Precision Sports Therapy

Dr. Travis Conley, D.C., D.A.C.B.S.P.

Patient Information:

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Date of Birth: _____ Age: _____

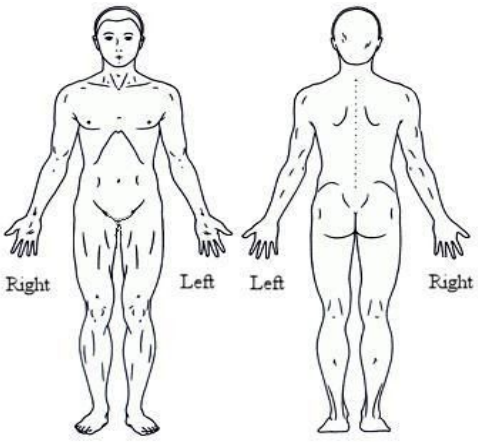
Emergency Contact: _____ Phone: _____

Referred by: _____ Marital Status: S M D W

Occupation: _____ Email: _____

Insurance: _____ ID#: _____ Group #:_____

Primary insured (if not patient): _____ DOB:_____



Chief Complaint:

Location of pain: _____

Date of onset: _____ Pain Level: 0/10: _____

Pins and Needles: Y / N ; Location: _____

Aggravated by: _____

_____

Relieved by:_____

Pain is: Constant / Intermittent / Improving Worsening Same

Pain interferes with: Sleep / Work / Hobbies: _____

Previous treatment for this condition Y / N ; How many? _____

Type of treatment received: _____

Comments:_____

What types of Sports or Hobbies do you part take in: _____

Work out at a gym, name: _____ How long : _____

Style of your workouts (Circuit, bodybuilding, Pilates): _____

Have you changed your workout regime in the last 2 yrs:Y / N; How:_____

Sports/Athletics as a youth: Y / N ; What type: _____

Recent weight loss Y / N ; Weight gain: Y / N ; How much:_____

Other symptoms/complaints: _____

_____

TREATMENT GOALS:_____

PAST HISTORY: Any hospitalizations, illnesses, surgeries, pregnancies, accidents, injuries, x-rays, MRI's, etc.:

1. Year/Description(s): _____

_____

MEDICATIONS OR SUPPLEMENTS you are currently taking:

Med./Supp. Name & Dosage:_____

_____

Precision Sports Therapy

Dr. Travis Conley, D.C., D.A.C.B.S.P.

Review of Systems – (Check box if you have had trouble with any of the following)

GENERAL SYMPTOMS

__ Convulsions
__ Dizziness
__ Fainting
__ Headache; Most recent:_____
__ Nervousness
__ Numbness
__ Wheezing

MUSCLES & JOINTS

__ Low Back Problems
__ Pain between Shoulders
__ Neck Problems
__ Arm Problems
__ Leg Problems
__ Swollen Joints
__ Painful Joints
__ Stiff Joints
__ Sore Muscles
__ Weak Muscles
__ Walking Problems
__ Sprains/Strains
__ Broken Bones

CARDIO-VASCULAR

__ High Blood Pressure
__ Heart Attack
__ Pain over Heart
__ Poor Circulation
__ Heart Trouble
__ Rapid Heart
__ Slow Heart
__ Strokes
__ Swelling Ankles

EAR/NOSE/THROAT

__ Earache
__ Ear Noises
__ Enlarged Thyroid
__ Frequent Colds
__ Hay Fever
__ Nasal Blockage
__ Nose Bleeds
__ Pain Behind Eyes
__ Poor Vision
__ Sinusitis
__ Sore Throats
__ Tonsillitis

GASTRO-INTESTINAL

__ Belching/Gas
__ Colon Problems
__ Constipation
__ Diarrhea
__ Excessive Hunger
__ Excessive Thirst
__ Gall Bladder Trouble
__ Hemorrhoids
__ Liver/Gallbladder
__ Nausea
__ Abdominal Pain
__ Ulcer
__ Poor Appetite
__ Poor Digestion
__ Vomiting
__ Vomiting Blood
__ Black Stool
__ Bloody Stool

RESPIRATORY

__ Asthma
__ Chronic Cough
__ Difficulty Breathing
__ Spitting Blood
__ Spitting Phlegm

GENITO-URINARY

__ Blood in Urine
__ Frequent Urination
__ Kidney Infection
__ Painful Urination
__ Prostate Problems
__ Loss of Bladder Control

SKIN OR ALLERGIES

__ Boils
__ Bruising Easily
__ Dryness
__ Eczema/Rash/Dermatitis
__ Hives
__ Itching
__ Sensitive Skin
__Allergies_____
_____

FOR WOMEN ONLY

__ Birth Control _____
__ Hormone Replacement
__ Cramps/Backaches
__ Hot Flashes
__ Irregular Cycle
__ Miscarriage
__ Painful Periods
__ Breast Pain

LIFESTYLE

_____ Exercise (3 = 5+ times per week, 2 = 2-4 times per week, 1 = once per week, 0 = none)
_____ Stress (3 = heavy/chronic, 2 = moderate/often stressed, 1 = light/occasionally stressed, 0 = none)
_____ Changed jobs (3 = within last 2 months, 2 = within last 6 months, 1 = within last 12 months)
_____ Divorced (3 = within last 6 months, 2 = within last year, 1 = within last 2 years, 0 = never)
_____ Work over 40 hours/week (3 = always, 2 = usually, 1 = occasionally, 0 = never

FAMILY HISTORY (Circle all that apply): Cancer / Diabetes / Heart Disease / Stroke / Other: _____

NUTRITION:

Circle one: Paleo / Vegan / Vegetarian / Omnivore / Ketogenic / Other: _____

Alcohol drinks/wk: _____ Cigarettes/Vape: Y / N ; Frequency: _____ Coffee: Y / N ; # cups: _____ Grains/Wheat: Y / N

Artificial Sweeteners/Sugar: Y/ N ; Form: _____ Fast Food times per week: _____

Precision **Sports** *Therapy*
Dr. Travis Conley, D.C., D.A.C.B.S.P.

INFORMATION & FINANCIAL AGREEMENT

I hereby certify that the statements and answers given on this form are accurate to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my health. Your insurance coverage is a contract between you and the insurance company and it is your responsibility to know your insurance benefits. As a courtesy, we will bill your primary insurance company. We will submit your claims and assist you in any way we reasonably can to help get your claims processed. When insurance coverage is verified, the provider is informed that payments and benefits are NOT a guarantee of payment. Therefore, if your insurance company denies payment or a filed claim you are liable for the remaining balance.
I understand that all services rendered and performed are to be paid for at the time of service unless other arrangements have been made. I authorize Precision Sports Therapy and its employees to bill my insurance or person accordingly for all services rendered and agree to sign over or reimburse all payments received by me from my insurance company for services rendered back to Precision Sports Therapy within 5-7 business days from date of receipt.
I have received this financial policy and understand that regardless of any insurance coverage I may have, I am personally responsible for payment in full of my account. I understand that delinquent accounts can be referred to a collection agency for collection service.
Patient Signature: _____ Date:_____
Patient Name Printed: _____
Signature of Parent or Guardian:_____

CONSENT TO TREATMENT

Health care providers are required to advise patients of the nature of the treatment to be provided, the risks and benefits of the treatment, and any alternatives to the treatment.
There are some risks that may be associated with treatment, in particular, you should note:

A) 'While rare, some patients have experienced rib fractures or muscle and ligament sprains or strains following treatment;
B) There have been rare reported cases of disc injuries following cervical and lumbar spinal adjustment although no scientific study has ever demonstrated such injuries are caused, or may be caused by spinal or soft tissue manipulation or treatment.
C) There have been cases of injury to a vertebral artery following an osseous spinal manipulation. Vertebral artery injuries have been known to cause a stroke, sometimes with serious neurological impairment, and may, on rare occasions, result in paralysis or death. The possibility of such injuries resulting from cervical spine manipulation is extremely remote;

Osseous and soft tissue manipulation has been the subject of government reports and multidisciplinary studies conducted over many years and has demonstrated it to be a highly effective treatment of spinal conditions including general pain and loss of mobility, headaches and other related symptoms.
Musculoskeletal care contributes to your overall well being. The risk of injuries or complications from treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.
I acknowledge I have discussed the following with my healthcare provider:
a. The condition that the treatment is to address;
b. The nature of the treatment;
c. The risks and benefits of that treatment; and
d. Any alternatives to that treatment.
I have had the opportunity to ask questions and receive answers regarding the treatment.
I consent to the treatments offered or recommended to me by my healthcare provider(s), including osseous and soft tissue manipulation. I intend this consent to apply to all my present and future care with OC Rehab and Sports Medicine.

Patient Signature (or Legal Guardian): _____

Print Name: _____ Date: _____