

Korman Relief & Wellness Center
Returning Established Patient Health Evaluation

PATIENT CONDITION

Overall Health (Circle One) Excellent / Very Good / Good / Fair / Poor / Other _____

Chief Complaint / Reason you are here _____

Cause of complaint or how complaint began _____

What type of pain are you experiencing? (Circle all that apply) - Sharp / Burning / Dull / Tingling
Throbbing / Cramps / Numbness / Stiffness / Aching / Swelling / Shooting / Other _____

When did your symptoms first appear? _____

Is this condition getting progressively worse? Yes / No

How often do you have this pain / condition? _____

Is it constant, or does it come and go? _____

Does it interfere with (circle all that apply) Work / Sleep / Daily Routine / Recreation / Activities

Are any of these movements painful to perform? Sitting / Standing / Walking / Bending / Lying Down

Previous treatment for this complaint? _____

Are you currently under the care of a physician or other health professional? Yes / No

If "yes", please give name and date of last visit. _____

Have you had Spinal X-rays, MRI, or CT Scan for your area(s) of complaint? Yes / No

List recent imaging or tests. _____

At what facility was imaging / testing done? _____

Is this condition due to an accident? Yes / No If "yes", date of accident? _____ / _____ / _____

What type of accident did you have? Auto / Work Related / Home / Other _____

To whom have you reported the accident? Auto Insurance / Employer / Work Comp / Other

SOCIAL HISTORY (Please circle all that apply to you)

Smoking - Never / Former / Current # Packs per day _____

Alcohol - None / Casual / Moderate / Heavy / Beer Only / Wine Only / # Drinks per week _____

Coffee / Caffeinated Drinks - None / Less than 3 drinks per day / 3-6 drinks per day / More than 6 per day

Drug Use - None / Recreational / Current or Former Addiction _____

Exercise - Never / Daily / Weekly / Walk only / Run / Swim

Patient Name _____

Korman Relief & Wellness Center
Returning Established Patient Health Evaluation

HEALTH HISTORY

Please check-mark below any health issues YOU currently have or have ever had, leaving blank if the condition does not apply to you. If a condition applies to a family member, please indicate which family member using the following abbreviations:

M = Mother | **F** = Father | **S** = Sister | **B** = Brother | **MGM** = Maternal Grandmother

MGF = Maternal Grandfather | **PGM** = Paternal Grandmother | **PGF** = Paternal Grandfather

<u>YOU</u>			<u>FAMILY</u>	<u>YOU</u>			<u>FAMILY</u>
<u>Past</u>	<u>Present</u>	<u>Issue</u>		<u>Past</u>	<u>Present</u>	<u>Issue</u>	
_____	_____	Anemia	_____	_____	_____	High Blood Pressure	_____
_____	_____	Cancer	_____	_____	_____	High Cholesterol	_____
_____	_____	Diabetes	_____	_____	_____	Kidney Disease	_____
_____	_____	Heart Disease	_____	_____	_____	Stroke (date _____)	_____
_____	_____	Heart Failure	_____	_____	_____	Thyroid	_____
_____	_____	Rheumatoid Arthritis	_____				

Please check below all that apply to your personal health.

- | | |
|---|--|
| <input type="checkbox"/> Recent Fever | <input type="checkbox"/> Currently Pregnant, # Weeks _____ |
| <input type="checkbox"/> Corticosteroid Use (Cortisone, etc.) | <input type="checkbox"/> Abnormal Weight Gain |
| <input type="checkbox"/> Birth Control Pills | <input type="checkbox"/> Abnormal Weight Loss |
| <input type="checkbox"/> Dizziness / Fainting | <input type="checkbox"/> Marked Morning Pain / Stiffness |
| <input type="checkbox"/> Visual Disturbances | <input type="checkbox"/> Pain Unrelieved by Position or Rest |
| <input type="checkbox"/> Numbness in Groin / Buttocks | <input type="checkbox"/> Pain at Night |
| <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Menstrual Problems | <input type="checkbox"/> Epilepsy/Seizures |
| | <input type="checkbox"/> Other Health Problem _____ |

Please circle "Yes" or "No" if you CURRENTLY have problems with the following. If yes, describe.

- | | |
|-----------------------------------|-----------------------------|
| Y / N Skin _____ | Y / N Musculoskeletal _____ |
| Y / N Ears / Nose / Throat _____ | Y / N Respiratory _____ |
| Y / N Cardiovascular _____ | Y / N Blood / Glands _____ |
| Y / N Gastrointestinal _____ | Y / N Urinary _____ |
| Y / N Neurological _____ | Y / N Reproductive _____ |
| Y / N Psychiatric _____ | Y / N Eyes _____ |
| Y / N Endocrine / Metabolic _____ | Y / N Other _____ |
| Y / N Pacemaker _____ | |

Patient Name _____ Date _____

Korman Relief & Wellness Center
Returning Established Patient Health Evaluation

LIST ALL INJURIES

DATES

LIST ALL SURGERIES

DATES

LIST ALL HOSPITALIZATIONS

DATES

LIST IMMUNIZATIONS

FLU SHOT? _____

DATES

CURRENT MEDICATIONS

MEDICATION

STRENGTH (MG, ML, ETC)

TIMES PER DAY

DATE BEGAN

LIST ANY SUPPLEMENTS, VITAMINS, ETC.

LIST ALLERGIES

ALLERGIC REACTION

I certify, to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this practitioner, I understand that I am liable for all charges for services rendered, and I agree to notify this practitioner immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my chiropractor may need to contact my physician if my condition needs to be co-managed. Therefore, I give authorization to my chiropractor to contact my physician if necessary.

Patient Signature _____ **Date** _____

Korman Relief and Wellness Center
Laura R. Korman, DC, DACBN
16954 Toledo Blade Blvd.
Port Charlotte, FL 33954
Ph# (941) 629-6700

**OFFICE & PAYMENT
POLICY INFORMATION**

FINANCIAL POLICY:

Payments for Healthcare Services provided in this office are due the day that services are rendered, unless other arrangements have been made prior to seeing the doctor. Patients are personally responsible for all charges.

OUR GOAL:

We believe that a clear definition of our office policies will allow you, the patient, and us, the doctor, to concentrate on the big issue - REGAINING AND MAINTAINING YOUR HEALTH. It is the goal of this office to provide you with the finest quality healthcare available. If you have any questions regarding your healthcare, or any of our policies, please let us know. We welcome your referrals and look forward to a mutually rewarding doctor-patient relationship.

INSURANCE POLICY:

I understand, and agree, that health and accident insurance policies are an arrangement between my insurance company and myself, and **not** between my insurance company and this office.

Assignment of Insurance benefits will be accepted upon proper verification of coverage and at the discretion of this office, however **benefits quoted are not a guarantee of payment**. Benefits are determined at the time of processing. In the event that an "Explanation of Benefits" comes back stating patient responsibility, the patient will be sent a bill.

This office does not file for, or accept assignment for, out-of-network or secondary insurance benefits. We will, however, provide you with documentation to assist you in collecting from your insurance carriers.

APPOINTMENT POLICY:

We want to thank you for choosing us as your healthcare provider. Please remember that we have reserved appointment times especially for you, and we attempt to honor all appointments at the scheduled time. Therefore, in the event you are unable to keep an appointment for any reason, we request that you call immediately to reschedule your visit. This will enable us to schedule other patients for that time.

When you cancel your appointment at the last minute, everyone loses - you, the doctor, and other patients who would like to have utilized your appointment time. ***In the event that you do not contact our office to cancel or reschedule your appointment, at least 2 hours prior to your scheduled time, you may be billed a \$20 missed appointment fee. Failure to comply may result in dismissal of care.***

I have read and understand the above policies. Any questions I had have been answered to my satisfaction, and I understand my responsibility as a patient. I also understand that if my insurance does not respond within 90 days, or if I suspend or terminate my schedule of care as prescribed by Korman Relief & Wellness Center, all fees will be due and payable immediately.

Should there be any instance of a bounced or returned check, I acknowledge that I will be charged a fee of **\$10 per bounced check**.

PATIENT SIGNATURE: _____ **DATE:** _____

Korman Relief & Wellness Center
Laura R. Korman, DC, DACBN
16954 Toledo Blade Blvd.
Port Charlotte, FL 33954
941-629-6700

INFORMED CONSENT FOR THERAPY TREATMENT

Physicians and physical therapists who perform soft tissue therapies and spinal manipulations are required by law to obtain your informed consent before starting treatment.

I, _____, do hereby give my consent to the performance of conservative, non-invasive treatments to the joints and soft tissues. I understand that the procedures may consist of soft tissue and/or spinal manipulations involving movement of the joints and soft tissues.

Physiotherapies and exercises which may be used by this office include:

1. Class IV Deep Tissue Laser
2. Infrared Light Therapy
3. Vibration Plate and/or Whole Body Vibration
4. Back on Trac (Low Back Decompression and/or Cervical Decompression)
5. Knee Trac (Knee Decompression)
6. EMS
7. Ultrasound
8. Rebuilder
9. Specialized Myoneural Therapy

Although these treatments are considered to be safe for neuromuscular problems, I realize that there are possible risks and complications associated with these procedures, as follows:

- **Soreness:** I am aware that, like exercise, it is common to experience muscle and/or joint soreness after the first few treatments.
- **Physiotherapy Burns:** Some of the therapies used in this office generate heat and may rarely cause a burn. Despite precautions, if a burn is obtained, there will be a temporary increase of pain and possible blistering.
- **Bruising:** Mild bruising may occur as a result of the soft tissue therapies.
- **Joint Injury:** I further understand that, in isolated cases, underlying physical defects, deformities, or pathologies, such as weak bones from osteoporosis, may render a patient susceptible to injury. When osteoporosis, degenerative disc(s), or any other abnormality is detected, this office will proceed with caution.

TREATMENT RESULTS

I also understand there are beneficial effects associated with these treatment procedures, including decreased pain and inflammation, increased circulation, and mobility. However, I appreciate that there is no certainty that I will achieve these benefits.

I have read, or have had read to me, the above explanation of soft tissue treatment. Any questions have been answered to my satisfaction. I made this decision freely and voluntarily.

Signature _____ Date _____