

PHOENIX HEALING

Confidential Health Information Questionnaire

First Name _____ Last Name _____

Street Address _____

City _____ State _____ Zip _____

E-mail _____

Home Phone _____ Cell _____ Work _____

Date of Birth _____ Age _____ Marital Status: M S D W

Spouse's Name _____ Spouse's Date of Birth _____

Insurance Company _____

Employer _____ Occupation _____

Employment Status: F/T P/T Retired Not Employed Student

How were you referred to Dr. Amy Iaquinta?

Friend: _____ Internet: (site) _____

Ad: _____

Other: (please be specific) _____

List Present Complaints, injuries and duration:

1. _____

2. _____

3. _____

Have you had chiropractic care before? Y N Do you have a primary care doctor? Y N

Name of doctor and approx. date of last visit _____

Name of person to contact in event of an emergency _____

Relationship to you _____ Contact number _____

Patient's Name _____

Patient's Signature _____ Date _____

HEAD:

- D Headache
 - o sinus (allergy)
 - o entire head
 - o back of head
 - o forehead
- D temples
 - o migraine
- O Head feels heavy
- O Loss of memory
- O Light-headedness
- D Fainting
- D Light bothers eyes
 - o Blurred vision
 - o Double vision
 - o Loss of vision
- D Loss of taste
- D Loss of balance
 - o Dizziness
 - o Loss of hearing
 - o Pain in ears
 - o Ringing in ears
 - o Buzzing in ears

NECK:

- O Pain in neck
- O Neck pain with movement
 - o Forward
 - D Backward
 - o Turn to left
 - D Turn to right
 - o Bend to left
 - D Bend to right
- D Pinched nerve in neck
- Neck feels out of place
- Muscle spasms in neck
 - o Grinding sounds in neck
 - o Popping sounds in neck
 - o Arthritis in neck

SHOULDERS:

- o Pain in shoulder joint [R L]
- o Pain across shoulders
- o Bursitis [R L]
- o Arthritis [R L] D
- Can't raise arm
 - o above shoulder level
 - o over head
- o Tension in shoulders
- D Pinched nerve in shoulder [R L]
- o Muscle spasms in shoulder

ARMS & HANDS:

- o Pain in upper arm [R L]
- o Pain in elbow [R L]
- o Movement aggravated
- o Tennis elbow [R L]
- D Pain in forearm [R L]
- D Pain in hands [R L]
- o Pain in fingers [R L]
- o Pins & needles in arms [R L]
- D Pins & needles in fingers [R L]

ARMS & HANDS (cont):

- o Numbness in arms [R L]
- o Numbness in fingers [R L]
- o Fingers go to sleep [R L]
- o Hands cold [R L]
- o Swollen joints in fingers [R L]
- o Sore joints in fingers [R L]
- o Arthritis in fingers [R L]
- o Loss of grip strength [R L]

MID-BACK:

- o Mid-back pain
- o Location _____
- D Pain between shoulder blades
- o Sharp stabbing
- o Dull ache
- o Pain from front to back
- o Muscle spasms
- o Pain in kidney _____ area

CHEST:

- o Chest pain
- D Shortness of breath
- o Pain around ribs
- o Breast pain
- o Dimpled or orange-peel breast
- o Irregular heartbeat

ABDOMEN:

- D Nervous stomach
- o Foods can't eat
- o Nausea
- o Gas
- o Constipation
- D Diarrhea
- G Hemorrhoids

LOW BACK:

- o Low back pain
 - o Upper lumbar
 - o Lower lumbar
 - o Sacroiliac
- o Low back pain is worse when:
 - o working
 - o lifting
 - o stooping
 - o standing
 - o sitting
 - P bending
 - o coughing D
 - lying down (sleeping)
 - o walking
- o Pain relieves when _____
- o Slipped Disc
- o Low back feels out of place
- D Muscle spasms
- o Arthritis

HIPS, LEGS, & FEET:

- o Pain in buttocks [R L] D
- Pain in hip joint [R L] o
- Pain down leg [R L]
- o Pain down both legs
- o Knee pain [R L]
 - o Inside
 - o Outside
- o Leg cramps [R L]
- o Cramps in feet [R L]
- o Pins & needles in leg [R L]
 - o Numbness of leg [R L]
- o Numbness of feet [R L]
- o Numbness of toes [R L]
- o Feet feel cold [R L]
- o Swollen ankles [R L]
- o Swollen feet [R L]

WOMEN ONLY:

- o Menstrual pain _____ (where)
- o Cramping
- o Irregularity
- o Cycle _____ days
- o Birth control _____ (type)
- o Hysterectomy
- o Genital cancer _____
- D Discharge
- D Menopause _____
- o Tumors
- o Abortions
- o Are you or do you think you might be pregnant?

MEN ONLY:

- D Frequent urination D
- Difficulty in starting
- o Night urination
 - o Prostate pain/swelling

GENERAL:

- D Nervousness
- D Irritable
- o Depressed
- o Fatigue
- o Generally feeling run-down
- o Normal sleep _____
- o Loss of sleep
- o Loss of weight
- o Gain weight
- o Cigarettes _____ pack/day
- o Diabetes
- o Hypoglycemia
- o Other _____

REMARKS:

PHOENIX HEALING

Privacy Policy

We are very concerned with protecting your privacy. We may disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for diagnosis, assessment, or treatment of your health, to another party if they are potentially responsible for the payment of your services, or within our practice for quality control.

You have the right to request that we do not disclose your health information to specific individuals, companies or organizations. Any requests, such as these, must be made in writing. However, we are not required to agree to your restrictions.

Your chiropractor and members of the staff may need to use your: name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you.

If this contact is made by phone and you do not answer, a message will be left on your answering machine. Our office sends out new patient letters, post cards, birthday cards and statements periodically.

By signing this, you give Dr. Amy laquinta and Phoenix Healing permission to send mail to the address and or email address given on your introductory paperwork. You are consenting to treatment and if needed, allowing Phoenix Healing to bill your insurance and have the payment sent straight to our office.

Name Printed _____ Date _____

Patient Signature _____ Authorized Rep. _____

PHOENIX HEALING

Consent for Care

Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

THE NATURE OF THE ADJUSTMENT:

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. You may or may not feel some movement.

ANALYSIS/EXAMINATION/TREATMENT:

As part of the analysis, examination and treatment, you are consenting to the following procedures although depending on your case not all may be used on you.

Spinal Manipulative Therapy	Palpation	Vital Signs
Range of Motion Testing	Orthopedic Testing	Basic Neurological Testing
Muscle Strength Testing	Postural Analysis	EMS
Ultrasound	Hot/Cold Therapy	X-rays

THE MATERIAL RISKS INHERENT IN CHIROPRACTIC ADJUSTMENT:

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

THE PROBABILITY OF THOSE RISKS OCCURING:

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and if X-rays are taken. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. Since my adjustments never involve the twisting of the cervical spine and do not involve any high-velocity

forces the risk would be even less than that. The other complications are also generally described as rare.

THE AVAILABILITY AND NATURE OF OTHER TREATMENT OPTIONS:

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain killers
- Hospitalization
- Surgery

If you chose to use one of the above noted “other treatment” options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician. We do not administer any of the “other treatment options” and would refer you to your primary care physician for such need.

THE RISKS AND DANGERS ATTENDANT TO REMAINING UNTREATED:

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW

I have read [] or have had read to me [] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Amy Iaquina and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated: _____

Dated: _____

Patient’s Name

Doctor’s Name

Signature

Signature

_____ Signature of Parent or Guardian (if a minor)

PHOENIX HEALING

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR

Private and group accident and health insurance

I hereby direct and instruct my insurance company to pay by check made out and mailed directly to,

**Phoenix Healing S. C.
1920 Sunset Ridge Rd. Glenview. IL 60025**

If my current policy prohibits direct payment to doctor. then I hereby also direct and instruct you to make out the check to me and mail it as follows,

**Phoenix Healing S.C.
1920 Sunset Ridge Rd. Glenview. IL 60025**

The professional or medical expense benefits allowable and otherwise payable to me under my current policy as payment towards the total charges for professional services rendered. This is a direct assignment of my rights and benefits under this policy. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in current manner, any balance of said professional service charges over and above the insurance payment.

MEDICARE PATIENTS ONLY

Medicare will only pay for services that it determines to be "reasonable and necessary" under Section 1962 (a) (1) of the Medicare law. If Medicare determined that particular service, although it would otherwise be covered, is "not medically necessary" under Medicare program standards. Medicare will deny payment for that service. A photocopy of this assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case. Use this form as an example of my "signature on file". I have been notified by my physician that Medicare is likely to deny payment for any x-rays taken and any examinations performed and I agree to be personally responsible for the payment of the agreed services.

date: _____

SIGNATURE OF POLICY HOLDER _____

WITNESS _____

SIGNATURE OF CLAIMANT IF OTHER THAN POLICYHOLDER
