Today's Date ________________ Print Name:____________________

MEDICAL HISTORY

Age:_____ **Sex**: F M **Primary Care Doctor's Name**:______________________**Did they evaluate this problem?** Y N

Dominant Hand: R L **Height:______Weight:** _______ **Birthday:_________________**

Who requested that you be seen here? Primary care provider Emergency room or urgent care provider yourself other

What problem are you being seen for today?____

____

When did your problem start or what was the date of the injury?

____

Were you seen in the E.R. for this problem? Y N **Which E.R.?**________________________________Date _____________

What tests/treatments have you had for this problem? X-Rays MRI CT scan Bone scan Ultrasound
□ Nerve Test (EMG/NCV) Physical Therapy Medications Previous surgery for this problem Other____________________

Since my problem started, it is: Getting better Getting worse Unchanged

Has your problem kept you from: Working Recreational activities Activities of daily living like cleaning & dressing yourself

I experience: Pain Bruising Numbness Tingling Weakness Loss of control bowel/bladder
□ Locking Catching Instability Swelling Stiffness Other ________________________

If you have pain: How would you describe the type of pain? Sharp Dull Stabbing Throbbing Aching Burning

On a scale of 0 - 10 (10 is the worst) what is your pain TODAY? (circle) 0 1 2 3 4 5 6 7 8 9 10

On a scale of 0 - 10 (10 is the worst) how severe can your pain get? (circle) 0 1 2 3 4 5 6 7 8 9 10

The pain is: Constant Intermittent (comes & goes)

Does the pain radiate/travel/move? Y N If yes, where ____

Does your pain wake you from sleep? Y N

What makes your symptoms worse? Walking Stairs Exercising Twisting Kneeling Direct pressure
□ Standing Sitting Lying flat Bending Lifting Coughing / sneezing

What makes your symptoms better? Rest or not moving Sitting Lying Standing Exercise / movement Elevation
□ Ice Heat Compression or bracing Injections Pain pills Other medications

If there was a specific injury, please describe what happened:

REVIEW OF SYSTEMS

Have you recently had any of these symptoms? Please check all that apply. If none of the below apply, then mark NONE.

Skin
□ Frequent Rashes
□ Open Wounds
□ Itchy/Red

Eye
□ Blurred Vision
□ Vision Loss
□ Double Vision

Lung
□ Short of Breath
□ Wheezing
□ Chronic Cough

ENT
□ Hearing Loss
□ Hoarseness
□ Difficulty Swallowing

Digestive
□ Heartburn
□ Nausea/Vomiting
□ Blood in Stool

Blood
□ Easy Bruising
□ Easy Bleeding

Neuro
□ Headaches
□ Numbness
□ Weakness
□ Frequent Falls

Glands
□ Excessive Thirst
□ Frequent Urination
□ Always Hot/cold
□ Lymphedema

Kidney/Bladder
□ Painful Urination
□ Kidney Problems
□ Urinary Infections

Bones/Joints
□ Osteoporosis
□ Joint Problems
□ Broken Bones

Constitutional
□ Weight Loss/Gain
□ Frequent Fever
□ Loss of Appetite

Cardio
□ Chest Pain
□ Irregular Beat
□ Calf Pain
□ Swelling Feet/Ankle

Psych
□ Drug Abuse
□ Alcohol Abuse
□ Depression
□ Anxiety

Female
□ Abnormal cycles
□ Pregnancy

Male
□ Erectile Dysfunction
□ Frequent Urination

PAST MEDICAL HISTORY

List any other doctors and their specialty that you see:____

Do you have a history of any of the following: (Please check all that apply)

Bones/Joints	**Circulation**	**Lung**	**Kidney**	**Digestive**
□ Broken	□ Blood Clots	□ Asthma	□ Infection	□ Heartburn
□ Osteoporosis	□ Hypertension	□ COPD	□ Stones	□ Reflux
□ Arthritis	□ Stroke	□ Emphysema	**Neuro**	□ Ulcers
	□ High Cholesterol	□ Sleep Apnea	□ Neuropathy	□ Dialysis
Heart	**Current Infection**	**Glands**	□ Seizures	**Other**
□ Open Heart	□ Pneumonia	□ Diabetes Type I	**Psych**	□ Liver Disease
□ Stents	□ Hepatitis	□ Diabetes Type II	□ Anxiety	□ Cancer
□ Heart attack	□ HIV/Aids	□ Thyroid	□ Depression	__________
□ Pacemaker				

List all past surgeries and what *year* that they occurred: **NONE** Appendectomy Tonsil Adenoids C-section/s Bypass
□ Gall bladder Tubes in ear Hernia repair Oral surgery Hysterectomy Tubal ligation Orthopedic surgery (please list below)
□ Others: ____

____

____

____

Current medications, the dose and frequency (list all prescription and over the counter medications / supplements):
□ **NONE** **Please see list on separate sheet (please date the sheet and write your name on the sheet)**

____

____

____

____

____

Are you allergic to any medications? Y N If yes, please list below and list the reaction (hives/stopped breathing/rash/swelling):

____

____

□ **Other Allergies:** Latex Food Seasonal Other **Have you ever had a reaction to anesthesia?** Y N __________

FAMILY HISTORY

□ Adopted and family medical history is not known No significant medical history of any direct relatives

List any major medical problems (examples: diabetes, heart disease, cancer, arthritis …) of your direct relatives:
Mother:________________________________alive (YES / NO)
Father:________________________________alive (YES / NO)
Grandparents:________________________________
Brothers/Sisters:________________________________
Children:________________________________

SOCIAL HISTORY

Do you use tobacco? No Quit Yes - How much?____packs per day **Alcohol use?** No Yes How much? __________

Caffeine use? No Yes How much?__________ **Artificial Sweetener use?** No Yes How much? __________

Nutritional Supplements? **No** **Yes** ________________________________

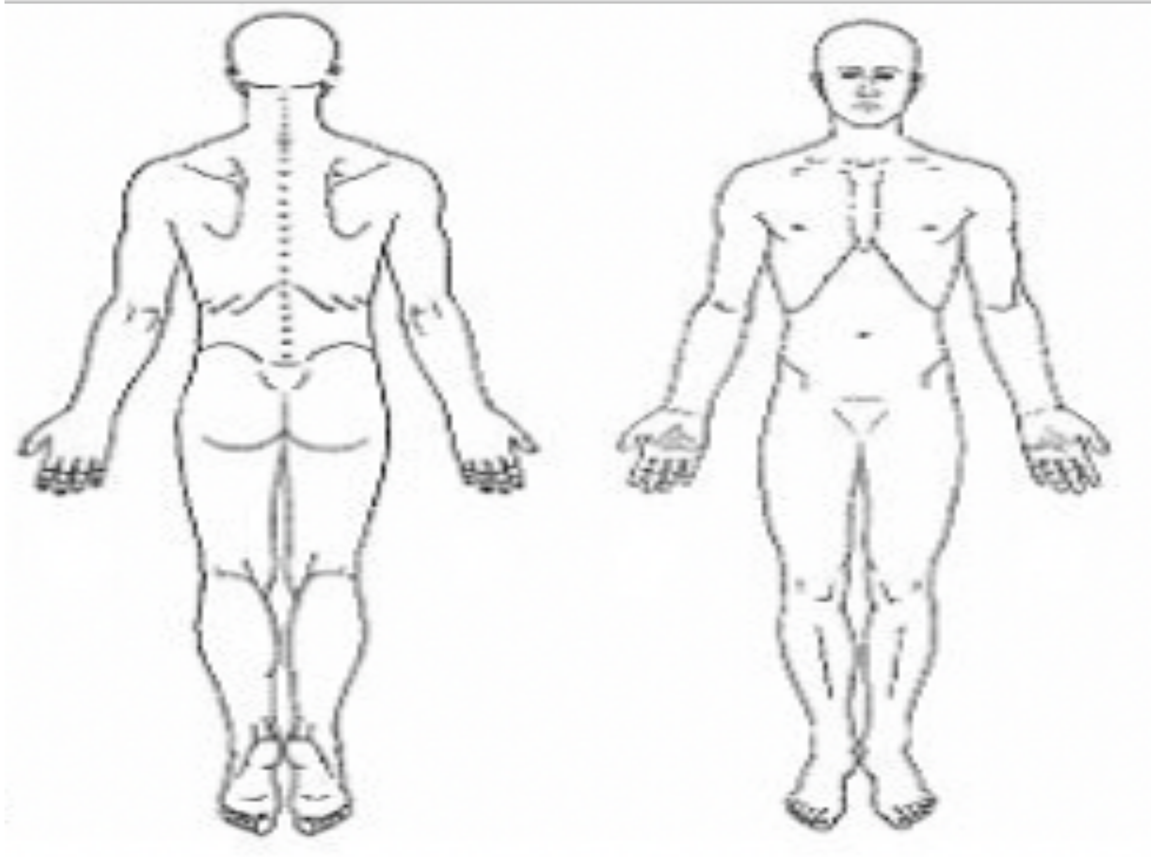
Exercise Habits? ________________________________

Sign Below:

____

Patient Signature The information on this form is accurate to the best of my knowledge. **Date**

PLEASE CIRCLE THE AREAS OF THE BODY WHERE YOU ARE EXPERIENCING YOUR MAIN COMPLAINT OR PAIN:



REASON FOR THIS VISIT:

- **FALL**
- **AUTO ACCIDENT**
- **SPORTS**
- **WORK INJURY**
- **CHRONIC PAIN**
- **OTHER:____________________**

CURRENTLY ENROLLED IN MEDICARE? ___Y ____N

PHONE:______________________

DO YOU WANT TO RECEIVE TEXT/EMAIL APPOINTMENT REMINDERS? __Y__N

EMAIL:____

DO YOU WANT TO BE PUT ON OUR EMAIL NEWSLETTER LIST?__Y___N

HOW DID YOU HEAR ABOUT US?

- FAMILY
- FRIEND
- WEBSITE
- INSTAGRAM
- FACEBOOK
- OTHER HEALTHCARE PROVIDER (IF SO, WHO?)______________
- OTHER:____________________

EMERGENCY CONTACT:______________________________________

EMERGENCY CONTACT NUMBER:______________________________

GUARDIAN (IF APPLICABLE):__________________________________

*By opting in to text appointment reminders, you agree to receive texts from a 3rd party on behalf of this office approximately 24 hours in advance of your scheduled appointment time. You further acknowledge that missed text reminders, regardless of who is at fault, do not negate the patient cancellation/missed appointment policy. Text reminders are in automated convenience option and it is ultimately your responsibility to be aware of and keep your scheduled appointments.

**By giving us your email address, you acknowledge your email will be used for communication purposes, including informing you of upcoming events and specials. You have the option to opt out of these communications at any time. We respect your privacy and we promise never to share, trade, sell, deliver, reveal, publicize, or market your email address in any way, shape or form.

Authorization and Release

I certify that I am the patient or legal guardian listed above and I have the legal authority to authorize the examination and treatment of the above patient. I have read and understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office. I authorize and consent to physical examination and receipt of healthcare services including, but not limited to, diagnostic procedures and medical treatment necessary to my care, health coaching and wellness screening services as the doctors see fit. I understand this authorization applies and extends to subsequent visits and shall be valid until rescinded in writing or replaced by one of a later date. By agreeing to receive treatment, I acknowledge that my/my child's medical care, services and treatment will be provided by physicians as well as other assisting healthcare professionals, (such as, Chiropractic Assistants, Residents, Interns, Personal Trainers or other providers as designated by the treating physician). I hereby authorize the doctor to release all information necessary to any other medical provider or attorney incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment regardless of possible insurance reimbursement status. I understand that this is a self-pay practice and am responsible for all costs personally.

Patient/Guardian Signature: ____________________________________ **Date:** ________________

Address:____

City/State/Zip Code:____

NEW PATIENT PROCEDURE CONSENT FORM

Please **initial** next to each procedure as indication of your consent for the below to be performed by Dr. Pedigo, DC, MS at Southern Spine & Rehab LLC. Please note that not all of the treatment options below may be utilized, however, consent to all in case they may be needed for your individualized treatment plan.

____Detailed History Taking

____Vitals

____Any Physical Examination Deemed Necessary by Dr. Pedigo

____Chiropractic Manipulative Therapy ("Chiropractic Adjustments")

____Rehabilitative or Corrective Exercises

____All Types of Soft Tissue Mobilization

____Instrument-Assisted Manipulation

____Report of Findings on Your Condition and Discussion of Treatment Plan

____Referral for Diagnostic Imaging, Diagnostic Procedures, or Evaluation of Another Healthcare Specialty if Indicated.

____Any Other Procedures Deemed Necessary for Increasing Patient Outcomes by Dr. Pedigo

Patient or Guardian Print Name & Date :____

Patient or Guardian Sign Name & Date:____

PATIENT FINANCIAL AGREEMENT

In an effort to lower the cost of treatment for patients, Southern Spine & Rehab LLC has elected to operate as a "Self-Pay Practice." This allows us to offer a lower-priced fee schedule due to the lower administrative costs incurred by our office.

Physical Medicine Provided by Southern Spine & Rehab LLC:

$100 for the first visit (45 minute – 1 hour appointment that consists of consultation, detailed examination, and same day treatment). Every patient new to the clinic must first schedule and pay this fee to become an established patient at Southern Spine & Rehab LLC.

Follow-Up Visits for Active Complaint or Injury: $65

Re-evaluation visits: $80

All payments are due at time of service. We can provide you with a super-bill that contains the procedure codes, diagnostic codes, amount paid and the clinic contact information along with the national provider ID (NPI) or tax ID for the treating provider.

We are not currently accepting Medicare patients due to federal guidelines and our type of practice.

Please keep in mind, your insurance policy is a contract between you and your insurance company and our office will not directly engage in any processing of your claim for insurance submission. We will not be responsible for generating claim forms, filing claims, processing medical necessity support documents, writing reports or any other documentation with regards to processing claims. If needed, patient medical records/office notes may be requested in writing, hard copies may be subject to copying fees.

By signing this form, you agree that you are directly responsible for all costs of care incurred at this office. You further agree to hold this office harmless from any coverage decision your insurance company makes regarding payment should you elect to seek reimbursement from them.

Patient Name: ____ **Date:**__________

Patient/Guardian Signature:

____