DR. CARL E. HILLER
NMS Spine & Joint Institute

Name:_____ DOB:_____SS#_____ Today's Date: _____

Address:_____ Apt#_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____

Work Phone:_____ E-Mail:_____

Race:_____ Ethnicity:_____ Gender: _____Preferred Language:_____

Primary Care Physician: _____ Referring Physician: _____

Primary Care Physician Address: _____

How did you hear about our practice? _____

Pharmacy Name and Phone: _____

Emergency Contact Name:_____ Emergency Contact Phone Number:_____

PLEASE GIVE ALL INSURANCE CARDS TO THE FRONT DESK

Primary Insurance

Type of Coverage: [ ] Health [ ] Workers Comp [ ] Auto Accident [ ] Slip & Fall

Date of Injury / Accident: _____If worker's comp, employment status: [ ] F/T [ ] P/T [ ] Self-employed

Employer's Name/Address/Zip/Phone: _____

_____

Insurance Company Name/Address/ Zip/Phone: _____

_____

Certification/I.D./Claim Number _____ Group Number: _____

Adjustor Name: _____ Adjustor Phone # _____

Subscriber Name: _____ Patient's Relationship: [ ] Self [ ] Spouse [ ] Child [ ] Other

Subscriber Address: (if different than patient) _____

Subscriber S.S. # _____ Subscriber Date of Birth: _____

Secondary Insurance

Insurance Company Name/Address/Zip/Phone:_____

_____

Certification/I.D. Number: _____ Group Number: _____

Subscriber: _____ Patient's Relationship: [ ] Self [ ] Spouse [ ] Child [ ] Other

Subscriber S.S. # _____ Subscriber's Date of Birth: _____

Is patient responsible for bills? _____YES _____NO If **NO**, please provide the following:

Name of Guarantor: _____ Date of Birth: _____

Address: _____

City, State, Zip Code: _____ Social Security #: _____

Relationship to patient: _____ Phone #: _____

Date:_____Signature of Patient, Parent or Guardian: _____

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MEDICAL HISTORY FORM

HISTORY OF PRESENT ILLNESS/INJURY

Name:_____ DOB:_____ Age:_____ Date:_____

Referred by: _____ Onset/Date of Injury: _____

Body Part(s): _____ □ Right □ Left □ Bilateral (both sides)

Height: _____ Weight: _____

Did this occur suddenly or gradually? _____

Complaint: □ Pain □ Numbness □ Swelling □ Weakness □ Other: _____

Severity:
□ Mild
□ Mild/Moderate
□ Moderate
□ Moderate/Severe
□ Severe

Status:
□ Unchanged
□ Better
□ Fluctuating
□ Improving
□ Worse
□ Resolved

Frequency:
□ Intermittent
□ Occasional
□ Constant
□ Rare

Quality:
□ Aching
□ Burning
□ Dull
□ Sharp
□ Throbbing

Context: □ Injury □ Sports Injury □ MVA □ Work Injury □ Other _____

Are you experiencing radiating pain? □ Yes □ No If "yes", where does the pain radiate to: _____

Aggravated by:
□ Bending
□ Climbing Stairs
□ Descending Stairs
□ Lifting
□ Movement
□ Pushing
□ Sitting
□ Standing
□ Walking
□ Other: _____

Relieved by:
□ Brace/Splint
□ Elevation
□ Exercise
□ Heat
□ Ice
□ Injection
□ Massage
□ Pain/Rx Meds: _____
□ Mobility
□ OTC Meds: _____
□ PT
□ Rest
□ Stretching
□ Other: _____

Associated Symptoms/Pertinent Negatives:
□ Bruising
□ Crepitus (cracking sounds)
□ Decreased Mobility
□ Difficulty going to sleep
□ Instability
□ Limping
□ Locking
□ Night Pain
□ Night-time awakening
□ Numbness
□ Popping
□ Spasms
□ Swelling
□ Tingling in the arms
□ Tingling in the legs
□ Tenderness
□ Weakness
□ Other _____

Have you had similar symptoms before? □ Yes □ No If "yes", when _____

Doctors who have treated you for this problem: _____

Did that doctor refer you here? □ Yes □ No

Please list all diagnostic tests and treatment performed elsewhere for today's problem (please provide When/Where/What):

_____

_____

_____

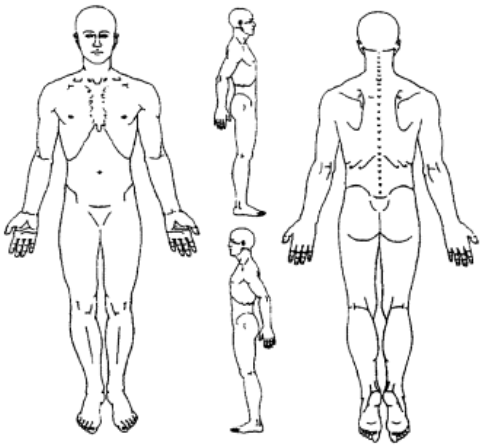
In the rare instance of an emergency whom should we contact?

Name_____

Phone( )_____

Do you participate in any sports, exercise programs or activities on a regular basis? □ Yes □ No

Please indicate on the picture below where your symptoms are located:



Numeric Pain Rating Scale

1. How would you rate your pain RIGHT NOW.

   0 1 2 3 4 5 6 7 8 9 10

   No Pain Worst Pain Imaginable

2. How would you rate your USUAL level of pain during the last week.

   0 1 2 3 4 5 6 7 8 9 10

   No Pain Worst Pain Imaginable

3. How would you rate your BEST level of pain during the last week.

   0 1 2 3 4 5 6 7 8 9 10

   No Pain Worst Pain Imaginable

4. How would you rate your WORST level of pain during the last week.

   0 1 2 3 4 5 6 7 8 9 10

   No Pain Worst Pain Imaginable

_____ _____ _____

Patient's Signature Date Signature of Guardian if patient is a minor

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Past Medical History Form

Patient Name _____ Date _____

Are you presently working? ☐ Yes ☐ No Date of next physician's visit: _____

Date of Injury/Surgery: _____ Have you ever had these symptoms before? ☐ Yes ☐ No

Check which apply to your current condition:

☐ Work-related injury ☐ Recurrence of previous injury ☐ Injury related to falling
☐ Motor vehicle accident ☐ Injury related to lifting ☐ Other _____
☐ Cause unknown ☐ Athletic / recreational injury

Have you had a related surgery? ☐ Yes ☐ No

Do you have, or have you had any of the following?

	Yes	No		Yes	No
Diabetes	☐	☐	Allergies to Aspirin	☐	☐
Chest pain / Angina	☐	☐	Allergies to Heat	☐	☐
High Blood Pressure	☐	☐	Allergies / Poor tolerance to Cold	☐	☐
Heart Disease	☐	☐	Other Allergies	☐	☐
Heart Attack	☐	☐	Hernia	☐	☐
Heart Palpitations	☐	☐	Seizures	☐	☐
Pacemaker	☐	☐	Metal implants	☐	☐
Headaches	☐	☐	Dizziness / Fainting	☐	☐
Kidney Problems	☐	☐	Recent Fractures	☐	☐
Are you pregnant?	☐	☐	Surgeries	☐	☐
Cancer	☐	☐	Skin Abnormalities	☐	☐
Osteoporosis	☐	☐	Nausea / Vomiting	☐	☐
Bowel / Bladder Abnormalities	☐	☐	Ringing in your ears	☐	☐
Urine leakage	☐	☐	Rheumatoid Arthitis	☐	☐
Asthma / Breathing Difficulties	☐	☐	Stroke / CVA	☐	☐
Liver / Gallbladder Problems	☐	☐	Hypoglycemia	☐	☐
Smoking	☐	☐	Depression	☐	☐
Other _____	☐	☐	Anxiety	☐	☐

If yes on any of the above, please briefly explain and give approximate dates

_____

_____

Is there any other information regarding your past medical history that we should know about?

_____

_____

List current medications (prescriptions, over the counter, herbals, vitamin/mineral/dietary supplements) including name, dosages, frequency and route.

_____

_____

_____

_____

_____

_____

_____

REVIEW OF SYSTEMS (Please check all that apply)

Constitutional:
□ Fatigue
□ Fever

Metabolic/Endocrine:
□ Cold Intolerant
□ Heat Intolerant

Neurological:
□ Seizure
□ Dizziness
□ Poor Coordination

Immunological:
□Environment Allergies
□ Food Allergies

HEENT:
□ Headache
□ Vision Loss

Hematologic/Blood:
□ Bleeding

Respiratory:
□ Cough
□ Dyspnea (shortness of breath)

Cardiovascular:
□ Chest Pain
□ Cyanosis (blue coloration of skin)
□ Irregular Heartbeats/Palpitations

Integumentary/Skin:
□ Rash
□ Lesion/Wound

Gastrointestinal:
□ Constipation
□ Diarrhea
□ Nausea
□ Vomiting

Genitourinary:
□ Dysuria (painful urination)
□ Hematuria (blood in the urine)

□ **None of the above**

Current Medications: □ **NONE** □ **List attached**
_____
_____
_____

Allergies/Reactions: □ **NONE**
_____ / _____
_____ / _____
_____ / _____

Do you have a history of infection with a bacteria called MRSA? □ Yes □ No Date treated: _____

PATIENT'S MEDICAL HISTORY (Please check all that apply)

□ Alcoholism
□ Alzheimers
□Anemia
□ Angina
□ Arthritis
□ Asthma
□ Atrial Fibrillation
□ Benign Prostatic Hypertrophy
□ Cancer
□ Cerebrovascular Accident (Stroke)
□ Congestive Heart Failure (CHF)
□ COPD (Emphysema)
□ Coronary Artery Disease
□ Crohn's Disease
□ Degenerative Joint Disease
□ Depression
□ Diabetes
□ Drug Abuse
□ DVT (Blood Clot)
□ Fibromyalgia
□ Gallbladder Disease
□ GERD
□ Gout
□ Hepatitis
□ Hyperlipidemia
□ Hypertension
□ Inflammatory Bowel Disease
□ Juvenile Rheumatoid Arthritis
□Kidney Disease
□Liver Disease
□ Lyme Disease
□ Migraine Headaches
□ Multiple Sclerosis
□ Myocardial Infarction (heart attack)
□ Obesity
□ Osteoarthritis
□ Osteoporosis
□ Parkinson Disease
□ Peptic Ulcer Disease
□ Psoriasis
□ PVD
□ Renal Disease
□ Rheumatoid Arthritis
□ Scoliosis
□ Seizure Disorder
□ Sleep Apnea
□ SLE (Lupus)
□ Spinal Stenosis
□ Thyroid Disease
□ Valvular Disease
□ **None**
□ **Other**:

PAST SURGICAL HISTORY □ No Prior Surgery

Operation (please verify what side of the body when necessary)	**DATE**

PATIENT'S FAMILY HISTORY

Heart Disease □ Yes □ No **Cancer** □ Yes □ No **Diabetes** □ Yes □ No
Rheumatologic/Gout Disorders □ Yes □ No **Bleeding Disorders** □ Yes □ No **History of Blood Clots** □ Yes □ No
Family history of chronic/inherited diseases: _____
Is your father living □ Yes □ No | **Is your mother living** □ Yes □ No
If no, cause of death(s) : _____

PATIENT'S SOCIAL HISTORY

Tobacco Use: □ Yes □ No □ Former/Year Quit _____ **Consume Alcohol:** □ Yes □ No □ Former/Year Quit _____
Substance Abuse: □ Yes □ No □ Former/Year Quit _____
Activity Level: □ Sedentary □ Moderate □ Vigorous **Type of Exercise**: _____
Hand Dominance: □ Left □ Right □ Ambidextrous
Occupation: _____ **Employment Status**: □ Full Time □ Part Time □ Unemployed □ Unable to work □ Light Duty

Date: _____ **Signature of Patient, Parent, or Guardian:** _____

Date: _____ **Reviewing Physician Signature:** _____

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AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize Neuromusculoskeletal Chiropractic & Rehabiltation Associates, P.C. (Covered Entity) to release the health information described below of myself or_____ to:

Recipient Name: _____
Relationship of Recipient to me or the individual named above
Recipient Address: _____
Recipient Phone #: _____

Specific Documents/Information I authorize to be released:

☐ All General Medical Initial _____ ☐ Alcohol/Substance Abuse Initial _____

☐ Mental Health Initial _____ ☐ AIDS/HIV Initial _____

☐ OTHER: (please specify, including dates of treatment and/or names of providers where appropriate) Initial _____

Purpose of Disclosure (explain or indicate "at the request of the individual"):

I understand that the terms of this Authorization are governed by the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 ("Original HIPAA"), as amended by the Health Information Technology for Economic and Clinical Health Act ("HITECH", and collectively with Original HIPAA, the "HIPAA Statute"), along with regulations promulgated by the Secretary of the Department of Health and Human Services under the HIPAA Statute, (collectively the "HIPAA Rules" and together with the HIPAA Statute, collectively, "HIPAA"), as well as any other applicable laws concerning the privacy and security of health information.

I understand that I have the right to revoke this Authorization, at any time prior to Covered Entity's compliance with the request set forth herein, provided that the revocation is in writing. I further understand that additional information relating to the exceptions to the right to revoke and a description of how I may revoke this Authorization is set forth in the Covered Entity's Notice of Privacy Practices. I understand that any revocation must include my name, address, telephone number, date of this Authorization and my signature and that I should send it to:

Neuromusculoskeletal Chiropractic & Rehabiliation Associates, P.C.
100 Arrandale Blvd.
Suite 105
Exton, PA 19341

I understand that I am not required to sign this Authorization and that the Covered Entity may not condition treatment on my execution of this Authorization.

I understand that the information used or disclosed pursuant to this Authorization may be subject to redisclosure by the Recipient listed above and, in that case, will no longer be protected by HIPAA.

This Authorization expires:
- ☐ One (1) year from date of authorization as set forth below.
- ☐ Upon Covered Entity's release of the information described above.
- ☐ _____days after the Date of Authorization, as set forth below.

I hereby acknowledge receipt of a copy of this Authorization.

_____ _____ _____
Patient Name (Printed) *Signature of Patient/Personal Representative* *Date of Authorization*

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INFORMATION DISCLOSURES TO INDIVIDUALS INVOLVED IN PATIENT'S CARE

I authorize Neuromusculoskeletal Chiropractic & Rehabilitation Associates, P.C. disclose information about my care and treatment to the individuals listed below for purposes of *their role in my treatment or payment* for the health services that I have received. This form does not give authorization for the below individuals to discuss HIPAA-protected information if they are not involved in the patient's care or other responsible party.

NAME(S) OF INDIVIDUAL(S)	RELATIONSHIP(S) TO PATIENT	INFORMATION TO DISCLOSE
_____	_____	☐ Treatment ☐ Payment
_____	_____	☐ Treatment ☐ Payment
_____	_____	☐ Treatment ☐ Payment

Authorization to text appointment reminders and leave answering machine/voicemail messages ☐ Yes ☐ No

_____
Patient Name (Printed)

_____ _____
Signature of Patient/Representative Date