Fusion Medical Center
Patient Information

Date: _____

Name: _____
Last First MI

Email address: _____

Mailing Address:
_____City_____State_____Zip_____

Phone # (H)_____ (W) _____

(Other) _____

Date of Birth:_____ Sex: ❑ Male ❑ Female SS#: _____

Marital Status:❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑ Minor

Emergency contact: _____

Relation: _____ Phone #: _____

Phone #:(H) _____(W) _____

How did you hear about our practice? _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have reviewed the Notice of Privacy Practices of Fusion Medical Center. (Please initial one of the following options and sign below.)

_____ I wish to receive a paper copy of Privacy Notice.

_____ I do not request a copy of the Privacy Notice at this time. I acknowledge that I can request a copy at any time and the Privacy Notice is posted in the office. If I should have a problem or question in regard to my rights, I may speak with the Privacy Officer about my concerns.

I acknowledge that it is the policy of this office to leave reminder messages via text, email, and/or phone (with or without voicemail). I may make a request of an alternative means of communication (within reason) in writing.

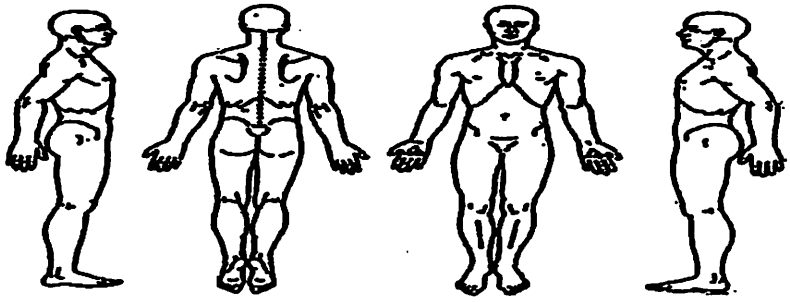
X_____ _____
Signature of Patient/Guardian Date

X_____ _____
Witness (Office Staff) Date

PATIENT INTAKE FORM

Patient Name: _____ Date: _____

Indicate on the drawings below all the areas where you have pain/symptoms:



First Complaint: _____

How often do you experience your symptoms?

□ Constantly (76-100% of the time) □ Occasionally (26-50% of the time)
□ Frequently (51-75% of the time) □ Intermittently (1-25% of the time)

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:_____

How are your symptoms changing with time? □ Getting Worse □ Staying the same □ Getting Better

Using a scale from 0-10 (10 being the worst), how would you rate your problem?

Indicate Pain Level (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Shoot Me Pain)

How much has the problem interfered with your work?

□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely □ N/A

How much has the problem interfered with your social activities?

□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

Who else have you seen for your problem?

□ Chiropractor □ Massage Therapist □ Primary Care Physician □ Neurologist
□Orthopedist □ ER physician □ Physical Therapist □ Other:_____

Provider Name / Date of visit: _____

How long have you had this problem? _____

How do you think your problem began? □ Cause Not Known □ Auto Accident □ Work Injury □ Slip / Fall
□ Sports Injury □ Other _____

What aggravates your problem?

□ Nothing □ Sneezing □ Bending □ Coughing □ Lifting □ Walking □ Reaching □ Sitting □ Straining at Stool
□ Standing □ Pulling □ Turning □ Other – Describe: _____

What makes your problem better?

□ Nothing □ Rest □ Sitting □ Stretching □ Exercise □ Standing □ Heat □ Ice □ Medications □ Massage
□ Adjustments □ Sleeping □ Other – Describe:_____

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

What concerns you the most about your problems; what does it prevent you from doing?

_____

Second Complaint: _____

How often do you experience your symptoms?

□ Constantly (76-100% of the time) □ Occasionally (26-50% of the time)
□ Frequently (51-75% of the time) □ Intermittently (1-25% of the time)

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:_____

How are your symptoms changing with time? □ Getting Worse □ Staying the same □ Getting Better

Using a scale from 0-10 (10 being the worst), how would you rate your problem?

Indicate Pain Level (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Shoot Me Pain)

How much has the problem interfered with your work?

□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely □ N/A

How much has the problem interfered with your social activities?

□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

Who else have you seen for your problem?

□ Chiropractor □ Massage Therapist □ Primary Care Physician □ Neurologist □ Orthopedist □ ER physician □ Physical Therapist □ Other:_____

Provider Name / Date of visit: _____

How long have you had this problem? _____

How do you think your problem began? □ Cause Not Known □ Auto Accident □ Work Injury □ Slip / Fall □ Sports Injury □ Other _____

What aggravates your problem?

□ Nothing □ Sneezing □ Bending □ Coughing □ Lifting □ Walking □ Reaching □ Sitting □ Straining at Stool □ Standing □ Pulling □ Turning □ Other Describe:_____

What makes your problem better?

□ Nothing □ Rest □ Sitting □ Stretching □ Exercise □ Standing □ Heat □ Ice □ Medications
□ Massage □ Adjustments □ Sleeping □ Other – Describe: _____

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

What concerns you the most about your problems; what does it prevent you from doing?

_____

What is your: Height_____ **Weight** _____ **Date of Birth** _____

Occupation _____

CANCER HISTORY (PLEASE INCLUDE DATE):_____

Name:_____

How would you rate your overall Health? ◻ Excellent ◻ Very Good ◻ Good ◻ Fair ◻ Poor
What type of exercise do you do? ◻ Strenuous ◻ Moderate ◻ Light ◻ None

Indicate if you have any immediate family members with any of the following:
◻ Rheumatoid Arthritis ◻ Diabetes ◻ Lupus ◻ Heart Problems ◻ Cancer ◻ ALS

Please check to indicate if you are currently or have ever experienced any of the following conditions:

Medical
- ❑ Abdominal Pain
- ❑ Allergies
- ❑ Asthma
- ❑ Cancer
- ❑ Cold Sweats
- ❑ Cold Feet/Hands
- ❑ Diabetes
- ❑ Kidney Disease
  - ❑ Dialysis
- ❑ Liver Disease
  - ❑ Hepatitis
- ❑ Skin Rashes
- ❑ Sleeping Difficulties
- ❑ Stomach Problems
  - ❑ Ulcers
  - ❑ Constipation
  - ❑ Diarrhea
- ❑ Sudden Weight Loss
- ❑ Sudden Weight Gain
- ❑ Thyroid Problems
  - ❑ Cancer
  - ❑ Hypothyroid
  - ❑ Hyperthyroid
  - ❑ Goiter
- ❑ Tumors/Growths
- ❑ Vitamin D deficiency

GYN/GU
- ❑ Bladder Changes
- ❑ Breast Cancer
- ❑ Breast Lump
- ❑ Cervical Cancer
- ❑ Erectile Dysfunction
- ❑ Low libido
- ❑ Prostate Problems
  - ❑ Prostate cancer
  - ❑ Prostate enlargement
- ❑ Uterine Cancer

Cardiac/Pulmonary
- ❑ Carotid artery blockage
- ❑ Chest Pain
- ❑ Fainting
- ❑ Heart Disease
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ Leg Swelling
- ❑ Pacemaker
- ❑ Palpitations
- ❑ Shortness of Breath
- ❑ Stroke
- ❑ Tuberculosis
- ❑ Varicose Veins

Neurological
- ❑ Dizziness/Vertigo
- ❑ Epilepsy
- ❑ Headaches
  - ❑ Migraines
  - ❑ Other:
- ❑ Loss of Memory
- ❑ Numbness/tingling

Hematology/Blood Disorder
- ❑ Anemia
- ❑ Bleeding Disorder
- ❑ Taking a Blood Thinner

Psychological
- ❑ Alcoholism
- ❑ Anxiety
- ❑ Chemical Dependency
- ❑ Depression
- ❑ Psychiatric Care
  - ❑ Current
    Reason:
  - ❑ Past
    Reason:
- ❑ Suicide Attempt

Eye Disorders
- ❑ Blurred Vision
- ❑ Cataracts
- ❑ Glaucoma

Musculoskeletal
- ❑ Arthritis
- ❑ Ankle Pain
- ❑ Arm/Hand Pain
- ❑ Back Pain or Stiffness
  - ❑ Upper Back
  - ❑ Mid Back
  - ❑ Low Back
  - ❑ Sciatica
- ❑ Foot pain
- ❑ Gout
- ❑ Hip pain
- ❑ Knee pain
- ❑ Hip pain
- ❑ Neck Pain/Stiffness
- ❑ Osteoporosis
- ❑ Polio
- ❑ Shoulder pain
- ❑ Wrist pain

Please list all other medical conditions NOT listed on this form:

_____

_____

_____

_____

_____

_____

_____

MEDICAL HISTORY

NAME:_____

Are you currently under medical care? ❑ Yes ❑ No Who is your primary care Dr? _____

Please all medications: (**Be sure to include dosage and frequency**)_____

_____

_____

Are you on any anti-inflammatory meds? (Aleve, Naproxen, Motrin, Ibuprofen, Celebrex, Meloxicam, Mobic, Voltaren, Diclofenac, etc.) Yes_____ No_____

Do you take blood thinners (Coumadin, Plavix, Aspirin, Xarelto, Eliquis, Pradaxa)?

Yes_____ No_____

Supplements (vitamins/herbs/minerals): _____

Allergies (Please list medication and reaction.): _____

_____

WOMEN ONLY: Date of LMP:_____ ***Any possibility of pregnancy: YES or NO***

Surgical History: (Please note ALL joint replacement surgeries!)

Surgeries and/or hospitalizations (**type & date**): _____

_____

_____

Family History: Is there a family history of any of the following conditions? (Indicate parents, grandparents, children, & siblings)

❑ Heart Disease _____ ❑ Diabetes _____
❑ Cancer _____ ❑ Arthritis _____ ❑ Other _____

Social History:
Intake of following: Cigarettes _____ packs/day Alcohol _____drinks/week Caffeine ___ cups/day

NAME:_____

Regular Exercise	Frequency			Distance or Time
❑Walk	❑Never	❑Daily	❑ Weekly	
❑Run	❑Never	❑Daily	❑ Weekly	
❑Swim	❑Never	❑Daily	❑ Weekly	
❑Other:	❑Never	❑Daily	❑ Weekly	

Informed Consent to Care

A patient coming to the doctor gives him/her permission and authority to care for them in accordance with appropriate test, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the physician. This office does not perform heart, lung, breast, pelvic, prostate, rectal, or full skin evaluations. These examinations should be performed by your family physician, GYN, and/or dermatologist to exclude cancers, or abnormal skin lesions that should undergo biopsy/removal or other treatments. This clinic does not provide care for any condition (such as high blood pressure, diabetes, high cholesterol) other than those addressed in your physical medicine care plan. We also do not prescribe or refill ANY controlled substances. All prescriptions should be refilled by your original prescriber and any new prescriptions should be issued by your primary care provider or specialist.

The patient assumes all responsibility/liability if the patient does not report on health forms any past medical history, illnesses, medicines, or allergies.

I agree to settle any claim or dispute I may against or with any of these persons or entities, whether related to the prescribed care or otherwise, will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

Sign here: X_____I have read and understand the above consent form.

Date:_____

Fusion Medical Center

Phone: (561) 752-4646 Fax: (561) 737-7664

Authorization for Release of Protected Health Information

Patient Name: _____ Birth Date: _____

Social Security #: _____

I hereby authorize the release of medical records to Fusion Medical Center. My revocation must be in writing, on a form that will be provided to me upon request. I am aware that my revocation will not be effective to the extent that Fusion Medical Center has acted in reliance on this authorization. I understand that if my protected health information is disclosed to someone who is not required to comply with the Federal Privacy regulations, then such information may be re-disclosed and no longer protected by the Federal Privacy regulations. I release Fusion Medical Center and its workforce members from all liability arising from the disclosure of my health information pursuant to this agreement. I have the above and authorize the disclosure of protected health information as stated.

_____ _____

Signature of Patient/Patient Representative Date

_____ _____

Print Name of Patient/Patient Representative Relationship to Patient