Medical Exam Date: _____ **PT Eval Date**: _____

Name: _____ **Gender**: M F **Birth Date**: _____ / _____ / _____
Address: _____ **City, State, Zip** _____
Home Phone: ( ) _____ **Mobile**: ( ) _____
Email Address: _____ **SSN #**: _____ - _____ - _____
Marital Status: S M D W **Occupation**: _____ **Referred to AWSC by**: _____
Emergency Contact: _____ **Phone**: ( ) _____ **Rltnship**: _____

HPI - KNEE COMPLAINT

Please check ALL that apply for each question below.

WHICH KNEE: ☐ BOTH ☐ Left ☐ Right **What part of knee?** ☐ Inside ☐ Outside ☐ Back ☐ Front
When did it first start? _____ _____
INJURY: ☐ None **Date:** _____ Dx: _____ _____

SYMPTOMS: ☐ Stiff or Achy ☐ Cracking/popping sounds ☐ Other _____
☐Pain/Throbbing ☐ Unsteadiness ☐ Weakness ☐ Knee buckling ☐ Use rail on stairs ☐ Cane/walker

IS THIS CONDITION:
☐ Constant ☐ Comes & goes ☐ Upset by activity ☐ Worse after inactivity _____

WHAT AGGRAVATES SYMPTOMS? _____ _____
☐ Standing ☐ Walking ☐ Stairs ☐ Driving ☐ Prolonged Positioning
☐ Sitting ☐ Rising from sitting ☐ Sleep ☐ Humidity ☐ Cold

DOES COMPLAINT(S) INTERFERE WITH: _____
☐ Work ☐ Sleep ☐ Hobbies ☐ Daily Routine ☐ Exercise ☐ Household duties

WHAT HAS GIVEN SOME RELIEF IN THE PAST? _____
☐ Walking/Exercise ☐ Therapy ☐ Brace ☐ Rest ☐ Injections ☐ Pain medicines ☐ Hot/cold packs

PREVIOUS KNEE INJECTIONS: ☐ N/A
☐ Steroid: **Left Right** When: _____
☐ Visco Supplement: **Left Right** When: _____

PLEASE CIRCLE YOUR WORST PAIN LEVEL IN THE PAST COUPLE DAYS:
(Mild) **0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10** (Severe)

How long can you **WALK** before you need to rest? _____ min **STANDING:** _____min

PHYSICAL THERAPY/EXERCISE: ☐ Yes ☐ Never
If yes, Where? _____ When? _____
How long did it help? _____

KNEE BRACING: ☐ I have been prescribed a brace ☐ I purchased my own brace ☐ I **DO NOT** have a brace

CURRENT MEDICATIONS: ☐ N/A
_____ _____ _____ _____
_____ _____ _____ _____

Have you ever taken any of the following:
☐ Advil ☐ Ibuprofen ☐ Asprin/Excedrin ☐ Aleve/ Naproxen ☐ Mobic/Meloxican ☐ Celebrex
☐ Tylenol ☐ Tramadol ☐ Naposyn/Naproxen ☐ Etodolodac ☐ Diclofenac ☐ Arthrotec

MEDICINE ALLERGIES: ☐ N/A
_____ _____ _____ _____

Medical Exam Date: _____ **PT Eval Date**: _____

Medical Conditions/What have you been diagnosed with:

☐ Hypertension ☐ Diabetes Mellitus ☐ High Cholesterol ☐ Hypothyroidism
☐ Meniscal tear ☐ Osteoporosis/Osteopenia ☐ Osteoarthritis (bone-on- bone)

_____ _____ _____ _____

Please check/list **ANY AND ALL SURGERIES** you have had:

☐Arthroscopic Joint ☐ Gall bladder removal ☐ Hysterectomy ☐ Tonsillectomy
☐ Spinal surgery ☐ Spinal fusion ☐ Appendectomy ☐ Cesarean
☐ OTHER: _____

_____

Check any and all of the following that you have experienced in the past 6 months:

□ Chest Pain	□ Difficulty Breathing	□ Abdominal Pain	□ Pain in joints	□ Any Weakness
□ Palpitations	□ Hearing changes	□ Vision changes	□ Cough	□ Asthma/wheezing
□ Nausea/Vomiting	□ Diarrhea	□ Constipation	□ Black/reddish stools	□ Urination difficulties
□ Headache/ Migraine	□ Dizziness/ Fainting	□ Seizures	□ Fatigue	□ Numbness/Tingling
□ Snoring	□ Sleep difficulties	□ Weight gain	□ Weight loss	□ Sinusitis
□ Reflux/Heartburn	□ Recurrent colds	□ Allergy/Hay fever	□ Thyroid problems	□ Ulcer
□ Depression/ Anxiety	□ Hair falling out	□ Menstrual discomfort	□ Mood swings/irritability	□ Rash

□ Are you a smoker? □ Never Current: _____ pk/day Previous: _____ years

□ Do you drink? □ Never Current: _____ drinks per week □ Social Settings/On occasion

Any other substance use? **Y** **N** _____ How frequently? _____

□ Other: _____

********** **FOR STAFF USE ONLY** **********

OA: 1° □ M17.0 (B/L) □ M17.11 (R) □ M17.12 (L) **Pain:** □ M25.561(R) □ M25.562 (L) DR Init. _____ Date:_____

OA: 2° □ M17.5 (B/L) □ M17.4 (U/L) **Pain:** □ M25.561(R) □ M25.562 (L) DR Init. _____ Date:_____

MD Diagnosis: 1) _____ 2) _____ 3) _____ 4) _____ DR Init. _____ Date: _____

PT Diagnosis: 1) _____ 2) _____ 3) _____ 4) _____ DR Init. _____ Date:_____

X-ray: □ 72042 (C) □ 72080 (T) □ 72100 (L) □ 72020 (Single) □ 73560 (Knee) □ 73562 (Knee)

PT: □ 97001 □ 97002 □ 97140 □ 97110 □ 97112 □ 97530 □ 29200 □ 29240 □ 29530 □ 29540 □ 29260

G-CODES: **100-80** **80-60** **60-40** **40-20** **20-0**

Visit Frequency: _____ x a week for _____ weeks OR PRN **Height:** _____ **Weight:** _____

MJL	**L**	**R**	_____	**Med Inst**	**L**	**R**	_____	**Flxn:**	**L**	_____		**R**	_____			
LJL	**L**	**R**	_____	**Lat Inst**	**L**	**R**	_____	**Extsn**	**L**	_____		**R**	_____			
McM-L	**L**	**R**	_____	**Swelling**	**L**	**R**	_____	**Quad Atrophy**	**L**	_____		**R**	_____			
McM-M	**L**	**R**	_____	**Creptus**	**L**	**R**	_____	**Gast Atrophy**	**L**	_____		**R**	_____			
Varus	**L**	**R**	_____	**Patella**	**L**	**R**	_____	**Lachman's**	**L**	_____		**R**	_____			
Valgus	**L**	**R**	_____	**Pes A**	**L**	**R**	_____	**X-ray: Right**		_____	**Ost**	**Compartment:**		**Med**		**Lat**
								X-ray: Left		_____	**Ost**	**Compartment:**		**Med**		**Lat**

POA:

☐ **Brace : R L B/L Valgus Varus** ☐ **No Bracing Indicated**

☐ **Cortisone** ☐ **Prolozone**

☐ **Start VES:** ☐ **Hyalgan (Medicare, BCBS FEP, Anthem)** ☐ **Orthovisc (Cigna, Aetna)** ☐ **Synvisc (BCBS)** ☐**???**

☐ **Start PT next visit** ☐ **PT ONLY (not eligible for VES)** ☐ **Eligible for VES on Date:**_____

Notes:_____

INSURANCE INFORMATION

I clearly understand that all insurance coverage, whether accident, work related, or general health coverage is an arrangement between my insurance carrier and myself. I understand that if this office chooses to bill any services to my insurance carrier they are performing these services strictly as a convenience to me. Advanced Spine & Wellness Center will provide any necessary reports or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny my claims and that I am ultimately responsible for any unpaid claims or balances.

I understand that there may be some services that my insurance company will not cover. If my insurance company notifies me that they are refusing payment for any services I have received, I will contact Advanced Spine & Wellness Center immediately to notify them of the nonpayment/rejection notice. I authorize the assignment of all insurance benefits to be directed to Advanced Wellness Systems, LLC (d/b/a Advanced Spine & Wellness Center) for services rendered.

Patient's Signature_____ Date_____

Parent/Guardian's Signature _____ Date_____

Who should receive charges on your account?

☐ Health Insurance ☐ Medicare ☐ Auto Insurance ☐ Workers' Compensation

☐ Patient ☐ Spouse ☐ Parent/Guardian

Name of Insurance Co. _____ Policy #_____

Policyholder information (if different from patient)

Insured's Name_____ Insured's Birth Date _____/_____/_____

Patient's Relationship to Insured _____ Insured's SS # (optional) _____

Do you have a secondary or supplemental insurance policy? ☐ Yes ☐ No

Secondary Insurance Co. _____ Policy #_____

If auto accident or work injury:

Accident Location (City & State) _____ Date of Injury _____/_____/_____

Which auto insurance should be billed for medical claims?
If you have a **Maryland** policy, we must bill the vehicle owner's insurance or your auto insurance, NOT the at-fault party's.
If you have a **Virginia** policy, we must bill your auto insurance or the vehicle owner's insurance, NOT the at-fault party's.
If you have a **DC** policy, we must bill your health insurance first; then your auto insurance if the accident happened outside DC.
Please note: We cannot bill the at-fault party's auto insurance; we are required to bill your auto insurance or health insurance.

Insurance Carrier _____ ☐ patient's insurance ☐ vehicle owner's

Claim # _____ Policy State _____

Adjuster _____ Phone # _____

Mailing Address _____ Fax # _____

Personal Injury Protection (PIP) or Med-Pay Policy Limit $_____ Used $_____

Do you have an attorney on your case? ☐ Yes ☐ No

Attorney _____ Phone # _____

Mailing Address _____ Fax # _____

CARE AUTHORIZATION

I hereby authorize Advanced Spine & Wellness Center (ASWC) and its licensed doctors/specialists, based on my complaints and the history I have provided, to undertake an examination and provide treatment which may include chiropractic adjustments, manual therapies, modalities and other tests and procedures considered therapeutically appropriate. I also wish to rely on ASWC doctors/specialists to make those decisions about my care, based on the facts then known, that they believe are in my best interest. The specifics of the provider's recommended treatment plan will be further explained during a Report of Findings following your examination and any subsequent examinations and significant changes in your diagnosis or treatment plan.

I acknowledge that: (1.) ASWC may not be a participating insurance provider (2.) ASWC may have applied to become a participating insurance provider (3.) if so, the insurance carrier may not have yet completed the assessment of qualifications of the treating provider to provide services as a participating provider; and any covered services received must be reimbursed by the insurance carrier at the participating provider rate.

I understand that I am responsible for all fees incurred for the services provided, and agree to ensure full payment of all charges.

The health care providers will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another health care practitioner, or are not related to the spinal structural or extremity conditions diagnosed at this clinic.

By signing below I acknowledge my consent to be examined and allow ASWC, as deemed appropriate by the examining physician, to take radiographs (x-rays) of my spine and/or extremities. I affirm that to my knowledge that I am not pregnant. _____ **(Initial)**

Patient's Signature_____ Date_____

I hereby authorize ASWC to administer care as deemed necessary to my child or dependent, a minor under the age of 18 years old.

Parent/Guardian's Signature _____ Date_____

NOTICE OF PRIVACY PRACTICES

We care about our patients' privacy and are committed to protecting the confidentiality of your personal and medical information. We are required by law to maintain the privacy of protected health information and to inform you of our privacy practices.

Treatment at Advanced Spine & Wellness Center is provided in an open room where other patients are also being treated. Other persons in the office may overhear some of your health information during the course of your treatment. Should you need to speak with your health care provider in private, the doctor or specialist will provide a private room for these conversations. You may also request a private room should you need to discuss financial matters with a billing professional.

Your personal information and clinical records may be used for the following purposes:

- To provide you the best care and service possible, including for quality control and training purposes.
- To contact you with appointment reminders, health-related email messages, and birthday or holiday cards.
- To coordinate treatment with other health care professionals, including referring practitioners and primary care providers.
- To obtain payment, billing information and medical records may be provided to your insurance and to our billing service.

You have the following rights with regard to your health information:

- The right to review the above notice prior to signing this consent.
- The right to receive a copy of this notice of privacy practices for your records.
- The right to request restrictions as to how your personal or contact information may be used. Requests must be in writing.
- The right to request copies of your medical records. There may be a reasonable fee for photocopying and postage.
- The right to ask us, in writing, to amend your medical records if you feel the information is incomplete or inaccurate.
- The right to file a written complaint with our office or with the Department of Health and Human Services if you believe your privacy rights have been violated. You will not be penalized or discriminated against for filing a complaint.

I have reviewed the notice of privacy practices provided to me by Advanced Spine & Wellness Center and grant permission for ASWC to use and disclose my protected health information in accordance with the conditions listed above.

Patient or Parent/Guardian's Signature _____ Date_____

May we include you on our email list? ☐ YES ☐ NO (You will be included unless you opt out.)