INDEPENDENT MEDICAL SERVICES – INTAKE FORM

Name: ____ Date: ______________
DOB: ___________ Age: _____ Height: ______ Weight: ______
Date of Injury or Accident__________________ MVA___ Work____ Other___ Unknown______

Chief Complaint *(Describe the area of your body that bothers you the most (if you have more than one area of complaint, please ask for an **Additional Complaint Form**)*____________________
____
____
____

Duration: *When did symptoms begin?*_______________ *Did you go to a hospital or clinic immediately?* ____ *Which one?*________________________________ *By Ambulance?*_____

History of Injury: If this is an **INJURY**, in your own words, please describe what occurred. If not an injury, please state if your complaint occurred as a gradual onset or if cause is unknown:

____
____
____

Quality of Pain/Sensation: *(Check off the words that best describe your pain – the space below each word, please note where the pain is located)*

☐ Stabbing	☐ Throbbing	☐ Shooting	☐ Sharp	☐ Cramping
☐ Aching	☐ Burning	☐ Dull	☐ Sore	☐ Tender
☐ Crushing	☐ Heavy	☐ Gnawing	☐ Tight	☐ Stiffness

Radiation of Pain*:* *Does your pain radiate to another body part?* Yes ____ No ____
If yes, please list: ____

Modifying Factors - What activities make your symptoms **better**? (Rest, medicine, heat, etc.)____________________________
____
____
____

Modifying Factors – What activities make your symptoms **worse**? (bending, lifting, etc, .) ______________________________
____
____
____

Pain Scale/Severity: Rate your pain on a daily basis (0 = none, 10 = most severe)

1 2 3 4 5 6 7 8 9 10

Rate Improvement: How would you rate your improvement since the time of your injury between 0% and 100%: ____

Treatments: List everyone you saw for this condition (including hospitals, emergency rooms, 24-hour clinics, primary care physician, specialists, etc.)

Date Treatment Started	Doctor/Therapist and Location	Treatment Received	Your Response to Treatment	Last Visit There

What were your doctors' recommendations: ____

What was your **absolute last date** you were treated for this injury: ___________________________

Past Injuries: (auto accidents, etc).: ____

Allergies: *Do you have any allergies? If yes, please list:*______________________
____

Medications: *(please list all medicines your are currently taking)*_____________
____

Past Medical History – *please check any that apply*:

- ○ Angina
- Edema
- ○Osteoporosis
- ○ Anxiety Disorder
- ○ Heart Disease
- ○ Thyroid
- ○Arthritis
- ○Hepatitis
- ○Ulcer
- ○Cancer
- ○ Cholesterol
- ○Carpal Tunnel
- ○Hypertension
- ○Chronic Lung
- ○Kidney
- ○ Depression
- ○Lung Disease
- ○Diabetes
- ○Migraines
- Other ___________

Past Surgical History – *please check any that apply*:

- ○ Appendectomy
- ○D & C
- ○Stent Insert
- ○ Artificial Joint Replacement
- ○ Gallbladder
- ○Tonsillectomy
- ○Back Surgery
- ○Hemorroidectomy
- ○ Tubal Ligation
- ○Breast Surgery
- ○Hip Replacement
- ○Cardiac Surgery
- ○ Hysterectomy
- ○Carpal Tunnel Surgery
- ○Knee Surgery
- ○ Colon/Intestinal Surgery
- ○ Neck Surgery
- ○C-Section
- ○Shoulder Surgery
- ○ Other ____________________________________

Social History: Family Physician ______________________ Marital Status: _____________________

Children? Yes/No _____ How many _____ How many living at home? _______________________

Do you smoke? Yes/No ____ How Long? ____ Did you smoke in past? ____ When did you quit? ______

Do you use tobacco in any other form? ______ Do you wear glasses? _____

Do you exercise? None _____ Light _____ Moderate _____ Heavy _____

Caffeine consumption: No caffeine_____ Yes Caffeine_____ Cups per day_______

Do you have problems Reading?____ Writing? _____ Right or Left Handed? ______________

Education: Highest Grade Completed _____ College Yes/No _____ Year graduated _____

Occupation _____________________________ Other training/degrees: ____________________________

Family History:	**NO**	**Father**	**Mother**	**Sibling**	**Child**	**Grandparent**
Arthritis						
Cancer						
Diabetes						
Headaches						
Heart Attack						
Heart Disease						
Hypertension						
Migraines						
Psychiatric Illness						
Thyroid Disease						
Other: __________						

Review of Systems – *please check all that* ***currently*** *apply to you*

	YES	**NO**		**YES**	**NO**
Chills			Ulcers		
Hearing Loss			Skin Ulcers		
Sore Throat			Skin Rashes		
Chest Pain			Joint Pain		
High Blood Pressure			Backaches		
Shortness of Breath			Numbness		
Coughing			Strokes		
Coughing Blood			Seizures		
Blood in Stools			Pregnancy (Due Date_________)		
Blood in Urine			Psychiatric Problems		
Liver Problems			Diabetes		
Kidney Problems			Thyroid Disease		
Heart Problems			Anemia		
Fever			Cancer		
Visual Problems			Allergic/Immunological Disease		

Work Related Injury: ***(ONLY FILL THIS OUT IF THIS IS A WORK-RELATED INJURY)***

Did your injury occur at work? Yes/No _______ Was an accident report completed? Yes/No_________

Are you currently working? Yes/No ______. What was the last date you worked as a result of this injury? _________________ _______ When are you scheduled to return to work? __________

If you are currently working, at what capacity? ______ Full Duty ______ Light Duty

What is the name, address, and phone number of your employer at the time of this injury?

____

____

Is this company still in business? Yes/No _______ Your supervisors name?__________________________

What was your job title and describe your duties at work in detail (lifting, hours, etc.) _______________

____

Patient Signature: ____ Date: ____________________

ADDITIONAL COMPLAINTS

Patients, please fill out the following for any complaints you have in addition to the Chief Complaint listed on page 1 of your Patient Intake Form. *As much detail as possible is greatly appreciated.*

Complaint :

Body part/system: ____

Onset (when did symptoms begin): ____

History of injury as described by you:____________________________________

____

____

____

____

Character (deep, sharp, etc.): ____

Radiating: ____

Modifying Factors

What activities make symptoms better, i.e., medicine, rest, heat?

____

____

____

What makes symptoms worse, i.e., lifting, walking, driving?):

____

____

____

Severity: (on average, how would you rate your pain on a daily basis? 0=none, 1=least, 10=most):

1 2 3 4 5 6 7 8 9 10

Progress:____

____

____

Past Treatment/Tests:____

____

____

____

INDEPENDENT MEDICAL SERVICES, PLLC
REGISTRATION FORM
(Please Print)

Date:_____________ Referred By:__________________________Prior Patient: Yes No

Patient Name____Date of Birth:___________________

Physical Address: ____

Mailing Address: ____

Home Phone:_____________________________ Cell Phone:____

Social Security #:_______________________________________ __Married __Single __Divorced __Widowed

Email Address: ____

Employer Name____

Employer & Address____

Occupation: _________________________________ Work Phone: ____

Spouse's Name___________________Employer &Address____

Work Phone:_______________ Cell Phone:_____________DOB:__________ Social Security #________________

INSURANCE INFORMATION

Insurance: ____

ID # or Claim#:____

Group#:___________________________________ Claims Adjuster:____________________________________

Cardholder Name: ___________________________Relationship: ______________________________________

Secondary Insurance: ____

ID #:______________________________________ Group#:____

Cardholder Name: ___________________________Relationship: ______________________________________

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):____

Relationship to patient:__________Home Phone #: _________________Work Phone #_______________________

I give Independent Medical Services permission to provide services and treatment either to me or my dependent.

____ ___________________________________

Patient/Guardian Signature Date

Patient: ___________________________________

Acknowledgement of Receipt of Notice of Privacy Practices

In general, any information that is about your health, the healthcare you receive, or payment for that care is considered confidential and protected by our practice. We may need to use your protected health information to carry out treatment, payment, healthcare operations, and/or other purposes. Our Notice of Privacy Practices provides a more complete description of permitted uses and disclosures.

Sign below to acknowledge that you have read this abbreviated copy of our Notice of Privacy Practices.

Refer to our website no-paintoday.com for the complete policy. If you would like a personal copy, you may request one.

_______________________________________ ______________________

Signature of patient or patient's representative **Date**

Printed name of patient or patient's representative: ______________________________
Relationship to the patient: ____

Please return this acknowledgement as soon as possible. If you received this form when you arrived at our practice for service, return this form in person before you leave. If you do not return the form in person, you may return this form by mail to our privacy officer at the following address:

INDEPENDENT MEDICAL SERVICES, PLLC
1007 S. Oakwood Ave., Suite 950
Beckley, WV 25801

For use ONLY by a representative of the Practice

A good faith effort was made to obtain a written acknowledgement of receipt of our Notice of Privacy Practices that was provided to (circle one) the patient/ the patient's representative on _ _/_ _/_ _ _ _ .

The acknowledgement was not obtained for the following reason(s):________________
____
____
Signature of representative:____

INDEPENDENT MEDICAL SERVICES, PLLC

FINANCIAL POLICY

As of March 1, 2012, we are participating providers with Aetna, BC/BS Highmark, Carelink, CIGNA, Humana, 4 Most, PEIA, Select Net Plus, and all WV Workers' Compensation companies. Deductibles and/or copay are due when services are rendered. Any balance left by your insurance company becomes patient responsibility. We will bill your insurance company as a courtesy to you. If we have not received payment within eight weeks, it becomes your responsibility to contact your insurance company to see why payment has not been made. Please remember, our contract is with you, not your insurance carrier, and you are ultimately responsible for all charges. If your workers' compensation claim is denied, you will have 7 days to contact this office with your health insurance information or the balance will become your responsibility. If an individual doesn't have insurance, we will set up reasonable payment options.

It is the patient's responsibility to provide accurate insurance information at the time of the visit. We will attempt to call the insurance company to verify chiropractic or any medically necessary diagnostic testing coverage and the approximate amount you may expect to pay. However, it ultimately falls upon the patient to verify this before their initial visit.

If your injury is due to an automobile accident, we will attempt to bill **your** automobile insurance for PIP coverage. If you do not have PIP coverage, then you will need to make arrangements with your health insurance carrier. If you have an attorney, we MUST have a letter of protection.

Independent Medical Services requires a parent or guardian accompany their minor child to their visit unless written authorization to treat is received at the time of the visit.

Your signature below authorizes the release of any medical information necessary to process your claim and to authorize payment of your medical benefits directly to Independent Medical Services for services rendered. This authorization shall be in force for the life of the patient. I recognize that I can withdraw my authorization at any time.

We have dedicated ourselves to the task of providing high quality medical care efficiently and thus preparing to resist high increases in the cost of your care.

______________________________________ ________________

Patient or Legal Guardian Date

INDEPENDENT MEDICAL SERVICES, PLLC

1007 S. Oakwood Avenue
Suite 950
Beckley, WV 25801
(304) 253-3489
(304) 253-3148 fax

REQUEST FOR MEDICAL RECORDS

To: ____________________________ RE: ____________________________

____________________________ DOB:______________________

____________________________ SSN:______________________

Dear Medical Records Department:

I authorize release of my medical records for ____________________________ rendered by you or under your supervision. This information will be used to further assist in my medical care, and should be faxed to (304) 253-3148. If you are unable to fax the above-referenced information, please mail it to the above listed address.

Thank you for your kind cooperation and consideration in this matter.

Signed: ___________________________ Date: _________________________

Informed Consent for Physical Medicine / Chiropractic Treatment

TO THE PATIENT: *You have a right to be informed about your condition, the recommended chiropractic treatment/physical medicine treatment and the potential risks involved with the recommended treatment. This information will assist you in making an informed decision whether or not to have the treatment. This information is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or refuse to give your consent to treatment.*

I request and consent to chiropractic adjustments and other chiropractic procedures, including various modes of physical medicine and diagnostic X-rays. The treatment may be performed by the Doctor of Chiropractic named below and/or other licensed Doctors of Chiropractic working with Independent Medical Services. Treatment may also be performed by a Doctor of Chiropractic who is serving as a backup for Independent Medical Services.

I have had the opportunity to discuss with the Doctors of Independent Medical Services named below, my diagnosis, the nature and purpose of my treatment, the risks and benefits of my treatment, alternatives to my physical medicine treatment, and the risks and benefits of alternative treatment, including no treatment at all.

I understand that, there are some risks to chiropractic treatment / physical medicine including, but not limited to:

- Broken bones
- Dislocations
- Sprains/strains
- Burns or frostbite (physical therapy)
- Worsening/aggravation of spinal conditions
- increased symptoms and pain
- No improvement of symptoms or pain
- Infection (acupuncture)
- Punctured lung (acupuncture)
- Other _______________________________

In rare cases there have been reported complications of vertebral artery dissection (stroke) when a patient receives a cervical adjustment. The complications reported can include temporary minor dizziness, nausea, paralysis, vision loss, locked in syndrome (complete paralysis of voluntary muscles in all parts of the body except for those that control eye movement), and death.

I do not expect the doctor to be able to anticipate and explain all risks and complications. I also understand that no guarantees or promises have been made to me concerning the results expected from the treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions. All of my questions have been answered to my satisfaction. By signing below, I consent to the treatment plan. I intend this consent form to cover the entire course of treatment for my current condition.

To be completed by the patient:

____
print name

____
signature of patient

____
date signed

____
witness to patient's signature

To be completed by the patient's representative:

____
print name of patient

____
print name of patient's representative

____
signature of patient's representative

as:_________________________________
relationship/authority of patient's representative

____
date signed

Independent Medical Services
Michael Kominsky D.C.
1007 S Oakwood Ave.
Beckley, WV 25801