

hHealth Quest

Chiropractic & Physical Therapy

with ADVANCED WEIGHT LOSS
NUTRITION & FUNCTIONAL MEDICINE

Confidential Patient Case History

Personal Information

Name: _____ Social Security #: _____

Address: _____

City/State/Zip: _____ Email: _____

Home Ph: _____ Work Ph: _____ Cell Ph: _____

Birth date: _____ Age: _____ Male () Female () Marital Status: M () S () D () W ()

Emergency Contact Name and Phone: _____

Occupation: _____ Height: _____ Weight: _____

Primary Care Dr.: _____ May we send a report to him/her? Yes () No ()

How did you hear about us? _____ Insurance is under: Self () Other: _____

Are you interested in learning about our Weight Loss, Nutrition or Functional Medicine services? Yes () No ()

Health Information

Is your visit because of a work- or auto-related injury? Yes () No () If Yes, date of injury: _____

If No, when did symptoms begin: _____

Please circle the symptoms you have noticed SINCE the onset of your condition:

Headache	Irritability	Numbness in Toes	Flushed Face	Cold Feet
Neck Pain	Chest Pains	Shortness of Breath	Buzzing in Ears	Cold Hands
Neck Stiffness	Dizziness	Fatigue	Loss of Balance	Upset Stomach
Sleeping Problems	Head Seems Heavy	Depression	Fainting	Constipation
Back Pain	Pins/Needles in Arms	Light Sensitivity	Loss of Smell	Cold Sweats
Nervousness	Pins/Needles in Legs	Loss of Memory	Loss of Taste	Fever
Tension	Numbness in Fingers	Ringling in Ears	Diarrhea	_____

Are your symptoms Getting Worse () Constant () Comes and Goes () Moves/Spreads ()

Is this condition interfering with your () Work () Sleep () Daily Routine

Other doctors who have treated this condition?: _____

What medications do you take? _____

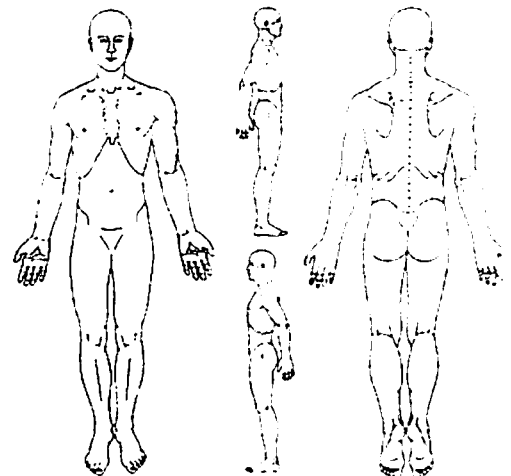
➡ Please mark your areas of pain on the figures to the right ➡

If applicable for an injury, please enter Insurance Company name, Claim #,
Attorney's/Adjuster's name, address & phone number below:

The information on this sheet is, to the best of my knowledge, true and accurate. I hereby consent to the performance of chiropractic adjustments and/or other chiropractic, physical therapy and diagnostic procedures by Health Quest Chiropractic & Physical Therapy, LLC for the treatment of my present condition and for any future condition(s) for which I seek treatment. I understand I am financially responsible for all treatment I receive that is not paid for by my insurance policy(ies).

Signature: _____

Date: _____



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Confidential Patient Health History

Patient's Name: _____ (please print)

Please circle any item(s) that are an ongoing or significant part of your health history:

<p style="text-align: center;"><u>General</u></p> <ul style="list-style-type: none"> - Fever/Chills - Night Sweats - Loss of Sleep/Fatigue - Nervousness - Weight Loss or Gain - Allergies - Bleeding Problems - Anemia - Diabetes - Cancer _____ - HIV/AIDS - Thyroid Disease/Goiter - Alcoholism - Drug Abuse <p style="text-align: center;"><u>Ear, Eye, Nose, Throat</u></p> <ul style="list-style-type: none"> - Poor Vision - Pain in Eyes - Deafness/Difficulty Hearing - Nosebleeds - Nose Problems - Sinus Trouble - Dental Problems - Hoarseness - Tonsillectomy <p style="text-align: center;"><u>Gastrointestinal</u></p> <ul style="list-style-type: none"> - Poor Appetite - Poor Digestion - Difficulty Swallowing - Belching or Gas - Frequent Nausea - Vomiting - Vomiting Blood - Pain Over Abdomen - Ulcer - Black or Bloody Stools - Liver Problems - Gall Bladder Problems - Jaundice - Hernia - Diarrhea - Constipation - Hemorrhoids - Appendicitis <p style="text-align: center;"><u>Surgeries (Type and Date)</u></p> <p>_____</p> <p>_____</p> <p>_____</p>	<p style="text-align: center;"><u>Respiratory</u></p> <ul style="list-style-type: none"> - Difficulty Breathing - Chronic Cough - Spitting Phlegm - Spitting Blood - Wheezing/Asthma - Pneumonia - Tuberculosis <p style="text-align: center;"><u>Cardiovascular</u></p> <ul style="list-style-type: none"> - Irregular Heartbeat - High Blood Pressure - Pain Over heart - Previous Heart Trouble - Ankle Swelling - Varicose Veins - Rheumatic Fever - Stroke <p style="text-align: center;"><u>Genitourinary</u></p> <ul style="list-style-type: none"> - Frequent Urination - Painful Urination - Blood in Urine - Kidney Disease - Urinary Infection - Inability to Control Urination - Difficulty Starting Urine Flow - Get up at Night to Urinate - Breast Lump or Pain - Venereal Infection - Sexual Difficulties <p style="text-align: center;"><u>Skin</u></p> <ul style="list-style-type: none"> - Itching - Bruising Easily - Change in Mole(s) - Skin Cancer - Scar Location(s) _____ <p style="text-align: center;"><u>Neurologic</u></p> <ul style="list-style-type: none"> - Weakness - Twitching - Tremors - Headache - Fainting - Dizziness - Convulsions - Epilepsy/Seizures - Numbness/Tingling - Arm/Leg Pain - Mental Disorder 	<p style="text-align: center;"><u>Musculoskeletal</u></p> <ul style="list-style-type: none"> - Neck Stiffness/Pain - Pain Between Shoulders - Low Back Pain - Swollen Joints - Painful Joints - Muscle Aches/Soreness - Spinal Curvature - Arthritis <p style="text-align: center;"><u>Men Only</u></p> <ul style="list-style-type: none"> - Testicular Swelling - Prostate Problems <p style="text-align: center;"><u>Women Only</u></p> <ul style="list-style-type: none"> - Painful Periods - Excessive Flow - Irregular Cycles - Vaginal Burning/Itching - Hot Flashes - Date LMP: _____ - Date Last PAP: _____ <p style="text-align: center;"><u>Exercise</u></p> <ul style="list-style-type: none"> - None - 1-2 times/week - 3-5 times/week - 6-7 times/week <p style="text-align: center;"><u>Habits</u></p> <ul style="list-style-type: none"> - Smoking _____ packs/day - Drinking - Recreational Drug Use - Caffeine <p style="text-align: center;"><u>Family History – Do NOT include Yourself</u></p> <p>(Re: siblings, parents and grandparents)</p> <ul style="list-style-type: none"> - Diabetes - Thyroid Disease/Goiter - Tuberculosis - Kidney Disease - High Blood Pressure - Heart Disease - Cancer - Muscle, Bone or Nerve Disease - Lung Disease - Ulcers - Arthritis - Seizures/Stroke
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Patient's Name: _____ (please print)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand and have been provided with a *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures,

AUTHORIZATION FOR RELEASE OF RECORDS

I hereby authorize **Health Quest Chiropractic & Physical Therapy, LLC** (Health Quest) to furnish my attorney/insurance carrier with any information necessary for payment of services rendered to me or my dependent(s) by said office. I also authorize **Health Quest** to request relevant and necessary records on my behalf for my diagnosis and treatment at **Health Quest** by Dr. Paul M. Ettlinger, Dr. Nova Conetta and staff.

ASSIGNMENT OF BENEFITS/DOCTOR'S LIEN

I understand that health and accident policies are an arrangement between an attorney/insurance carrier and myself. Furthermore, I understand **Health Quest Chiropractic & Physical Therapy, LLC** will assist me in submitting claims to the attorney/insurance company. I hereby give a lien to Dr. Paul M. Ettlinger on any settlement, claim, judgment or verdict as a result of my injury/illness and authorize payment of any medical benefits for which I am entitled to be made directly to:

Dr. Paul M. Ettlinger / Dr. Nova Conetta / Dr. Sean Grady / Dr. Stefanie Coforio
Health Quest Chiropractic & Physical Therapy, LLC
7920 McDonogh Road, Suite 101
Owings Mills, MD 21117
410.356.9939 (phone) 410.356.9987 (fax)

FINANCIAL POLICY

I understand full payment of health insurance copays, estimated coinsurance, deductibles and/or services not covered by another party is due at the time of service. If my insurance plan requires a referral, I am responsible for bringing the referral prior to treatment. If I fail to provide a proper referral, I will be required to pay for my visit as if I was non-insured. I also understand it is my responsibility to notify **Health Quest Chiropractic & Physical Therapy, LLC** in writing of any changes in my personal information and/or changes of insurance information

I fully understand I am responsible for the full balance of any charges not paid by my settlement and/or under my insurance plan for which I am. I understand a finance charge of 30% will be assessed to my account if collections services are required for a delinquent balance.

I understand it is my responsibility to notify **Health Quest Chiropractic & Physical Therapy, LLC** 24 hours in advance if I am unable to make my scheduled appointment. There will be a \$25 fee assessed to my account if I fail to do so.

I understand all overpayments more than \$10.00 will be automatically refunded to me once all outstanding claims have been processed by my insurance. Overpayments under \$10 will remain credited to my account for future use unless I request a reimbursement.

Signature: _____ Date: _____



Informed consent for chiropractic treatment

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy on me (or the minor child named below, for whom I am legally responsible) by Dr. Paul M. Ettlenger, Dr. Nova Conetta and the staff of Health Quest Chiropractic & Physical Therapy, LLC.

The practice of chiropractic includes many standard examinations and testing procedures. These include physical examination, orthopedic and neurological testing, palpation, specialized instrumentation, laboratory tests, radiology examinations, physical therapy and rehabilitative procedures. Additionally, there is a procedure unique to the chiropractic profession – the chiropractic spinal/limb adjustment.

My treatment options with possible adverse affects have been explained as follows:

1. **Chiropractic Treatment:** Chiropractic adjustments involve the use of the hands or the use of hand-guided instruments to manipulate the spinal or limb joints for the purpose of increasing joint movement. In the practice of chiropractic, as in the practice of medicine, there are some risks to treatment, including but not limited to fractures, disc injuries, dislocations, musculoskeletal sprains or strains, and vertebral artery syndrome (VAS). The risks or complications are seldom enough to contraindicate care, but should be considered in making the decision to receive chiropractic care. (Risk of stroke after manipulation is 1.46 per million manipulations. Rand Study 1996)
2. **Drug Therapy:** This includes over-the-counter or prescribed (for NSAIDS) such as Ibuprofen, Tylenol, Alleve, etc. Serious gastronomical events are 1,000 per million in all ages; 3,200 per million in those 65 years and older. (Rand Study)
3. **Surgical Treatment:** In-hospital surgeries involve risk as well. Death from neck surgery is 6,900 per million; neurological complications is 15,600 per million. (Rand Study 1996)
4. **No Treatment:** Remaining untreated allows for the formation of adhesions which reduce mobility and can set up further pain reaction and potential impairment or disability.

I do not expect Dr. Ettlenger, Dr. Conetta, Dr. Grady or other licensed associates to be able to anticipate and explain all risks and complications, and I choose to rely on Dr. Ettlenger, Dr. Conetta, Dr. Grady or other associates to exercise their best professional judgement during the course of the procedures which they think, at the time, based upon the facts then known, is in my best interest.

I HAVE READ (OR HAVE HAD READ TO ME) THE ABOVE CONSENT. I have also had the opportunity to ask questions about its content, and by signing below, I agree to the aforementioned procedures. I intend this **INFORMED CONSENT** to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Name of patient (please print): _____

Signature of patient (or guardian)

Date