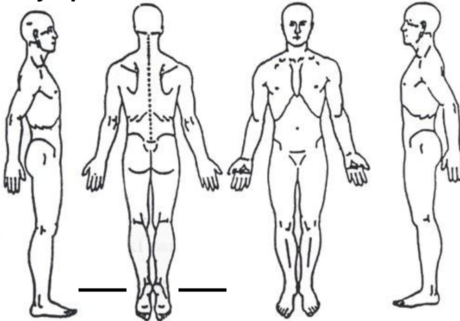
ABSAROKA
PAIN and REHAB

PATIENT INTAKE FORM

Patient Name: ___________________________
Date: _______________

1. Is today's problem caused by:
□ Auto Accident □ Workman's Compensation □ Other

2. Indicate on the drawings below where you have pain/symptoms



3. How often do you experience your symptoms?
□ Constantly (76-100% of the time) □ Frequently (51-75%)
□ Occasionally (26-50%) □ Intermittently (1-25%)

4. How would you describe the type of pain?
□ Sharp □ Numb
□ Dull □ Tingly
□ Diffuse □ Sharp with motion
□ Achy □ Shooting with motion
□ Burning □ Stabbing with motion
□ Shooting □ Electric-like with motion
□ Stiff □ Other:___________________

5. How are your symptoms changing with time?
□ Getting Worse □ Staying the Same □ Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?
0 1 2 3 4 5 6 7 8 9 10 (*Please circle*)

7. How much has the problem interfered with your work?
□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

8. How much has the problem interfered with your social activities?
□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

9. Who else have you seen for your problem?
□ Chiropractor □ Neurologist □ Primary Care Physician
□ ER physician □ Orthopedist □ Other:______________
□ Massage Therapist □ Physical Therapist □ No one

10. How long have you had this problem? ______________

11. How do you think your problem began?
____
____

12. Do you consider this problem to be severe?
□ Yes □ Yes, at times □ No

13. What aggravates your problem?
____
____

OFFICE USE ONLY (This half of page):

Custom Exam Sequence
(Medical Provider) Dr. M / R

1) **4)**
2) **5)**
3) **6)**

Posture:
FHP? ______"
Shoulder R High / Low L High / Low
Pelvis R High / Low L High / Low
Pelvic Tilt ant / post
Feet Pron R / L / Bilat
Sup. R / L / Bilat

Vitals: **B.P. _____/_____ R / L Pulse _____**
Ht. ____ft.____in. Wgt._____lbs

Dermatomes:
__________________________________ **levels / WNL**
(Hyper ↑ / Hypo ↓)

Reflexes:
____________**C-5 Biceps** **L-5 Pat.** ____________
____________**C-6 B.R.** **S-1 Ach.**____________
____________**C-7 Triceps**
(All WNL or #)

Grip: **R ____ ____ ____ lbs.** **Dominant hand: R / L**
L ____ ____ ____ lbs.

Adsons:
+ R / L / Bilat.
WNL or Incidental ______________________

Max. Cerv. Comp.:
+ R / L / Bilat. **Convex R / L**
Concave R / L
WNL or Incidental ______________________

Jackson's:
+ R / L / Bilat.
Dermatome (C5-T1) ________
WNL or Incidental ______________________

Shoulder Depression:
+ R / L / Bilat.
Dermatome (C5-T1) ________
WNL or Incidental ______________________

Cervical Distraction:
+ = Decrease in px
Local / Radicular / Both
WNL or Incidental ______________________

Valsalva:
+ R / L / Bilat.
Dermatome (C5-T1) _______
WNL or Incidental ______________________

Georges Test: **B.P. Both sides**
R ___/___ L ___/___
WNL or Incidental ______________________

14. What alleviates your problem? (for example: ice, heat, rest, stretching, massage, pain killers, etc.)

____

____

15. What concerns you the most about your problem; what does it prevent you from doing?

____

____

16. What is your:

Height__________ **Weight** ______ lbs **Age** ________

Occupation

____

17. How would you rate your overall Health?

□ Excellent □ Very Good □ Good □ Fair □ Poor

18. What type of exercise do you do?

□ Strenuous □ Moderate □ Light □ None

19. Indicate if you have any immediate family members with any of the following:

□ Rheumatoid Arthritis □ Diabetes □ Lupus
□ Heart Problems □ Cancer □ ALS

20. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past/ Present		Past /Present	
□	□ Headaches	□	□ High Blood Pressure
□	□ Neck Pain	□	□ Heart Attack
□	□ Upper Back Pain	□	□ Chest Pains
□	□ Mid Back Pain	□	□ Stroke
□	□ Low Back Pain	□	□ Angina
□	□ Shoulder Pain	□	□ Kidney Stones
□	□ Elbow/Upper Arm Pain	□	□ Kidney Disorders
□	□ Wrist Pain	□	□ Bladder Infection
□	□ Hand Pain	□	□ Painful Urination
□	□ Hip Pain	□	□ Loss of Bladder Control
□	□ Upper Leg Pain	□	□ Prostate Problems
□	□ Knee Pain	□	□ Abnormal Weight Gain/Loss
□	□ Ankle/Foot Pain	□	□ Loss of Appetite
□	□ Jaw Pain	□	□ Abdominal Pain
□	□ Joint Pain/Stiffness	□	□ Ulcer
□	□ Arthritis	□	□ Hepatitis
□	□ Rheumatoid Arthritis	□	□ Liver/Gall Bladder Disorder
□	□ Cancer	□	□ General Fatigue
□	□ Tumor	□	□ Muscular Incoordination
□	□ Asthma	□	□ Visual Disturbances
□	□ Chronic Sinusitis	□	□ Dizziness
□	□ Diabetes	□	□ Excessive Thirst
□	□ Smoking/Tobacco Use	□	□ Drug/Alcohol Depend.
□	□ Allergies	□	□ Depression
□	□ Systemic Lupus	□	□ Epilepsy
□	□ Dermatitis/Eczema/Rash	□	□ HIV/AIDS

For Females Only:

Past/ Present

□ □ Birth Control Pills
□ □ Hormonal Replacement
□ □ Pregnancy

Cervical ROM: **D.N.P. d/+ Px**

F _____(50°) Px ________; Ext _____ (60°) Px ________
LLF _____ (45°) Px _______; RLF _____ (45°) Px_______
LR _____ (80°) Px ________; RR _____(80°) Px _______

Lumbar ROM: **D.N.P. d/+ Px**

F _____ (60°) Px ________; Ext _____ (25°) Px_________
LLF _____ (25°) Px________; RLF _____ (25°) Px_______

Chiropractic Analysis:

Point Tend. 0 1 2 3 4 5 6 7; 1 2 3 4 5 6 7 8 9 10 11 12; 1 2 3 4 5; SI
Vert. Spasm 0 1 2 3 4 5 6 7; 1 2 3 4 5 6 7 8 9 10 11 12; 1 2 3 4 5; SI
Fixations 0 1 2 3 4 5 6 7; 1 2 3 4 5 6 7 8 9 10 11 12; 1 2 3 4 5: SI

Minors Sign:
+ R / L
WNL or Incidental ______________________

Bechterews:
LB px / SI px / Both
R / L / Bilat
WNL or Incidental ______________________

Kemp's Test:
+ Radicular: R / L / Bilat
+ Local: R / L / Bilat
ON Hyperext / NO Hyperext
WNL or Incidental ______________________

Straight Leg Raise:
R _____ Px ________ degree_____
L _____ Px ________ degree_____
WNL or Incidental ______________________

Bragard's Sign: SLR w/dorsiflexion foot
+ R / L / Bilat
WNL or Incidental ______________________

Goldthwaits: SLR w/ palp L5/S1
R / L / Bilat
Px before / after separation
WNL or Incidental ______________________

Thomas Test:
+ R / L / Bilat
WNL or Incidental ______________________

Patrick Fabere Test (frog leg):
+ R / L / Bilat
WNL or Incidental ______________________

Ely's Test: Prone Heel to Butt
Thigh Px: R / L / Bilat
No Ext Px: R / L / Bilat
WNL or Incidental ______________________

Soto Hall:
Px at C1-T3? _________
WNL or Incidental ______________________

Smoking Addressed: Y / N **Time Spent: _____ min.**

21. List all prescription medications you are currently taking:
____
____
____

22. List all of the over-the-counter medications you are currently taking:
____
____
____

23. List all surgical procedures you have had:
____
____
____

24. What activities do you do at work?
□ **Sit:** □ Most of the day □ Half the day □ A little of the day
□ **Stand:** □ Most of the day □ Half the day □ A little of the day
□ **Computer work:** □ Most of the day □ Half the day □ A little of the day
□ **On the phone:** □ Most of the day □ Half of the day □ A little of the day

25. What activities do you do outside of work?
____
____

26. Have you ever been hospitalized? □ No □ Yes
If yes, why?
____
____
____

27. Have you had significant past trauma? □ No □ Yes

28. Anything else pertinent to your visit today?____
____

Patient Signature____________________________________

Date:____________________

Additional Tests/Comments:

PATIENT REGISTRATION FORM

ABSAROKA PAIN & REHAB
1001 W Oak Street, Bldg C Ste 210
Bozeman, MT 59715
406-587-8446 phone 406-587-0898 fax

PATIENT INFORMATION

Patient (Legal) Name: ____________________

(Preferred Name): ____________________ **Previous/Maiden Name(s):** ____________________

Social Security #: ____________________ **Birth Date:** ____________________ **Male:** ☐ **Female:** ☐

Mailing Address: ____________________

City: ____________________ **Zip Code:** ____________________

Home Phone: ____________________ **Cell Phone:** ____________________ **E-mail:** ____________________

Patients Employer: ____________________ **Work Phone #:** ____________________

Primary Care Provider (or N/A if none): ____________________

Height: ____________________ **Weight:** ____________________

Spouse Name: ____________________ **Spouse Social Security #:** ____________________

Spouse Birth Date: ____________________ **Spouse Employer:** ____________________ **Spouse Work phone #:** ____________________

COMPLETE THIS SECTION IF PATIENT IS UNDER THE AGE OF 18 OR A STUDENT

Parent's Name: ____________________

Mother's Social Security #: ____________________ Father's Social Security #: ____________________

Address: ____________________

Mother's DOB: ____________________ Employer: ____________________ Work Phone #: ____________________

Father's DOB: ____________________ Employer: ____________________ Work Phone #: ____________________

NEAREST RELATIVE/FRIEND NOT LIVING WITH PATIENT

Name: ____________________ **Relationship:** ____________________

Address: ____________________ **Phone #:** ____________________

ABOUT YOUR INSURANCE – We will need a copy of all insurance cards

Primary Insurance: ____________________ **Secondary Insurance (if applicable):** ____________________

If Medicaid, Passport provider: ____________________

WORKERS COMPENSATION INJURY? ☐ **Yes** ☐ **No** **Date of Injury:** ____________________

AUTO ACCIDENT? ☐ **Yes** ☐ **No** **Date of Loss:** ____________________

IF YOU ANSWERED "YES" TO EITHER WORK COMP OR AUTO ACCIDENT PLEASE SEE THE NEXT PAGE OF THIS FORM FOR OTHER REQUIRED INFORMATION NEEDED TO PROCESS YOUR CLAIM

IMPORTANT INFORMATION (PLEASE READ)

I consent to examination, treatment and procedures which may be performed during office visits including emergency treatment considered necessary by the physician and/or his designated providers.

I authorize the release of any medical information necessary to determine benefits payable for insurance claims for services rendered and agree that all proceeds of insurance are assigned to this office where applicable.

I understand that I am financially responsible for all charges whether or not paid by my insurance.

I understand that should I default on payment of my account and collection agency services are required, all costs of collections, up to 45% of the balance, including attorney/court costs will be added to the balance of my account.

PATIENT OR GUARDIAN SIGNATURE: ____________________ **DATE:** ____________________
PATIENT OR GUARDIAN SIGNATURE: ____________________ **DATE:** ____________________

Payment Policy

As a courtesy to our patients, we offer the following billing choices. Please initial the payment plan that applies to you then sign at the bottom of the page.

Although we at Absaroka Pain and Rehab (APR) will contact your insurance company to verify your benefits, we recommend that you also call in order to fully understand your plan option. If you are aware of any limitation on your insurance benefits, please notify us immediately to allow us to try to maximize your coverage.

____ Self Pay

I will pay for all services as they are rendered on the date of my visit unless arrangements are made for a payment plan. I understand that I may contact APR for required documentation if I choose to submit my own insurance claims.

____ Insurance Submittal

I would like to assign my insurance benefits to APR and have you submit my insurance claims for me. If applicable, I understand that I am responsible for obtaining any necessary pre-authorization from my primary care physician. I understand that I am responsible for any balance as billed to me by APR that results from co-payments, deductibles, or non-covered services. I will also sign over to APR within 5 business days any insurance checks mailed to me for services received at APR.

____ Auto Accident/Personal Injury Claim

I was involved in an accident and would like to assign benefits to APR and have you submit all charges to my insurance for me. I will sign all liens necessary to protect your office. I also understand that, regardless of settlement I am personally responsible for the entire balance. If APR is not paid within 30 days of the case settlement, I will personally pay the entire overdue balance.

____ Worker's Compensation Claim

I was involved in an injury at work. I will ensure that my employer files the appropriate paperwork as needed for APR to receive compensation. I understand that it is in my rights as a Montana resident to have any bills paid that are incurred as a result of a work related injury. If after 90 days of my visit to APR my claim is not paid, I understand that I am responsible for the overdue balance.

Name (please print):____

Signature:____ Date: ______________________

Absaroka Pain and Rehab

Consent to Examination and Treatment

I hereby consent to the performance of examination and treatment performed by the licensed doctors of chiropractic, medical doctors and/or licensed physical therapist who may be employed by or engaged in practice in this clinic. I have had an opportunity to discuss with the doctor or other clinic personnel the nature and purpose of the different physical therapy procedures and chiropractic treatment (manipulation/adjustment). I understand that neither chiropractic treatment nor medical treatment is an exact science and that my care may involve judgments based on facts and information known to the doctor. The doctor uses this judgment to attempt to anticipate or explain risks and complications and un undesirable result does not necessarily indicate an error in judgment. No guarantee for results can be made or expected but rather I wish to rely on the doctors to choose and recommend a best course of treatment based upon facts known that is in my best interests.

I further understand that there are certain degrees of risk associated with chiropractic health care and physical therapy, which included rarely, but not limited to fractures, disc injuries, strokes and sprains/strains and am therefore willing to accept and consent to the risk associated with the care I am about to receive.

I have read the above information regarding consent. I have had an opportunity to ask questions about my examination and treatment. By signing below, I agree and intend this consent form to cover the procedures prescribed for my condition and for any future conditions for which I seek treatment.

Name (printed):____

Signature:____ Date:__________________

Consent to participate in Active Rehabilitation

The goals of the rehabilitation program include:

Determining the cause and extent of your problem.
Providing a therapeutic exercise program to strengthen you, increase your cardiovascular endurance, range of motion and flexibility and decrease your pain.
Return you to full duty, non-restricted work status and lifestyle.

Your participation in the rehabilitation program is voluntary. You can stop at any point in the program. Should you stop your program, we are obligated to notify your doctor, insurance company or attorney if it is applicable.

If at any point during the evaluation or rehabilitation process you have any questions, we will answer them to the best of our ability or refer you to someone more qualified. Please be advised that there are no guarantees that your personal goals and/or those listed above will be met to your satisfaction. The success of any rehabilitation process lies in the combined efforts of you and your providers. The team approach has the best chance of attaining your goals, so please ask as many questions as necessary for you to gain the maximum benefit from your rehabilitation program.

Since the process of strengthening and conditioning are a form of “controlled strain”, there is a chance of aggravation or injury. It is therefore imperative that you communicate to your provider any aggravation or injury that you may observe during the rehabilitation process. For example, the best exercise for you, if performed too early in your condition, may be your worst enemy if performed too soon. Communication with your provider will help put into perspective problems that may occur. Failure to discuss problems may only foster additional problems down the road.

I have read the above and understand the risks and benefits of the rehabilitation program. I agree to participate and have my rehabilitation information released to my doctor, insurance carrier and/or attorney if applicable.

Name (printed):____

Signature:____ Date:____________________

WORKER'S COMPENSATION

This information must be completed in order for us to bill for services. If it is not complete, the patient will be responsible for full payment at the time they are treated.

EMPLOYER AT TIME OF INFURY: ________________________________ **Phone #:** ________________________

ADDRESS: ____
STREET ADDRESS *CITY* *STATE* *ZIP*

SUPERVISOR: ________________________ **PART OF BODY INJURED:** ________________ **L** ☐ **R** ☐

In detail, explain how accident/injury occurred?

____

____

____

____

DATE OF INJURY: ________________________ **LAST WORKED DATE:** ________________________

WORK COMP INSURANCE CARRIER: ____

WORK COMP CARRIER ADDRESS: ____
STREET ADDRESS *CITY* *STATE* *ZIP*

Does your work comp carrier require you to make co-payments to the Doctor? ☐ ***yes*** ☐ ***No***

CLAIMS EXAMINER: ________________________________ **PHONE #:** ________________________

CLAIM #: ____

HAVE YOU RETAINED AN ATTORNEY? __________ **ARE YOU CURRENTLY IN LITIGATION FOR THIS INJURY?**______________

ATTORNEYS NAME________________________________ **OFFICE PHONE #**________________________

AUTO ACCIDENT

This information must be completed in order for us to bill for services. If it is not complete, the patient will be responsible for full payment at the time they are treated.

POLICY HOLDER: ____

CLAIM #: ________________________________**ACCIDENT DATE** ________________________

INSURANCE CARRIER: ____

MAILING ADDRESS:____
STREET ADDRESS *CITY* *STATE* *ZIP*

ADJUSTOR: ________________________________ **PHONE #** ________________________

HAVE YOU RETAINED AN ATTORNEY? ______________ **ARE YOU CURRENTLY IN LITIGATION FOR THIS INJURY?**__________

ATTORNEY'S NAME________________________________ **OFFICE PHONE #** ________________________

OTHER INJURY

PLEASE EXPLAIN:

____

____

____

____

Media Release Form

Absaroka Pain and Rehab
1001 W. Oak St. Bldg. C Ste. 210
Bozeman, MT 59715

Permission to Use Media

I grant to Absaroka Pain and Rehab, its representatives and employees the right to take photographs &/or videos of me and my property in connection with the above-identified subject. I authorize Absaroka Pain and Rehab, its assigns and transferees to copyright, use and publish the same in print and/or electronically. I agree that Absaroka Pain and Rehab may use such photographs &/or videos of me with or without my name and for any lawful purpose, including for example such purposes as publicity, illustration, advertising, and social media (Facebook) and/or Web content.

I have read and understand the above:

Signature ___________________________________

Printed name ________________________________

Date _______________________________________

Signature, parent or guardian ________________________ (if under age 18)