THRIVE
SPINE & SPORTS REHAB

Personal Information

Name:_____ Social Security Number:_____

Sex: M/F:____ Age_____ Date of Birth _____

Mailing Address _____ City _____ State _____ Zip Code:_____

Home Phone # _____ Cell #:_____ Work Phone#:_____

Employer:_____ Occupation:_____

Marital Status: S / M / D / W Email:_____

Insurance Information

Primary Insurance Co. Name:_____ Type: Medical/Auto/Other

Company Address _____ City _____ State _____ Zip Code:_____

ID # _____ Group#:_____ Claim#:_____

Subscriber Name:_____ Subscriber D.O.B:_____

Subscriber Social Security #:_____ Relation to Subscriber:_____

Coverage Effective Date:_____ Date of Injury:_____

Secondary Insurance Co. Name:_____ ID#:_____

Group#:_____ Coverage Effective Date:_____

Company Address _____ City _____ State _____ Zip Code:_____

Subscriber Name:_____ Subscriber D.O.B:_____

Subscriber Social Security #:_____ Relation to Subscriber:_____

In Case of Emergency Notify:

Name:_____ Phone Number:_____

How were you referred to Our Office?

Newspaper/Magazine:_____ Family/Friend:_____

Internet:_____ Physician:_____

Other:_____

Patient Medical History

Patient Name: _____

Name of Referring Doctor: _____ Name of Family Doctor: _____

Reason for Today's Visit: _____

Describe your symptoms _____

Rate your Pain (0= no pain, 10= worst imaginable pain) _____

When and how did it start? _____

What makes it better? _____ Worse? _____

Have you been treated for this condition in the past?. . . . . .YES / NO (If Yes, what treatments have you had?

_____

_____

Do you have any questions/ concerns about being treated?

_____

_____

List all Current Medications and Dosages:

Past Medical History

Diabetes	High Blood Pressure	Coronary Artery Disease	Vascular Disease
Heart Disease/Attacks	Congestive Heart Failure	Thyroid Disease	Depression
Lyme Disease	Bleeding Disorder	Seizures	Gastric Reflux
Multiple Sclerosis	Enlarged Prostate	Hepatitis	Liver Disease
Osteoarthritis	Rheumatoid Arthritis	Asthma	COPD
Cancer	Scoliosis	Stroke	Kidney Disease

Please List any Medical Conditions you may have that is not mentioned above: _____

_____

Family Medical History

Bleeding Disorder	Coronary Artery Disease	Hepatitis	Cancer
Heart Disease/ Attacks	Seizures	Strokes	Lung Disease
Rheumatoid Arthritis	Asthma	Scoliosis	Multiple Sclerosis

Please List any Medical Conditions your family may have had that is not mentioned above: _____

_____

Past Surgical History

Surgery	Date	Surgery	Date
Knee Arthroscopy (R/ L)		Shoulder Arthroscopy (R/ L)	
Spine Surgery (cervical/thoracic/lumbar)		Joint Replacement Surgery	
Hernia Repair		Hysterectomy	
Eye Surgery		Cardiac Catheterization	
Peripheral Bypass Surgery		Coronary Artery Bypass Graft	

Please List any other surgery you may have had that is not mentioned above:_____

_____

Do you smoke? ___Current Smoker ___Former Smoker ___ Never Smoked ___Pipe Smoker __Cigar Smoker
If yes, how much do you smoke? _____3 cigarettes or less/day _____ 1/2 pack/day ___More than a pack/day

Do you drink alcohol? ___YES ___NO
If yes, how frequent? ___ social only ___ Several times per week ___ Everyday

Do you or have you used illicit drugs? ___ YES ___ NO
If yes, what kind? ___ IV Drugs ___ Pills ___ Marijuana ___ Other: _____

Sports Participation: _____YES _____NO
If yes, what sports? ___ Golf ___ Tennis ___ Football ___ Soccer ___ Baseball ___Basketball ___ Running
List any other sports you play:_____

Please Circle any of the following symptoms that you have experienced lately:

Constitutional	Fever	Night Sweats	Weight Loss
Eyes	Red eyes	Blurring vision	Vision loss
Ears/Nose/Mouth	Nose bleeds	Sore throat	Hearing loss
Cardiovascular	Chest pains	Palpitations	Leg swelling
Respiratory	Shortness of breath	Chronic cough	Wheezing
Gastrointestinal	Nausea	Vomitting	Diarrhea
Genitourinary	Burning w/ urination	Blood in urine	Urinary incontinence
Skin	Rash	Hives	Skin infection
Neurological	Headache	Tremor	Seizures
Psychiatric	Depression	Panic attacks	Suicidal ideation
Endocrine	Excessive thirst	Cold intolerance	Excessive sweating
Hematological/ Lymph	Easy bruising	Swollen glands	Easy bleeding
Allergy/ Immune	Runny nose	Sinus congestion	Itchy eyes

Please describe in detail the symptoms and treatment you have had related to the problems circled above:

_____

Patient Signature: _____ Date: _____

Reviewed by Physician: _____ Date: _____

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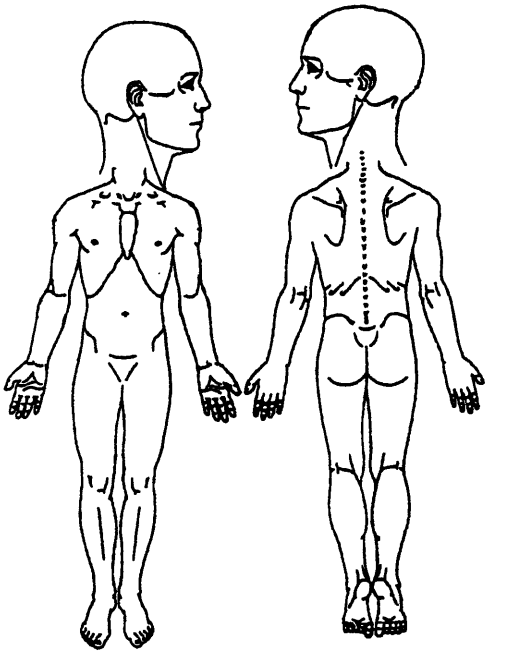
SHORT FORM McGILL PAIN QUESTIONNAIRE and PAIN DIAGRAM

Date: _____

Name: _____

Check the column to indicate the level of your pain for each word, or leave blank if it does not apply to you.

		Mild	Moderate	Severe
1	Throbbing			
2	Shooting			
3	Stabbing			
4	Sharp			
5	Cramping			
6	Gnawing			
7	Hot-burning			
8	Aching			
9	Heavy			
10	Tender			
11	Splitting			
12	Tiring-Exhausting			
13	Sickening			
14	Fearful			
15	Cruel-Punishing			



Mark or comment on the above figure where you have your pain or problems.

Indicate on this line how bad your pain is—at the left end of line means no pain at all, at right end means worst pain possible.

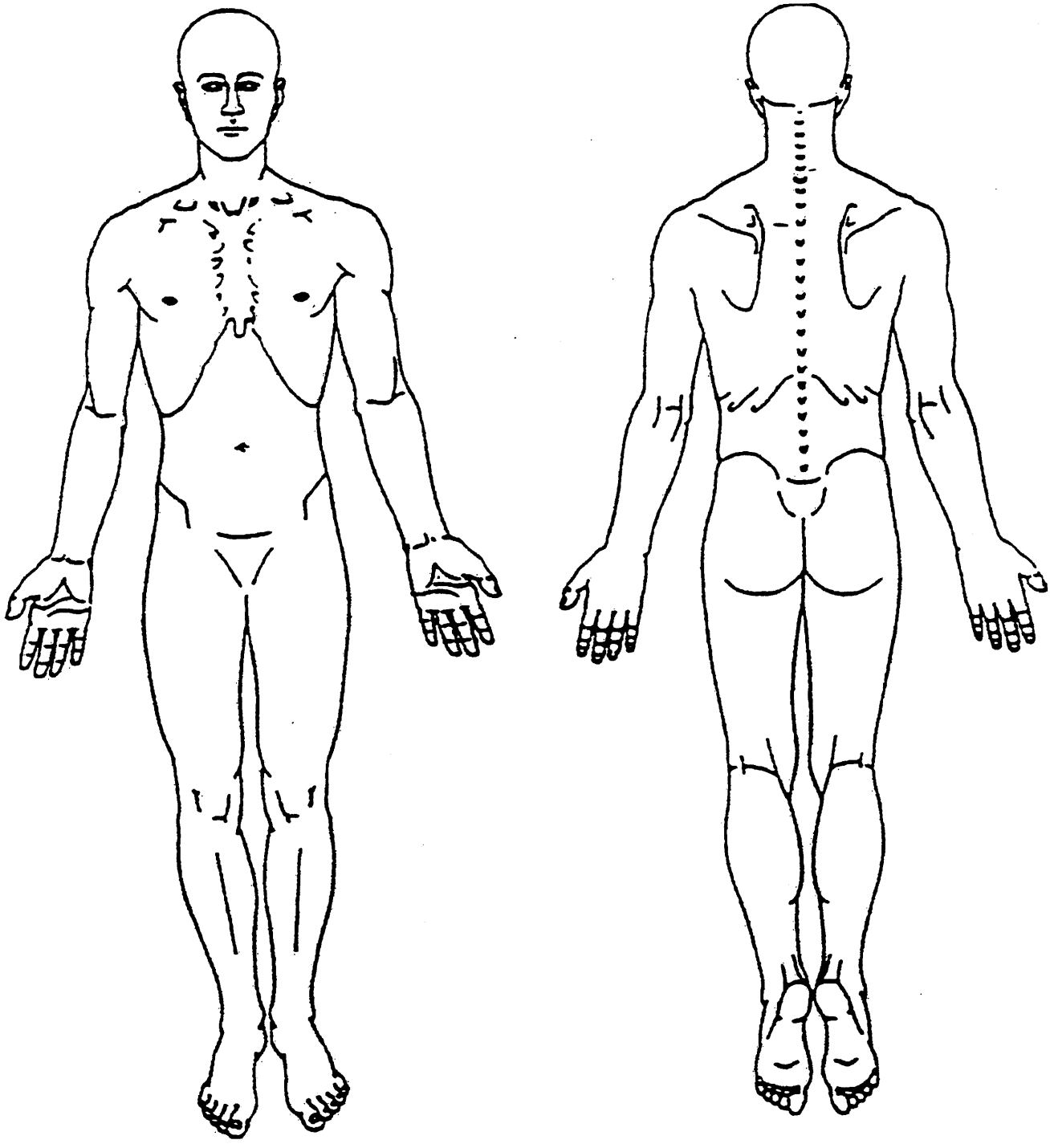
No Pain _____ Worst Possible Pain

S /33 A /12 VAS /10

Pain Diagram

Please mark below what symptoms you are having in the corresponding place on the body.

P= Achy Pain N= Numbness B= Burning S= Sharp Pain T= Tingling



Please Circle (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain imaginable)

Patient Signature:_____ Date: _____

Range of Motion

Cervical	Thoracic	Lumbar
Flexion ____/60Pain	Flexion ____/50Pain	Flexion ____/60Pain
Extension ____/75Pain	Extension ____/25Pain	Extension ____/25Pain
L Rotation____/80 Pain	L Rotation____/30 Pain	L Rotation____/30 Pain
R Rotation____/80 Pain	R Rotation____/30 Pain	R Rotation____/30 Pain
L Lat Flx____/45 Pain	L Lat Flx____/25 Pain	L Lat Flx____/25 Pain
R Lat Flx____/45 Pain	R Lat Flx____/25 Pain	R Lat Flx____/25 Pain

Neurological Evaluation:

Motor

C5	1/5	2/5	3/5	4/5	5/5
C6	1/5	2/5	3/5	4/5	5/5
C7	1/5	2/5	3/5	4/5	5/5
C8	1/5	2/5	3/5	4/5	5/5
T1	1/5	2/5	3/5	4/5	5/5
L1	1/5	2/5	3/5	4/5	5/5
L2	1/5	2/5	3/5	4/5	5/5
L3	1/5	2/5	3/5	4/5	5/5
L4	1/5	2/5	3/5	4/5	5/5
L5	1/5	2/5	3/5	4/5	5/5
S1	1/5	2/5	3/5	4/5	5/5

Sensory

C5 L_____R	L1 L_____R
C6 L_____R	L2 L_____R
C7 L_____R	L3 L_____R
C8 L_____R	L4 L_____R
T1 L_____R	L5 L_____R
	S1 L_____R

Reflexes

Biceps	+0	+1	+2	+3	+4	+5
Triceps	+0	+1	+2	+3	+4	+5
Brachio	+0	+1	+2	+3	+4	+5
Patellar	+0	+1	+2	+3	+4	+5
Achilles	+0	+1	+2	+3	+4	+5
M. Ham	+0	+1	+2	+3	+4	+5

Orthopedic Evaluation:

Cervical

Valsalva	+	-	L	R
Distraction	+	-	L	R
Compression	+	-	L	R
Bakody's	+	-	L	R
Shld Depress	+	-	L	R
Brudzinski's	+	-		
Lhermitte's	+	-		
Lindner's	+	-		
Soto Hall	+	-		
Rust's Sign	+	-		

Lumbar

Valsalva	+	-	L	R
SLR	+	-	L	R
Seated SLR	+	-	L	R
Kemp's	+	-	L	R
Yeoman's	+	-	L	R
Heel Walk	+	-	L	R
Toe Walk	+	-	L	R
Slump Test	+	-	L	R
Minor's Sign	+	-		

EDEMA, SPASM, TENDERNESS

E	S	T		T	S	E
			C1			
			C2			
			C3			
			C4			
			C5			
			C6			
			C7			
			T1			
			T2			
			T3			
			T4			
			T5			
			T6			
			T7			
			T8			
			T9			
			T10			
			T11			
			T12			
			L1			
			L2			
			L3			
			L4			
			L5			
			S1			

Other Tests

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

THRIVE
SPINE & SPORTS REHAB

PRIVACY NOTICE

ur Information, Your Rights, Our Responsibilities

is notice describes how medical information about you may be used and disclosed and how you can get access to this infor-
tion. Please review it carefully.

ur Rights

u have the right to:

et a copy of your paper or electronic medical record

orrect your paper or electronic medical record

equest confidential communication

sk us to limit the information we share

et a list of those with whom we've shared your information

et a copy of this privacy notice

hoose someone to act for you

ile a complaint if you believe your privacy rights have been violated

ur Choices

u have some choices in the way that we use and share information as we:

ll family and friends about your condition

rovide disaster relief

larket our services

ır Uses and Disclosures

rive Spine and Sports Rehab, LLC may use and share your information as we:

reat you

un our organization

ill for your services

lelp with public health and safety issues

o research

omply with the law

espond to organ and tissue donation requests

Vork with a medical examiner or funeral director

ddress workers' compensation, law enforcement, and other government requests

espond to lawsuits and legal actions

e undersigned has read this notice and has received a copy of this signed notice and the Notice of Privacy Practices, if requested.

ıme_____

gnature_____ Date_____

THRIVE
SPINE & SPORTS REHAB

Financial Policy Agreement/ Assignment of Benefits

Thank you for choosing Thrive Spine and Sports Rehab, LLC/ Thrive Point, LLC as your healthcare provider. We are always striving to provide optimal care to all of our patients, and we will always do everything we can to achieve this goal.

Thrive Spine and Sports Rehab, LLC/ Thrive Point, LLC is a private professional entity that is *not* contracted with any insurance plans with the exception of Medicare. Even though we are not a participating provider in your insurance plan's network, we pledge to help you understand and manage the financial aspects associated with providing you the best care possible.

Most insurance plans allow patients to select their own treating physician even if that physician is not contracted with their insurance plan's network. To help you understand your responsibilities, we will contact your insurance to gather information regarding your out-of-network coverage and explain what financial obligations you will have for our services.

Due to the fact that we are an out-of-network facility your treatment plan will not be limited by what an insurance company plan representative will approve, but it will be determined by the recommendations made by one of our board certified practitioners with the sole intent of improving your way of life.

All charges will be submitted to your insurance company on your behalf as an out-of-network provider. You may be responsible for your deductible and co-insurance on allowed payments up to your out-of-pocket maximum according to your plan's out-of-network plan's coverage. Most insurance plans allow reasonable and customary payment for services rendered at Thrive Spine and Sports Rehab, LLC/ Thrive Point, LLC in which case you will not receive any bills. In a few cases, however, your plan may not provide a reasonable and customary payment for services rendered, and in that case you may be responsible for some of the difference between what is billed and what your insurance plan allows for payment.

In addition, some insurance companies may send payment for services directly to you. You agree to relinquish all payments that you receive from your insurance company for services rendered at Thrive Spine and Sports Rehab, LLC/ Thrive Point, LLC. Failure to do so will result in legal action.

By signing below, you attest that you completely understand and agree with our financial policy as described above for all services provided by Thrive Spine and Sports Rehab, LLC/ Thrive Point, LLC.

Assignment of Benefits

I irrevocably assign to THRIVE SPINE AND SPORTS REHAB, LLC/ THRIVE POINT, LLC all my rights and benefits under any insurance contracts for payment for services rendered to me by THRIVE SPINE AND SPORTS REGAB, LLC/ THRIVE POINT, LLC. I irrevocably authorize all information regarding my benefits under any insurance policy relating to ant claims by THRIVE SPINE AND SPORTS REHAB, LLC/ THRIVE POINT, LLC to be released to THRIVE SPINE AND SPORTS REHAB, LLC/ THRIVE POINT, LLC. I irrevocably authorize THRIVE SPINE AND SPORTS REHAB, LLC/ THRIVE POINT, LLC to file insurance claims on my behalf for services rendered to me. I irrevocably authorize THRIVE SPINE AND SPORTS REHAB, LLC/ THRIVE POINT, LLC. I irrevocably authorize THRIVE SPINE AND SPORTS REHAB, LLC/ THRIVE POINT, LLC to act on my behalf and report any suspected violation of proper claims practices tot the proper regulatory authorities. This assignment of benefits has been explained to my full satisfaction, and I understand its nature and effect.

X_____

Patient Signature

_____ _____

Patient Name (Printed) **Date**

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X_____

Patient Signature

_____

Date

_____

Patient Name (Printed)

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Informed Consent

I,_____, hereby authorize the Licensed Acupuncturist at Thrive Spine & Sports Rehab LLC to administer any type of Oriental Medicine relevant to my diagnosis and treatment, including but not limited to the following:

1. Insertion of various styles and sizes of acupuncture needles into my body at various depths and locations.
2. A massage technique called "gua sha" may produce redness on the skin which remains for 1-5days. A slight bruising or tenderness may persist following the treatment.
3. Cupping may be used to promote blood circulation through the body. Cups may produce a red/ purple color on the area cupped which may remain for1-5 days.
4. Electrical stimulation may be used which produces a vibration/tapping sensation on the needles.
5. Infrared heat may be applied to an area to help promote blood flow. This can cause a redness in an area.

have been informed that I have the right to refuse any form of treatment. I understand the nature of the reatment, have been informed of the risks and possible consequences involved with treatment, and was iven the opportunity to ask questions pertaining to my treatment. Although acupuncture is a safe modality nd side effects are rare, I understand there is always possibility if unexpected complications and no guarntee can be made concerning the results of the treatment.

ignature of patient: _____

rinted Name: _____

)ate: _____

ractitioner Signature: _____