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RAYMER
SPINE AND SPORT

Medical Coding

CPT coding:

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** for office use only*

Welcome To Our Office! *Sports Therapy and Chiropractic Services*

Today's Date ____/____/____

Patient Title: ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. Gender ❑ Male ❑ Female Date of Birth ____ / ____ / ____ Age______

First Name ____________________________________ Preferred Name_____________________________________

Last Name____________________________________ Middle Name_______________________ Suffix___________

Address ____

City____ State___________ Zip Code_________________

Home Phone____________________ Work Phone_____________________ Mobile Phone_____________________

Cell Phone Provider____

Email Address____

Preferred Contact Method ❑ Home Phone ❑ Work Phone ❑ Mobile Phone ❑ Email

Marital Status ❑ Single ❑ Married ❑ Other Spouse's Name_____________________ # of Children_________

Emergency Contact________________________ Phone #________________________ Relationship_____________

Employment Status ❑ Employed ❑ Full-Time Student ❑ Part-Time Student ❑ Retired ❑ Other

Occupation ____________________________ Employer/School ____

Race ❑ White/Caucasian ❑ Black/African American ❑ Hispanic ❑ Other_________ ❑ I choose not to specify

Ethnicity ❑ Hispanic or Latino ❑ Non-Hispanic or Latino ❑ I choose not to specify

Referred to our office by____________________________________

Current Medications *(including frequency and dosage)*
If there are no current medications, check here: ❑

1)____

2)____

3)____

4)____

5)____

Known Allergies to Medications
If there are no known allergies, check here: ❑

1)____

2)____

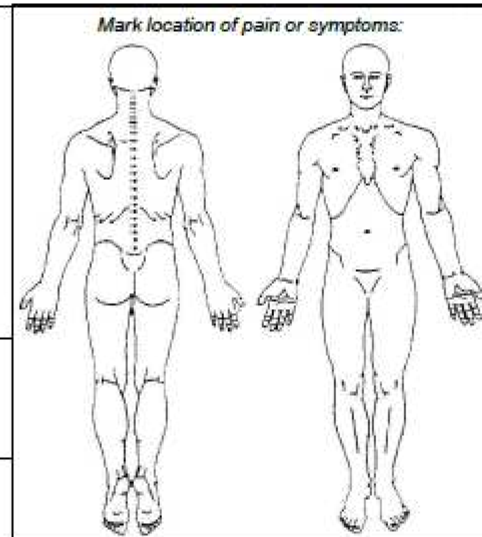
3)____

4)____

5)____

Current Problem

Reason for this visit___________________________



What level of intensity would you rate your pain?
(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Severe)

Please select all that apply:

- ❑ Achy ❑ Burning ❑ Cramping ❑ Deep ❑ Dull
- ❑ Numbness ❑ Radiating ❑ Sharp ❑ Shooting ❑ Soreness
- ❑ Stabbing ❑ Stiff ❑ Throbbing ❑ Tightness ❑ Tingling

What is the frequency of your symptoms?
❑ Constant ❑ Frequent ❑ Intermittent ❑ Occasional

What makes your symptoms worse?___________________________

What makes your symptoms better?___________________________

When did the symptoms start?___________________________

How did you injure yourself?___________________________

Have you ever experienced this before? ❑ Yes ❑ No ___________________________

How does this affect your personal life? (hobbies, sports, etc…)___________________________

How does this affect your job? (missed days, inability to lift, stand, sit, etc…)___________________________

What home remedies have you tried?___________________________

Have you been to another doctor for this problem? ❑ Yes ❑ No___________________________

Have you ever been to a Chiropractor before? ❑ Yes ❑ No___________________________

Past Health History

Have you ever...

Yes	No	
❑	❑	Been Knocked Unconscious?________________________________
❑	❑	Been in a car accident?________________________________
❑	❑	Been treated for a spine problem/nerve disorder?________________________________
❑	❑	Had any significant falls, slips, or injuries?________________________________
❑	❑	Fractured/broken a bone?________________________________
❑	❑	Had surgery?________________________________
❑	❑	Been hospitalized for other than surgery?________________________________

Do you currently smoke tobacco of any kind? ❑ Yes ❑ Former smoker ❑ Never been a smoker

If yes, how often do you smoke: ❑ Current every day smoker ❑ Current sometimes smoker # Packs per day____

If yes, what is your level of interest in quitting smoking? 0 1 2 3 4 5 6 7 8 9 10

No interest — *Very Interested*

Do you consume alcohol? ❑ Yes ❑ No # Drinks per week________

Do you consume caffeine? ❑ Coffee ❑ Soda ❑ Tea ❑ Energy Drinks # Drinks per day________

Do you exercise? ❑ No ❑ Infrequent ❑ Occasional ❑ Regular ❑ Avoid due to pain

Please mark any you currently have or have had previously:

❑ AIDS	❑ Cramps	❑ Kidney Infection	❑ Sciatica
❑ Alcoholism	❑ Depression	❑ Kidney Stone	❑ Shortness of Breath
❑ Allergies	❑ Diabetes	❑ Loss of Memory	❑ Sinus Infection
❑ Anemia	❑ Digestions Problems	❑ Loss of Balance	❑ Sleep Problems/Insomnia
❑ Arteriosclerosis	❑ Dizziness	❑ Loss of Smell	❑ Spinal Curvatures
❑ Arthritis	❑ Excessive Menstruation	❑ Loss of Taste	❑ Stroke
❑ Asthma	❑ Eye Pain/Difficulties	❑ Migraine Headache	❑ Swelling in Ankles
❑ Back Pain	❑ Fatigue	❑ Neck Pain or Stiffness	❑ Swollen Joints
❑ Breast Lump	❑ Frequent Urination	❑ Nervousness	❑ Thyroid Condition
❑ Bronchitis	❑ Headache	❑ Nosebleeds	❑ Tuberculosis
❑ Bruise Easily	❑ Hemorrhoids	❑ Pacemaker	❑ Ulcers
❑ Cancer	❑ High Blood Pressure	❑ Polio	❑ Varicose Veins
❑ Chest Pain/Conditions	❑ Hot Flashes	❑ Poor Posture	❑ ________________
❑ Cold Extremities	❑ Irregular Heart Beat	❑ Prostate Issues	❑ ________________
❑ Constipation	❑ Irregular Cycle	❑ Ringing in Ears	❑ ________________

Is there a family history of? *(Include Relationship)*

❑ Heart Disease________________________________

❑ Cancer________________________________

❑ Stroke________________________________

❑ Arthritis________________________________

❑ Diabetes________________________________

❑ High Blood Pressure________________________________

❑ Other________________________________

The information that I have provided above is accurate to the best of my knowledge and will be used to determine appropriate chiropractic care.

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Patient's Signature

Women Only

Are you pregnant? ❑ Yes ❑ No ❑ Maybe

Number of Weeks________________

Estimated Due Date________________

Notice of Privacy Practices

Our practice is dedicated to maintain the privacy of your health information according to the guidelines set forth by federal and state law. These laws also require us to provide you with notice of privacy practices, and to inform you of your rights and our obligations concerning your health information.

The undersigned hereby acknowledges that the Privacy Policy of Raymer Spine and Sport, which describes the Practice's policies and procedures regarding the use and disclosure of any of my Protected Health information created, Received or maintained by Raymer Spine and Sport, is on file and can be produced at any given time.

________________________________ ____/____/____
Signature Date

Statement of Informed Consent

Chiropractic adjustments are performed in our office by skilled doctors of chiropractic who have successfully completed advanced educational requirements, national board examinations, and state board examinations. As with any healthcare procedure, there are some inherent risks that exist. Whenever possible this risk is minimized to its lowest level. Our doctors and staff make every effort possible to provide the safest chiropractic care available.

The undersigned hereby consents to evaluation and treatment rendered according to the applicable standards of care. It is understood that options exist for treatment and that any/all treatments have risks and benefits. If the risks and benefits of proposed treatment are not clear to me, I understand that further information may be requested from the doctor.

________________________________ ____/____/____
Signature Date

Consent to Treat a Minor

I, ______________________ give my consent to Dr, Raymer at Raymer Spine and Sport, to examine and treat my child for any Deficiency and to administer any treatment that is deemed necessary. I hereby signify acceptance and responsibility for payment of charges incurred and understand that this agreement will remain in effect until the account is paid in full, even after my child reaches the age of majority.

Name of Minor_________________________________

Relationship to Minor_____________________________

Signature of Parent/Guardian_____________________________ Date____/____/____