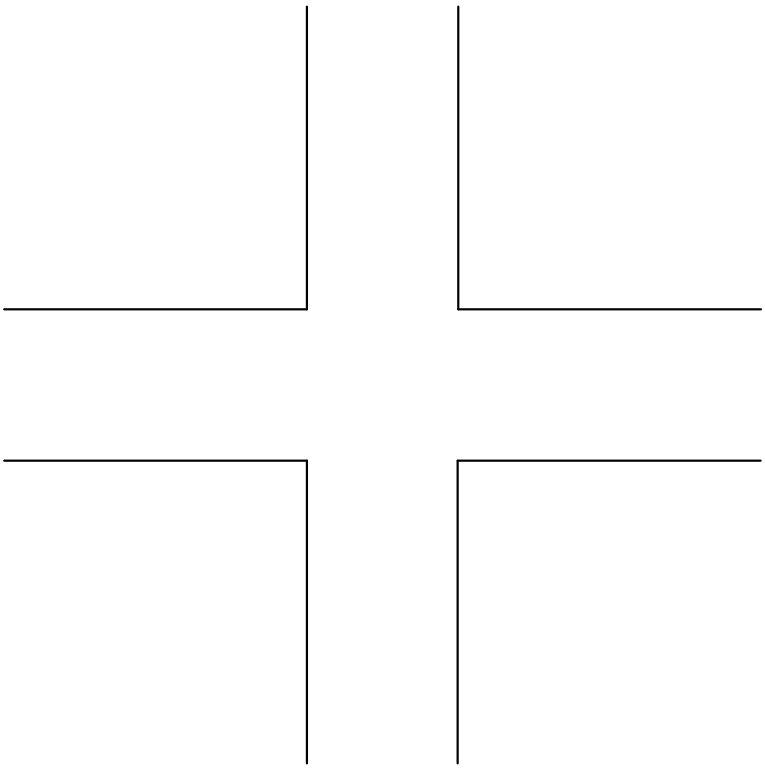
_____ _____ _____
City St Zip

Phone · W _____ Policy # · _____
· Fax _____ Claim # · _____

Attorney Name · _____ Phone W · _____
Address · _____ Fax · _____
Street

_____ _____ _____ Case ID# · _____
City St Zip

Please **draw** a picture of the accident (Mark your car "**A**" and the others as "**B**")



· Date of Accident · _____
· Time of Accident · _____
· Street · _____
· City · _____

· Road Conditions at time of accident ·
Dry Wet Icy Other _____
· Number of vehicles involved · _____
· Number of persons involved · _____

· Were you aware or surprised of the approaching accident? **Aware Surprised**
· Was your care stopped at the time of impact?
Y, Was your foot on the brake? **N Y**
N, Estimate Speed of your vehicle, _____ mph
Estimate Speed of other Vehicle,_____ mph
· Was this: slowing, speeding, or steady speed?
· What seat were you in? _____
· Restraints properly worn? **N** **Y**, shoulder/lap belt lap only
· Did you receive a bruise from the seat belt? **N Y**, _____(describe)
· Where is your head rest? **ABOVE BELOW AT BASE OF SKULL**
· Were you looking straight ahead or was your head turned? **Straight Turned**
· Was your body straight ahead or were you turned in your seat? **Straight Turned**
· Did the police come to the scene? **N Y** Is there a report? **N Y**
· Any noticeable bruises/ cuts sustained from accident? **N Y**
· Did you black out upon impact? **N Y**
· Did you go to the hospital? **N** **Y,** Which hospital ·_____(name/city)
· How did you get there · _____
· Were x-rays taken · _____
· What was done for you injuries · _____
· How long were you there · _____

Initial Complaint · _____ (1)

List of other complaints · _____ (2)

_____ (3)

(Fill out for Complaint 1)

· What makes the pain *worse*? _____

· What makes the pain *better*? _____

· Please circle the character of your pain:

· Dull / Sharp
· Achy / Stabbing
· Deep / Superficial
· Numbness (pins&needles) / Burning

· Does the pain travel down your arm / leg?

N Y, _____ (where)

· Please circle the pain's intensity · Slight Mild Moderate Severe

· How often does the pain occur?

· Intermediate (<1/4 of the time)
· Occasionally (1/4 – ½)
· Frequent (1/2 – ¾)
· Constant (3/4 – 100%)

· Have you lost sleep due to the pain: N Y

· Is the pain worse in: AM PM

· Does it interfere with your work and/or daily living? N Y

· Have you seen any other doctors for this condition?

N Y, (who, results) _____

• Please check symptoms which have started SINCE the accident:

- ❑ **Headaches**
- ❑ **Nervousness**
- ❑ **Dizziness**
- ❑ **Depression**
- ❑ **Fatigue**
- ❑ **Pins/needles arms**
- ❑ **Pins/needles legs**
- ❑ **Numbness fingers**
- ❑ **Numbness toes**
- ❑ **Loss of balance**
- ❑ **Memory loss**
- ❑ **Ringing in the ears**
- ❑ **Stiff Neck**
- ❑ **Nervousness**
- ❑ **Shortness of Breath**

Pt Name: _____

Date: _____

Visual Analog Pain Severity Scale

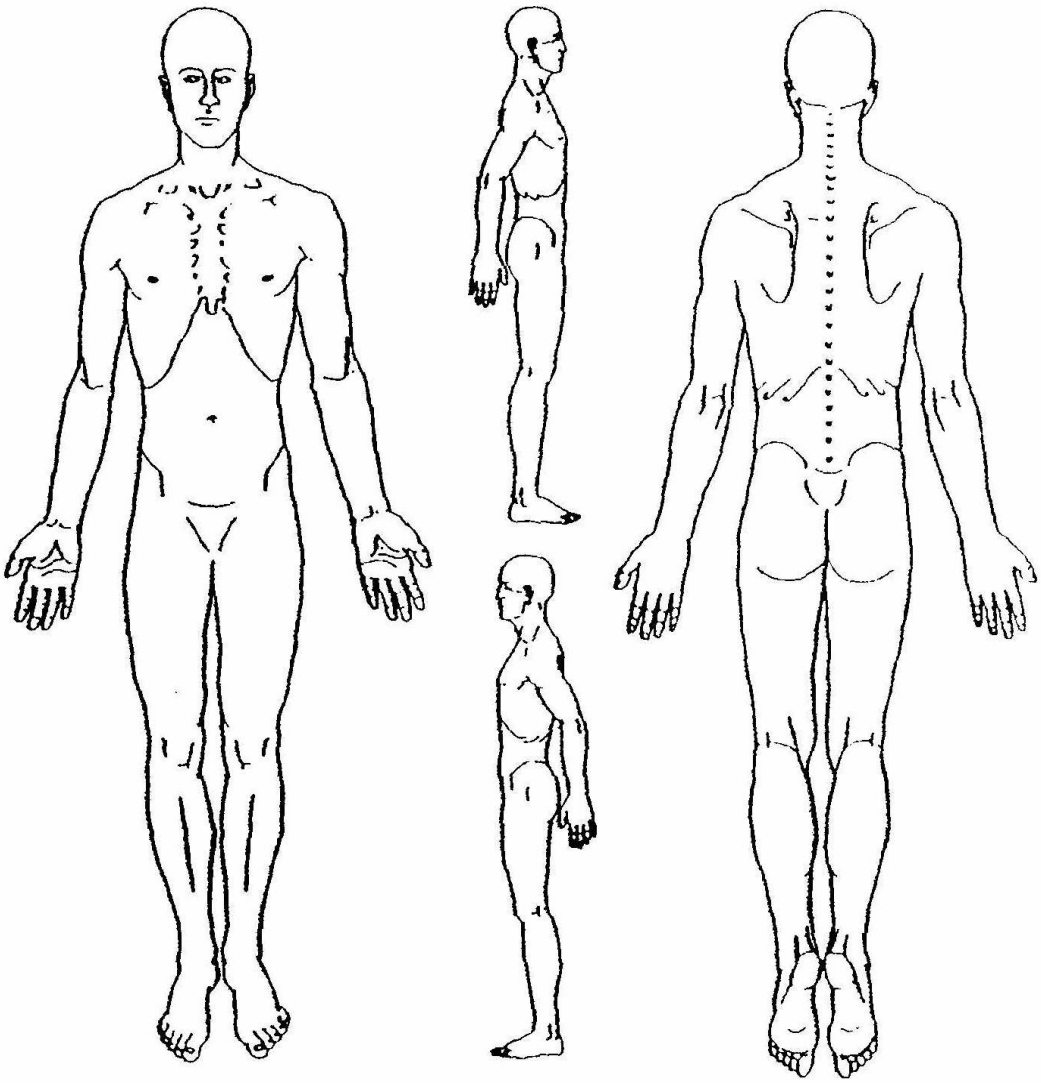
Instructions: please place a mark on the line that corresponds to how you presently feel.

NO PAIN ---------- Worst Pain Ever

Pain Diagram

On the diagram below, using the key, please indicate the location and type of pain you are currently experiencing

Key · A = Achiness B = Burning N = Numbness
X = Stabbing O = Pins and Needles



· Please check any conditions that you have had or currently have:

(P= past C= Current)

P	C	Musculoskeletal
❑	❑	Low Back Pain
❑	❑	Arm Pain
❑	❑	Fracture/Dislocation
❑	❑	Trouble Swallowing
❑	❑	Joint Pain/Stiffness
❑	❑	Leg Pain
❑	❑	Neck Pain
❑	❑	Mid Back Pain
❑	❑	Muscle weakness

Nervous System

❑	❑	Numbness
❑	❑	Dizziness
❑	❑	Fainting
❑	❑	Loss of Balance
❑	❑	Seizures
❑	❑	Stroke
❑	❑	Depressions
❑		Paralysis
❑	❑	Headaches

Gastro-Intestinal

❑	❑	Change in Appetite
❑	❑	Food intolerance
❑	❑	Nausea/ Vomiting
❑	❑	Gallbladder problems
❑	❑	Gas
❑	❑	Constipation
❑	❑	Abdominal Cramps
❑	❑	Ulcers
❑	❑	Diarrhea
❑	❑	Hemorrhoids
❑	❑	Liver Disease
❑	❑	Black/ Bloody Stools

Genito-Urinal

❑	❑	Excessive Urination
❑	❑	Difficult Starting/Stopping
❑	❑	Change in urine color
❑	❑	Prostate: Last Exam: ____
❑	❑	Discharge
❑	❑	Urinary Tract Infections
❑	❑	Flank/ Pelvic Pain
❑	❑	Birth Control Pills
		Type: _____
		How long: _____
❑	❑	Change in Sex Drive
❑	❑	Pain During Sex
❑	❑	Other _____
		_____

Cardio/Respiratory

❑	❑	Shortness of Breath
❑	❑	High Blood Pressure
❑	❑	Blood in Sputum
❑	❑	Cigarette Smoking
		Daily # _____
		Length _____
❑	❑	Chest Pain
❑	❑	Type _____
❑	❑	Asthma
❑	❑	Environmental Toxin
		Type _____
		Length _____
❑	❑	Calf Pain while walking
❑	❑	Heart Disease
❑	❑	Edema/Swelling
❑	❑	Pneumonia/ Lung Infection
❑	❑	Other

Eye/Ear/Nose/ Throat

❑	❑	Pain in Eyes
❑	❑	Visual Problems
❑	❑	Difficulty Hearing/Deaf
❑	❑	Ringing in Ears
❑	❑	Discharge
❑	❑	Nose Bleeds
❑	❑	Change in Ability to smell
❑	❑	Hoarseness
❑	❑	Dental Problems
❑	❑	Other _____
		_____

Females Only

·Menarche (1st Period)
Age _____ Year _____
·Flow
❑ Scant ❑ Moderate
❑ Light ❑ Heavy
·Regularity
Days _____
Duration _____

❑	❑	Abnormal/Painful Fluid Retention
❑	❑	Premenstrual Syndrome
		·Last PAP _____
		·Menopause Onset _____
		·# Pregnancies _____
❑	❑	·Difficult delivery

Notes: _____

_____

_____

· Please List any medications and/ or vitamins you currently take:

_____

_____

· Please *circle* those of which you have already had from the following:

(this list can affect your overall diagnosis, treatment plan, and possibly of being accepted for care)

- · Chicken Pox
- · Anemia
- · Small pox
- · Hepatitis
- · Tuberculosis
- · Polio
- · Rheumatic Fever
- · Pneumonia
- · Diphtheria

· **Medical History** (Please list any surgeries, hospitalizations, & car accidents)

_____

_____

_____

_____

_____

_____

·Do you have any family history of Cancer, Heart Disease, Diabetes, Neurological Disorder (Parents, Siblings, Kids, Grand parents)?

_____

_____

·What is and how long have you worked at your current job? _____

_____

·Any work injuries at any job in the past? N Y, _____

·Any chance that you could be pregnant at this time? N Y

_____ _____

Dr Signature Date

Pt Name: _____ Date: _____

Notes

_____

_____

_____

_____

_____

_____

_____

Office Use Only:

ADJ: **POST:**

PT: **HOME:**

RTC:

PRIVACY POLICY

POLICY STATEMENT

Core Health & Wellness Center (CH&WC) is committed to maintaining the privacy of your protected health information, which includes information about your medical condition and the care and treatment you receive from CH&WC and other health care providers. This notice details how your protected health information may be used and disclosed to third parties for purposes of your care, payment for your care, health care operations of CH&WC, and for other purposes permitted or required by law.

USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

The following are examples of the types of uses and/or disclosures of our protected health information that may occur. These examples are **not** meant to include all possible types of use and/or disclosure.

1. **Care** – In order to provide care to you, CH&WC will provide your protected health information to those health care professionals directly involved in your care so that they may understand your medical condition, needs, and provide advice or treatment (e.g. your physician).
2. **Payment** – In order to get paid for some or all of the health care provided by CH&WC, your protected health information may be provided directly or through a billing service, to appropriate third party payers, pursuant to their billing and payment requirements. For example, CH&WC may need to provide your health insurance carrier with information about health care services that you received from CH&WC so that CH&WC can be properly reimbursed.
3. **Health Care Operations** – In order for CH&WC to operate in accordance with applicable law and insurance requirements and in order for CH&WC to provide quality and efficient care, it may be necessary for CH&WC to compile, use and/or disclose your protected health information. For example, CH&WC may use your protected health information in order to evaluate the performance of CH&WC's personnel in providing care to you.

WHEN WRITTEN AUTHORIZATION MAY NOT BE REQUIRED

1. **Personal Representative** – To such a person who, under applicable law, has the authority to represent you in making decisions related to your health care.
2. **Public Health Activities** – Such activities include, for example, information collected by a public health authority, as authorized by law, to prevent or control disease, injury, or disability. This includes reports of child abuse or neglect.
3. **Abuse, Neglect, or Domestic Violence** – To a government authority if CH&WC believes that you have been the victim of abuse, neglect, or domestic violence. Any such disclosure will be made in accordance with the requirements of law, which may also involve notice to you of the disclosure.
4. **Required by Law or Law Enforcement Purposes** – In certain instances, your protected health information may have to be disclosed to a law enforcement official for law enforcement purposes. If otherwise required by law, but such use or disclosure will be made in compliance with the law and limited to the requirements of the law.
5. **Avert a Threat to Health or Safety** – CH&WC may disclose your protected health information if it believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to an individual who is reasonably able to prevent or lessen the threat.
6. **Workers' Compensation** –CH&WC may be required to disclose your protected health information to an individual or entity that is part of the Workers' Compensation system.

LIABILITY INSURANCE DISCLOSURE

1. As required by NRS 634.1295 CH&WC is required to inform you that Dr. Forsberg does not carry nor is covered by any liability insurance at this time.

Privacy Policy --- By signing I've acknowledged I've received or been offered the Privacy Practices for Core Health & Wellness Center.

_____ _____ _____
Print Name Signature Date

-or-

_____ _____ _____
Patient Representative Print Name Signature Date

SS# _____

DOB _____

❑ Decline, Reason _____

_____

Office Use Only

_____
Employee Signature

Date _____

CORE|HEALTH|&|WELLNESS|CENTER

Notice of Doctor's Lien

I do hereby authorize Core Health & Wellness Center, to furnish you, my attorney, with a full report of their examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was recently involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him for medical services rendered to me both by reason of this accident and by reason of any other bills that are due his office and to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect said doctor. Additionally, I hereby further give a Lien on my case to said doctor against any and all proceeds of my settlement judgment or verdict which may be paid to you, my attorney, or myself, as the result of the injuries for which I have been treated or injuries in connection therewith.

I agree never to rescind this document and that a rescission will not be honored by my attorney. I hereby instruct that in the event another attorney is substituted in this matter the new attorney will honor this lien as inherent to the settlement and enforceable upon the case as if it were executed by him.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for service rendered to me and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover said fee.

I direct that my attorney shall not withhold any portion of the amount due to the doctor under this lien to offset attorney fees which attorney now or hereafter may claim to be owing by doctor to attorney in connection with this lien.

Please acknowledge this letter by signing below and returning to the doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment and may declare the entire balance due and payable.

Promissory Note: If all fees are not pain in full prior to the trail on a personal injury case, I agree that this document shall also serve as a written Promissory Note for payment of all sums due and owing to the doctor and the doctor shall be entitled to an award of statutory interest from the date of the first court appearance and reasonable cost and attorney's fees if action is necessary to collect upon this Promissory Note.

_____ Date

_____ Patient Signature

Attorney shall promptly notify the doctor if and when the attorney ceases to represent this patient in the lawsuit described above or when patient retains additional attorneys to represent patient in said lawsuit. The attorney shall also promptly deliver copy of this lien to any additional or substitute attorneys retained by the patient in connection with said lawsuit. The attorney does hereby agree to observe all the terms of this lien stated above and agrees to withhold, without deduction for any attorney's fees, such sums from any settlement, judgment, or verdict as may be necessary to adequately protect and fully compensate the doctor

_____ Date

_____ Attorney's Signature

_____ Name of Attorney

_____ Office Phone Number

_____ Office Address