INNOVATIVE MEDICAL CENTER

PATIENT INFORMATION

Name: _____
(last) (first) (middle in.)

Address: _____

City: _____ State: _____ ZIP: _____

Hm #: (_____) _____ - _____ Cell #:(_____) _____ - _____

Email: _____

SS#: _____ - _____ - _____ Sex: ☐ M ☐ F

Birth date: ____ / ____ / _____ Age: _____

Occupation: _____

Employer: _____

Work #: (_____) _____ - _____ Extension: _____
☐ Married ☐ Widowed ☐ Single ☐ Minor
☐ Separated ☐ Divorced ☐ Partnered for _____ years

IN CASE OF EMERGENCY

Name: _____ Relationship: _____

Hm #: (_____) _____ - _____ Cell #:(_____) _____ - _____

How did you hear about Innovative Medical Center?
☐ Direct mail ☐ Family/Friend: _____
☐ Internet ☐ Facebook
☐ Radio ☐ Talk: _____
☐ Sign ☐ Other: _____

What specifically prompted you to choose us for your healthcare needs?

_____

Primary Care Provider: _____

City, State: _____

Last check up: ____ / ____ / _____

Are you under a doctor's care at the present time? ☐ Yes ■ No

If yes, for what? _____

Name of Doctor: _____

City, State: _____

INSURANCE INFORMATION

Primary Subscriber: _____

Relationship to Patient: _____

Insurance Co: _____

ID #: _____

Is there a Secondary Insurance? ☐ Yes ■ No

Insurance Co: _____

ID #: _____

ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS AS WELL AS AN APPOINTMENT AND/OR DESIGNATION AS MY PERSONAL REPRESENTATIVE AND AN ERISA/PPACA REPRESENTATIVE AND BENEFICIARY

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay Innovative Medical Center as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided. I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that ***have been*** **or** ***will be*** rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under. I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same. I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment, appointment, and designation will remain in effect unless revoked by me in writing. *It is my intent that the effective date of this document shall relate back to include all services, supplies, test, treatments, or medications that have been previously provided by Healthcare Provider.* A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

Signed this _____ day of _____, 20 ____.

_____(SEAL)
(Patient signature)

_____(SEAL) _____
(Signature of Guardian if applicable) (Print patient name)

MEDICAL HISTORY

GENERAL HISTORY (Check all that apply to you)

- ☐ Allergy Shots
- ☐ Anemia
- ☐ Back Trouble
- ☐ Blood Pressure: High
- ☐ Blood Thinners
- ☐ Blood/Plasma Transfusion
- ☐ Bulimia
- ☐ COPD
- ☐ Epilepsy
- ☐ Gallbladder Disorder
- ☐ Heart Disease
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Migraines Headaches
- ☐ Pinched Nerve
- ☐ Polio
- ☐ Pregnant
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tumors/Growths
- ☐ Venereal Disease
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Blood Pressure: Low
- ☐ Blood Clots/DVT/PE
- ☐ Bronchitis
- ☐ Cancer
- ☐ Diabetes
- ☐ Fractures
- ☐ Heart Attack
- ☐ Herniated Disc
- ☐ Hormone Replacement
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Pneumonia
- ☐ Poly Cystic Ovarian Syndrome
- ☐ Rheumatoid Arthritis
- ☐ Swelling Feet
- ☐ Tuberculosis
- ☐ Ulcers

☐Other: _____

☐Other: _____

☐Other: _____

SOCIAL HABITS

HABITS: (Please select all that apply)

Use of Alcohol: ☐ Never ☐ Rarely ☐ Moderate ☐ Daily

Use of Tobacco: ☐ Never ☐ Rarely ☐ Moderate ☐ Daily

Use of Drugs:
☐Never ☐Type/Freq: _____

Excessive Exposure at home or work to:
☐Fumes ☐Dust ☐Solvents ☐Airborne Particles ☐Noise

MEDICATIONS/SUPPLEMENTS

MEDICATIONS/SUPPLIMENTS:	DOSAGES:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

MEDICATION ALLERGIES:	GENERAL ALLERGIES:
_____	_____
_____	_____
_____	_____
_____	_____

Have you ever taken Fen-Phen/Redux? ☐ Yes ☐ No

Are you taking any medications (prescription or over the counter) for acid indigestion? ☐ Yes ☐ No
If "Yes," what? _____

FAMILY & SURGICAL HISTORY

POSSSIBLE HEREDITARY DISEASES:

_____

_____

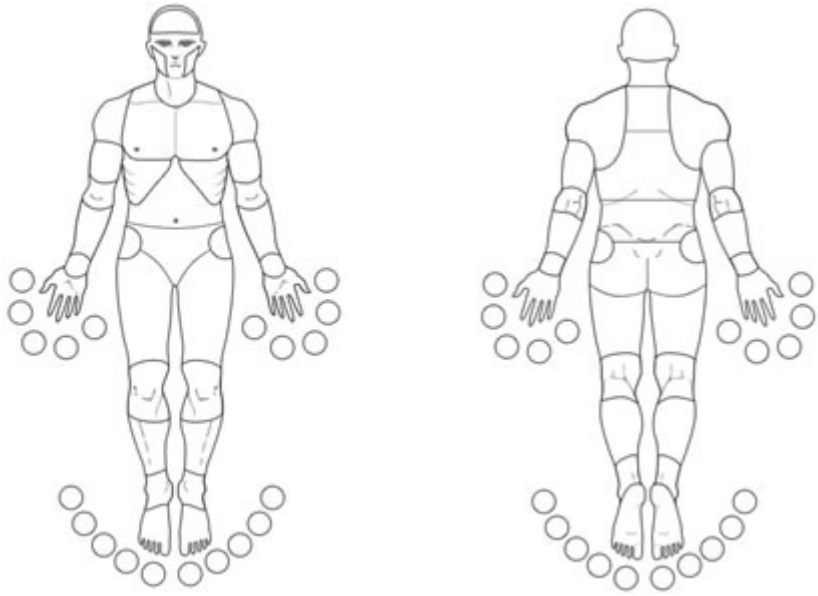
_____

_____

SURGICAL HISTORY:	YEAR:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

HEALTH HISTORY

On the diagrams to the right, please mark where you are experiencing any symptoms:



Use the following as a guide:
P = Pain
N = Numbness
T = Tingling
B = Burning
W = Weakness
A = Ache

☐ **Is the pain constant?** ☐ **Is the numbness/tingling constant?**

How long have you been suffering with your condition? _____

Have you had any problems like this in the past? _____

☐ **Has it been getting worse? If yes, how long?** _____

How would you rate your pain on a scale of 1 (best) to 10 (worst)?

Currently: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

On Average: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

At Its Best: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

At Its Worst: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Did your problem come on gradually or suddenly? Gradual ☐ Sudden ☐ Not sure ☐

☐ **Was there any type of injury that may have caused your problem?**

If yes, what kind of injury _____

What aggravates your problem? ☐Bending ☐Lifting ☐Twisting ☐Turning ☐Standing ☐Walking ☐Sitting-to-Standing ☐Standing-to-Sit ☐Sitting ☐Laying Down ☐Reading ☐Computer ☐Driving ☐Getting in/out of vehicle ☐Other: _____

Do any of these <u>RELIEVE</u> the pain? ☐Heat ☐Ice ☐Stretching ☐Pain Meds ☐Rest ☐Other:_____

Is your problem worse in the: ☐Morning ☐Afternoon ☐Evening ☐At Night ☐During Sleep ☐All the Same

Have you been told exactly what condition you have? _____

If yes, who and what did they say? _____

Have you tried any of the following?	**Results of treatment: (check only one for each)**		
☐ Muscle Relaxers (Prescription):	☐No Relief	☐ Worse	☐Temporary Relief
☐ Anti-Inflammatory (Prescription):	☐No Relief	☐ Worse	☐Temporary Relief
☐ Anti-Inflammatory (OTC i.e., Advil)	☐No Relief	☐ Worse	☐Temporary Relief
☐ Pain Medications (Prescription):	☐No Relief	☐ Worse	☐Temporary Relief
☐ Physical Therapy:	☐No Relief	☐ Worse	☐Temporary Relief
☐ Chiropractic:	☐No Relief	☐ Worse	☐Temporary Relief
☐ Massage Therapy:	☐No Relief	☐ Worse	☐Temporary Relief
☐ Acupuncture:	☐No Relief	☐ Worse	☐Temporary Relief
☐ Injections (including epidurals):	☐No Relief	☐ Worse	☐Temporary Relief
☐ Spinal Surgery:	☐No Relief	☐ Worse	☐Temporary Relief

Have you been told you need an injection? ☐YES ☐NO What Type? _____

Have you been told you need surgery? ☐YES ☐NO What Type? _____

Have you ever had:

☐ A spine fracture?
☐ Bone infection, disease, or disorder?
☐ Abdominal aneurism?
☐ Night cramping? Location_____
☐ Swelling? Location_____

Do you have any muscle weakness or muscle atrophy (loss of muscle tone) in:

☐ **Arms** ☐Right ☐Left

☐ **Legs** ☐Right ☐Left

Have you had any of the following in the last year?

☐ **MRI** **What area(s):** _____ What Facility? _____

☐ **CT** **What area(s):** _____ What Facility? _____

☐ **X-rays What area(s):** _____ What Facility? _____

How is this condition affecting your life? _____

How serious do you consider this condition? _____

What do you think will happen if this is left untreated? _____

SYMPTOMS/ISSUES EXPERIENCED IN THE LAST 1-2 MONTHS

0=Never 1=Rarely 2=Occasionally 3=Frequently 4=Constantly

Eyes/Ears/Nose/Throat/RESPIRATORY

	0	1	2	3	4
Asthma	☐	☐	☐	☐	☐
Stuffy Nose	☐	☐	☐	☐	☐
Hay Fever	☐	☐	☐	☐	☐
Sore Throat	☐	☐	☐	☐	☐
Chronic Cough	☐	☐	☐	☐	☐
Chest Congestion	☐	☐	☐	☐	☐
Frequent Sneezing	☐	☐	☐	☐	☐
Itchy/Watery Eyes	☐	☐	☐	☐	☐
Drainage	☐	☐	☐	☐	☐
Earache or Ear Infect	☐	☐	☐	☐	☐
Itching	☐	☐	☐	☐	☐
Hoarseness/Shortness of Breath	☐	☐	☐	☐	☐
Wheezing	☐	☐	☐	☐	☐

GENERAL

	0	1	2	3	4
Fatigue	☐	☐	☐	☐	☐
Malaise	☐	☐	☐	☐	☐
Weakness/Tiredness	☐	☐	☐	☐	☐
Lightheadedness	☐	☐	☐	☐	☐
Irritability	☐	☐	☐	☐	☐
Constipation	☐	☐	☐	☐	☐
Diarrhea	☐	☐	☐	☐	☐
Feeling Foggy	☐	☐	☐	☐	☐
Forgetfulness	☐	☐	☐	☐	☐

MUSKULOSKELETAL

	0	1	2	3	4
Muscle Aches	☐	☐	☐	☐	☐
Fibromyalgia	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐
Joint Pain	☐	☐	☐	☐	☐
Low Back Pain	☐	☐	☐	☐	☐
Neck Pain	☐	☐	☐	☐	☐
Wrist/Hand Pain	☐	☐	☐	☐	☐
Elbow Pain	☐	☐	☐	☐	☐
Shoulder Pain	☐	☐	☐	☐	☐
Hip Pain	☐	☐	☐	☐	☐
Knee Pain	☐	☐	☐	☐	☐
Ankle/Foot Pain	☐	☐	☐	☐	☐
Pain Between Shoulder Blades	☐	☐	☐	☐	☐

NEUROLOGICAL

	0	1	2	3	4
Headaches	☐	☐	☐	☐	☐
Migraines	☐	☐	☐	☐	☐
Dizziness	☐	☐	☐	☐	☐
Numbness	☐	☐	☐	☐	☐
Tingling	☐	☐	☐	☐	☐
Pins/Needles in Hands or Feet	☐	☐	☐	☐	☐
Loss of Consciousness	☐	☐	☐	☐	☐
Vertigo	☐	☐	☐	☐	

Check all that apply:

Leg pain walking over 1 block ☐
Leg pain walking less than 1 block ☐
Pain in legs while at rest ☐
Blood clots in legs ☐
Cold feet or hands ☐
Thyroid Problems ☐
Diabetes Type 1 ☐
Diabetes Type 2 ☐

Ulcers of lower legs ☐
Varicose Veins ☐
Aneurysm of arteries ☐
Other ☐
Amputation of toes ☐
Amputation of feet or legs ☐
Peripheral vascular disease ☐

On a scale from 1 to 10 (with 10 being the highest), what is your interest in getting help for the problem?

0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐	8 ☐	9 ☐	10 ☐

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

_____ _____
Signature of the Patient, Parent or Guardian Date

_____ _____
Doctor's Review (Pg 1 to 3) Date