IPMD
INTEGRATIVE PHYSICAL MEDICINE OF DAYTON

GENERAL INFORMATION

Name: _____ (Age) _____ Gender: M F

Home Address: _____ Phone#: _____

City, State, Zip: _____ Birth Date: _____/_____/_____

Email Address: _____ Social Security #: _____-_____-_____

Occupation: _____ Employer Name: _____

Emergency Contact: _____ Relationship: _____ Phone: ( ) _____

As a convenience to our patients, we offer appointment reminders through emails and text messages. Would you like to be set up on automatic text reminders? [ ] Yes [ ] No If yes, who is your cell phone provider? _____

ACCIDENT INFORMATION

Is this visit due to an accident? [ ] Yes [ ] No If yes, what type? [ ] Auto [ ] Work [ ] Other Date of Accident _____

Has the accident been reported? [ ] Yes [ ] No To Whom? _____ Claim Number_____

HEALTH INSURANCE INFORMATION

Name of *Your Health Insurance Co.*_____

Policy # _____ Group # _____

Insured's Name if different than yours _____ Insured's SS# _____/_____/_____

Relationship to Insured _____ Insured's Birth date _____/_____/_____ Employer_____

SECONDARY INSURANCE INFORMATION

Name of *Your Health Insurance Co.*_____

Policy # _____ Group # _____

Insured's Name if different than yours _____ Insured's SS# _____/_____/_____

Relationship to Insured _____ Insured's Birth date _____/_____/_____ Employer_____

I clearly understand that all insurance coverage, whether accident, work related, or general coverage is an arrangement between my insurance carrier and myself. If this office chooses to bill any services to my insurance carrier that they are performing these services are strictly as a convenience to me. The office will provide any necessary reports or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny my claims and that I am ultimately responsible for any unpaid balances. Any monies received will be credited to my account.

Signature of Patient/or Guardian of said Minor _____ Date _____

WORK/CAR ACCIDENT INFORMATION

Is this visit related to a (circle) work/car accident [ ] Yes [ ] No **Date of the accident** _____ Claim # _____

MCO/Insurance Name _____ Phone Number _____

Attorney Name _____ Phone Number _____

Please describe in detail the accident (use the back of this sheet if needed): _____

_____

_____

_____

_____

_____

Please answer the following questions only if you were injured in an automobile accident at work:

1. Were you the [] driver [] the passenger [] a pedestrian [] on a bicycle [] on a motorcycle.

2. Were you [] hit (by another vehicle) or [] at fault (you caused the accident)?

3. From which side were you struck [] behind [] the front [] the right side [] the left side [] the right front [] the left front [] the right back [] the left back.

4. At the time of impact were you [] stopped [] moving [] walking [] standing still [] running [] bicycling [] riding a motorcycle [] crossing the street.

5. Were you moving at the time of the accident [] yes or [] no? **If yes, what was your speed** _____?

6. Was the involved party moving when the accident occurred [] yes or [] no, **If yes what was their speed**_____?

7. Did you have your seatbelt on at the time of the accident [] yes [] no?

8. Was your head turned at the time of the accident [] yes or [] no, **If yes were you looking** [] forward [] looking to the right [] looking to left [] looking behind you [] looking up [] looking down.

9. Were you alone at the time of the accident [] yes or [] no? **If no who was with you** _____?

10. What parts of your body hit other structures at the time of impact [] head [] face [] forehead [] back of head [] right TMJ [] left TMJ [] right shoulder [] left shoulder [] right arm [] left arm [] right elbow [] left elbow [] right wrist [] left wrist [] right hand [] left hand [] Right leg [] left leg [] right knee [] left knee [] right ankle [] left ankle [] right foot [] left foot

11. What structures did you hit? [] steering wheel [] windshield [] side window [] door [] roof [] dashboard [] headrest [] seat [] floor [] Side of car [] hood of car [] bumper [] trunk [] the pavement [] tree [] another car [] another person [] another object [] a wall

12. How did you feel after the collision? [] stunned [] disoriented [] lost consciousness [] tightness [] felt mild discomfort [] felt moderate discomfort [] felt severe discomfort [] felt intense pain [] frightened [] felt a popping and ripping sensation [] went to hospital

13. Who was cited for the accident [] me [] other driver

14. Have you had one or more of the following symptoms since your accident? [] Cannot sleep due to the accident [] having trouble getting to sleep since the accident [] Lost time from work due to the accident [] have been depressed since the accident occurred

15. Have you been treated for injuries related to the accident already? [] yes [] no

If yes, by whom? _____ Did they perform any diagnostic testing? [] yes [] no

16. Have you lost wages or not been able to work due to the accident? [] yes [] no

HEALTH HISTORY

Who is your primary care physician? (doctor and/or practice) _____

Please check to indicate if you are currently experiencing any of the following symptoms:

- ☐ Neck Pain/Stiffness
- ☐ Back Pain/Stiffness
- ☐ Arm/Hand Pain
- ☐ Leg/Knee Pain
- ☐ Pins/Needles in Arms
- ☐ Pins/Needles in Legs
- ☐ Headaches
- ☐ Dizziness
- ☐ Blurred Vision
- ☐ Shortness of Breath
- ☐ Chest Pain
- ☐ Abdominal Pain
- ☐ Nausea
- ☐ Vomiting
- ☐ Constipation
- ☐ Diarrhea
- ☐ Problem Urinating
- ☐ Fever
- ☐ Rash
- ☐ Chills

Please check to indicate if you have ever been diagnosed with any of the following:

- ☐ Aids/HIV
- ☐ Allergies
- ☐ Anemia
- ☐ Arthritis
- ☐ Bleeding Disorders
- ☐ Cancer
- ☐ Depression/Anxiety
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fractures_____
- ☐ Goiter
- ☐ Gout
- ☐ Heart Disease
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Herniated Disc
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lung disease
- ☐ Migraines
- ☐ Multiple Sclerosis
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Parkinson's Disease
- ☐ Prostate Problems
- ☐ Prosthesis
- ☐ Rheumatoid Arthritis
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Other_____

Are you currently pregnant? ☐ Yes ☐ No

Are you currently under drug and/or medical care? ☐ Yes ☐ No If yes, explain _____

Please list any medications you are currently taking _____

Please list any surgeries you have had _____

Please list any supplements you are currently taking (vitamins, minerals, herbs)_____

Are you currently on any blood thinners – (aspirin regimen included)? ☐ Yes ☐ No List Type _____

Contraindications: A few procedures in the office should be avoided if patients have certain conditions.

Please CHECK if you have any of the following:

☐ A pacemaker ☐ Suffer from blood clots ☐ Knee/ hip replacement ☐ Local or systemic infection ☐ Egg allergy

☐ Corticosteroid or Local Anesthetic Allergy ☐ Allergies (please list) _____

Is there a family history of any of the following conditions? (Indicate family member including parents, grandparents & siblings)

☐ Heart Disease _____ ☐ Diabetes _____ ☐ stroke _____

☐ Cancer _____ ☐ Arthritis _____ ☐ Other _____

What is your daily/weekly intake of the following:

Alcohol _____ drinks/week Cigarettes_____ packs/day Recreational Drugs _____

I hereby certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.

Patient's / Guardian's Signature _____ Date

Doctor Reviewed Signature _____ Date_____

POLICIES, RELEASES AND FINANCIAL RESPONSIBILITY

1.) I understand that payment is due at the time of service unless we contracted with your insurance company, or you make other arrangements with our office.
2.) I understand that I am financially responsible for all fees incurred for the services provided, regardless of any applicable insurance or benefit payments, and I agree to ensure full payment. Please refer to our Insurance Company Payment Policy. It can be found on our website at www.ipmdohio.com.
3.) I understand in the event my account goes to collections, I am responsible for any and all collections fees.
4.) Patients are required to notify IPMD of any changes to their insurance and demographics. IPMD is not responsible for any denials for inaccurate insurance information.
5.) I clearly understand that if I terminate my care prematurely that all fees incurred will be due and payable at that time.
6.) I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.
7.) I consent to treatment necessary for the care of the individual named below.
8.) IPMD will attempt to identify and diagnose any ailments you may have that may be corrected through physical medicine, chiropractic care, and/or active/passive rehabilitation. If any condition or disease appears to be present out of our scope of practice, we will refer you to an appropriate physician to diagnose and/or treat that condition. Please refer to the Authorization of Care. It can be found on our website at www.impdohio.com.
9.) If you are unable to make your scheduled appointment, and we are not notified in advance, you may be charged a $20 cancellation fee. (Please refer to our appointment policy for further explanation by visiting www.impdohio.com).
_____**Initial**
10.) I understand I have certain rights regarding my protected health information and I authorize Integrative Physical Medicine of Dayton, LLC to disclose that information to carry out treatment, payment and healthcare operations. Please refer to our Notice of Privacy Practices for more information. It can be found at www.ipmdohio.com. _____ **Initial**
11.) I understand that strokes are a very rare event in the general population and have been reported after patients visit Chiropractors or primary care providers (medical doctors). Scientific evidence shows that the increased stroke risks are likely due to patients seeking care from Chiropractors or medical doctors because of an unusual type or severity of headache and neck pain. These symptoms are from an early stroke that is already occurring and progressing from prior damage to an artery in the neck. Once seen by a doctor, the risk of the stroke progressing has been found in the literature to be similar (no excessive risk) for patients who are seen by Chiropractors and Primary Care Providers. There is scientific evidence that shows that patients who have these developing strokes may have weakened or diseased artery vessel walls that are particularly vulnerable to a variety of motions or movements of the neck and head or they may occur spontaneously without any known reason. Research has shown that there are many stroke risk factors, including: disease of blood vessels, high blood pressure, birth control pills, environmental and genetic factors, infections, occurring during falls, violent car accidents, coughing/sneezing, sport activities, or even during such trivial movements as turning ones head to back up a car or to paint a ceiling. The literature shows that there are rare risks of strokes specifically from rotating and extending the head and neck during the physical examination, from cervical spine manipulation or other maneuvers that rotate or extend the head and neck, particularly the upper cervical spine. You are being informed of this reported association because a stroke may cause serious injury or even death. _____**Initial**

I have read and fully understand the above consent for treatment, financial responsibility, release of information and insurance authorization.

_____ _____
Patient or Legally Authorized Individual Signature Date

_____ _____
Print Patient's Full Name Time

_____ _____
Witness Signature Date

RADIOGRAPH CONSENT

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition.

By signing below, you give your consent to allow Integrative Physical Medicine of Dayton, LLC and its representatives, as deemed by the examining physician to take radiographs of your spine and/or extremities.

I also hereby declare that to my knowledge that I am not pregnant _____ (Initial)

Signature of Patient/or Guardian of said Minor _____ Date _____