Mountain View Pain Center

To Improve Your Quality of Life

Patient Information

If Patient is under the age of 18 please fill out parent or guardian's information:

Parent or Guardian First Name:	Middle Initial:	Last Name:
Patient First Name:	Middle Initial:	Last Name:

Date of Birth:	Social Security Number:	Gender: ☐ Male ☐ Female	Referral Source:
Street Address:		Email Address:	
City:	State:	Zip:	

Home Phone:	Work Phone:	Cell Phone:
Emergency Contact:	Phone Number	Relationship:

Insurance

Will you be using Health Insurance to supplement Payment to our office? ☐ Yes ☐ NO

Health insurance plans are intended only to supplement out of pocket expenses for health care, please understand that your insurance may not cover all of the care you need. We will contact your insurance company to verify all of your insurance benefits and report the coverage back to you. Our primary relationship is with you, the patient, not the insurance company. Given that we accept your case, our recommendations will be based upon what your needs are and what we believe is best for you.

I understand and agree to the following:
There is no guarantee that my health insurance plan or policy will pay for all or part of my care. As the patient or guardian of a patient, I am ultimately responsible for all charges incurred from services rendered at Mountain View Pain Center LLC.

Patient's Signature (*or guardian's signature*):_____Date:_____

Consent to Treat

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy, massage therapy and diagnostic X-rays, on myself (or on the patient named below, for whom I am legally responsible) by the doctors of chiropractic and the staff of Mountain View Pain Center.

I've had an opportunity to discuss with the Doctor of Chiropractic or staff of Mountain View Pain Center the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure. Based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient's Signature (*or guardian's signature*):_____Date:_____

Consent To X-Ray

I hereby authorize Mountain View Pain Center LLC and whomever the clinician may designate as his assistant(s) to take x-rays of myself (or said minor)

* Must be completed for all females of childbearing age*

Onset Date of patient's last menstrual period (LMP):_____

I hereby release Mountain View Pain Center LLC from any and all liability. I hereby affirm that I am not pregnant nor am I attempting to get pregnant as of this date. I have been informed adequately of the potential effects of radiation on a developing fetus. If pregnancy test has been performed, I am also aware that this test is not 100% accurate and may yield false results.

Patient's Signature (*or guardian's signature*):_____Date:_____

Depending on your insurance additional charges may apply for X-Ray's

HIPPA *(Health Insurance Portability and Accountability Act)*

PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

1. The Practice's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out is health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.
2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
3. I understand that, and consent to, the following appointment reminders that will be used by the Practice: a) a postcard mailed to me at the address provided by me; and b) telephoning my home and leaving a message on my answering machine or with the individual answering the phone.
4. The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.
5. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.
6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.
7. I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.
8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.

Patient's Signature (*or guardian's signature*):_____Date:_____

Consent To Intramuscular Manual Therapy aka Functional Dry Needling (FDN)

1) IMT / TDN involves placing a small needle into the muscle at the trigger point which is typically in an area which the muscle is tight and may be tender with the intent of causing the muscle to contract and then release, improving the flexibility of the muscle and therefore decreasing the symptoms. The performing therapist will not stimulate any distal or auricular points during the dry needling treatment.

2) IMT / FDN is a valuable treatment for musculoskeletal related pain such as soft tissue and joint pain, as well as to increase muscle performance. Like any treatment there are possible complications. While these complications are rare in occurrence, it is recommended you read through the possible risks prior to giving consent to treatment. Risks of the procedure:

3) Though unlikely there are risks associated with this treatment. The most serious risk associated with TDN is accidental puncture of a lung (pneumothorax). If this were to occur, it may likely only require a chest x-ray and no further treatment as it can resolve on its own. The symptoms of pain and shortness of breath may last for several days to weeks. A more severe lung puncture can require hospitalization and re-inflation of the lung. This is a rare complication and in skilled hands should not be a concern. If you feel any related symptoms, immediately contact your IMT / TDN provider. If a pneumonia is suspected you should seek medical attention from your physician or if necessary go to the emergency room.

4) Other risks may include bruising, infection and nerve injury. Please notify your provider if you have any conditions that can be transferred by blood, require blood anticoagulants or any other conditions that may have an adverse effect to needle punctures. Bruising is a common occurrence and should not be a concern unless you are taking a blood thinner. As the needles are very small and do not have a cutting edge, the likelihood of any significant tissue trauma from IMT / TDN is unlikely. Please consult with your practitioner if you have any questions regarding the treatment above.

5) Do you have any known disease or infection that can be transmitted through bodily Fluids? ☐ Yes ☐ NO

Patient's Signature (*or guardian's signature*):_____Date:_____

Depending on your insurance additional charges may apply for Dry Needling

Mountain View Pain Center

To Improve Your Quality of Life

Medical History

Thank you for choosing the Mountain View Pain Center LLC. In our clinic we carefully examine all of the systems in your body so that we may gather all the information necessary in order to best address your healthcare and wellness. Please bear with us and all the paperwork we present to you. Please do not assume that any question is irrelevant or unimportant to your case, everything we ask here is highly relevant and extremely important! We need you to carefully and honestly answer every question so that we may piece together the best approach to managing your case.

1) Are you currently taking any medications (prescribed or over the counter), if so please list them and include dosage:

A) _____ B) _____ C) _____ D) _____

E) _____ F) _____ G) _____ H) _____

2) Are you currently taking any herbs or nutritional supplements, if so please list them:

A) _____ B) _____ C) _____ D) _____

3) Do you have any known allergies, if so please list them:

A) _____ B) _____ C) _____ D) _____

4) What is your primary complaint? _____

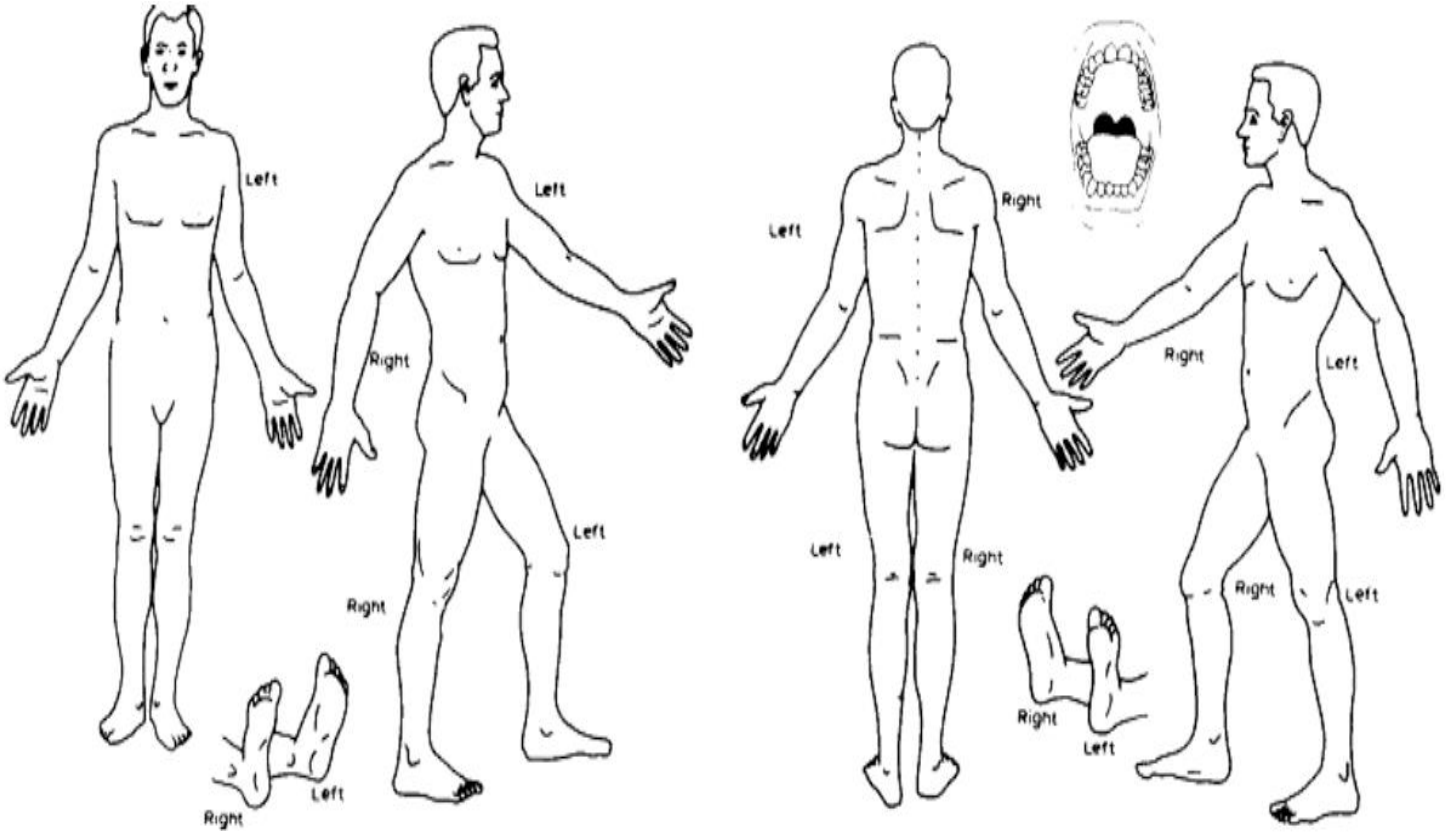
5) Is there pain associated with you complaint? ☐ Yes ☐ NO

A) What is your pain level from a scale of 0 - 10 (where 0 is no pain and 10 is worst possible pain)? _____

6) What do you think is causing your present health Problem(s)? _____

7) On the Diagram please mark the following symptoms, if you are experiencing them:

// = Stabbing Pain B = Burning Pain D = Dull Pain A = Aching Pain Sw = Swelling C = Cramps T = Tingling St = Stiffness N = Numbness



Medical History *(Cont.)*

8) Please list all operations or surgeries you hay have had:

9) Please List any Hospitalizations you may have had: _____

10) Please List Any and all traumas or injuries you've ever had: _____

11) Have you ever had a stroke or heart attack? ☐ NO ☐ YES _____

12) Do you use any tobacco products? ☐ NO ☐ YES _____

13) Have you had alcohol problems in the past? ☐ NO ☐ YES _____

14) Do you use recreational drugs? ☐ NO ☐ YES _____

15) Describe any other concerns or question in this space: _____

_____

_____

Review of Systems & Medical History

1) Are you currently experiencing any of the following symptoms, now or recently?

☐ Chest pain ☐ Shortness of breath ☐ Pale skin or pallor ☐ Swelling in your left/right arm ☐ Left / Right arm pain
☐ Jaw pain ☐ Blackouts ☐ Light headedness ☐ Sweating without exertion

2) Please check off any of the below symptoms that you are experiencing, now or recently?

☐ Nausea ☐ Vomiting ☐ Difficulty speaking ☐ Difficulty with swallowing ☐ Numbness
☐ Double vision ☐ Dizziness or vertigo ☐ Severe Headache ☐ Abnormal sweating

3) Have you noticed any of the following?

☐ Fever ☐ Change in appetite ☐ Unexplained weight gain or loss

4) Please mark any of the below conditions that apply to you, past or present:

☐ A cold, Date: _____
☐ Abdominal pain
☐ Abnormal movements
☐ Accidental fall
☐ Acne
☐ ADD or ADHD
☐ Adrenal disorder
☐ Alcoholism
☐ Allergies
☐ Anemia
☐ Anger easy
☐ Ankylosing spondylitis
☐ Anxiety
☐ Arm pain
☐ Arrhythmia
☐ Asperger's syndrome
☐ Asthma
☐ Atherosclerosis
☐ Autism (PDD or ASD)
☐ Auto accidents
☐ Autoimmune disease
☐ Awaken to urinate
☐ Double vision
☐ Dry skin
☐ Dyslexia
☐ Ear infections
☐ Balance problems
☐ Bedwetting
☐ Behavioral disorder
☐ Bladder infections
☐ Bleeding disorder
☐ Bleeding gums
☐ Bloating
☐ Blood clots / phlebitis
☐ Blood in stool
☐ Blood in urine
☐ Blurred vision
☐ Bone infection (osteomyelitis)
☐ Breast discharge
☐ Breast lumps / soreness
☐ Bronchitis
☐ Bruise easily
☐ Cancer
☐ Cataracts
☐ Celiac Disease (Sprue)
☐ Cervicogenic headaches
☐ Change in glove size
☐ Change in hair pattern
☐ Earaches
☐ Eating disorders
☐ Eczema
☐ Elbow pain
☐ Change in hat size
☐ Change in nails
☐ Change in skin color
☐ Change in skin mole
☐ Changes in skin sensation
☐ Chronic headaches
☐ Chronic/frequent cough
☐ Cirrhosis
☐ Cluster headaches
☐ Cold all the time
☐ Colon problems
☐ Concussions
☐ Conduct disorder
☐ Congestive heart failure
☐ Constipation
☐ Convulsions or epilepsy
☐ COPD
☐ Coston's syndrome
☐ Coughing up blood
☐ Coughing up mucus
☐ Craving excessive salts
☐ Craving sweets
☐ Emphysema
☐ Erectile dysfunction
☐ Excessive belching
☐ Excessive gas
☐ Crohn's disease
☐ Decreased energy
☐ Decreased sex drive
☐ Depression
☐ Dermatitis
☐ Diabetes
☐ Diarrhea
☐ Difficult with balance
☐ Difficulty breathing
☐ Difficulty losing weight
☐ Difficulty speaking
☐ Difficulty swallowing
☐ Difficulty urinating
☐ Difficulty walking
☐ Difficulty bowel movement
☐ Difficulty with focus
☐ Digestive issues
☐ Digestive problems
☐ Discharge from urethra
☐ Dislocated bones
☐ Diverticulitis
☐ Dizziness
☐ Excessive sweating
☐ Excessive thirst
☐ Experience passing out
☐ Fainting spells

Review of Systems & Medical History *(Cont.)*

- ☐ Feelings of hopelessness
- ☐ Feelings of suicide
- ☐ Urgency to urinate
- ☐ Foot or ankle pain
- ☐ Fractured bones
- ☐ Frequent colds or flues
- ☐ Frequent urination
- ☐ Gall bladder trouble
- ☐ Gastric ulcers
- ☐ Glaucoma
- ☐ Gonorrhea
- ☐ Gout
- ☐ Hand or wrist pain
- ☐ Head injury
- ☐ Head or arms feel tired
- ☐ Head seems heavy/tired
- ☐ Hearing loss
- ☐ Heart murmur
- ☐ Heart palpations
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Hepatitis
- ☐ Herniated disc
- ☐ Herpes
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Hip or pelvis pain
- ☐ HIV / AIDS
- ☐ Hoarseness
- ☐ Hormonal issues
- ☐ Hot all the time
- ☐ HPV / genital warts
- ☐ Hypertension headache
- ☐ Hypothyroidism
- ☐ Increased sex drive
- ☐ Indigestion
- ☐ Infrequent urination
- ☐ Intestinal issues
- ☐ Irregular heart beats
- ☐ Irritability
- ☐ Irritable bowel syndrome.
- ☐ Itching
- ☐ Jaw pain or click (TMJ)
- ☐ Kidney problems or disease
- ☐ Congenital heart disease
- ☐ Work or social stress
- ☐ Wheezing
- ☐ Weak muscles of face
- ☐ Warts
- ☐ Vertigo
- ☐ Venous insufficiency
- ☐ Vascular disease
- ☐ Varicose veins
- ☐ Vaginal discharge
- ☐ Upper back pain / stiffness
- ☐ Unsteadiness
- ☐ Unexplained skin rash
- ☐ Unexplained giddiness
- ☐ Under a lot of stress
- ☐ Ulcerative colitis
- ☐ Twitching muscles
- ☐ Trouble with walking
- ☐ Trouble with sleep
- ☐ Trouble sleeping
- ☐ Tremors (shaking)
- ☐ Tire easily
- ☐ Tinnitus
- ☐ Thyroid disorder
- ☐ The flu, Date:_____
- ☐ Tension headaches
- ☐ Temporal arteritis
- ☐ Syphilis
- ☐ Swollen or painful joints
- ☐ Swelling in legs or feet
- ☐ Stroke or CVA
- ☐ Stomach/duodenal ulcer
- ☐ Sprain or strain
- ☐ Sports injuries
- ☐ Spontaneous movement
- ☐ Sore throat
- ☐ Snoring
- ☐ Skipped heart beats
- ☐ Skin cancer
- ☐ Sinus problems
- ☐ Sinus headaches
- ☐ Shoulder pain
- ☐ Shortness of breath
- ☐ Short of breath at rest
- ☐ Shingles
- ☐ Seizures
- ☐ Seborrhea
- ☐ Scoliosis
- ☐ Scarlet fever
- ☐ Ringing in ears
- ☐ Rheumatoid arthritis
- ☐ Rheumatic fever
- ☐ Retinopathy
- ☐ Recent incoordination
- ☐ PTSD
- ☐ Psychological issues
- ☐ Psoriasis
- ☐ Prostate problems
- ☐ Premature ejaculation
- ☐ Polyps
- ☐ PMS problems
- ☐ Pituitary disorder
- ☐ Phobias
- ☐ Persistent headache
- ☐ Paralysis
- ☐ Panic attacks
- ☐ Painful urination
- ☐ Painful breathing
- ☐ Osteoporosis
- ☐ Numbness or tingling
- ☐ Nose bleeds
- ☐ Night sweats
- ☐ Neurological disease
- ☐ Nervousness
- ☐ Neck pain or stiffness
- ☐ Nausea &/or vomiting
- ☐ Muscle weakness
- ☐ Muscle problems
- ☐ Muscle cramping
- ☐ Mouth sores
- ☐ Motion sickness
- ☐ Mood changes
- ☐ Mini-stroke or TIA
- ☐ Migraines
- ☐ Mid back pain or stiffness
- ☐ Menstrual problems
- ☐ Menopause
- ☐ Macular degeneration
- ☐ Machine accident
- ☐ Lumbago or lumbago
- ☐ Low back pain or stiffness
- ☐ Lost muscle tone
- ☐ Loss of memory
- ☐ Loss of consciousness
- ☐ Losing time / blacking out
- ☐ Liver disease
- ☐ Leg pain with walking
- ☐ Leg pain
- ☐ Learning disability

This information is important in the doctor obtaining a clinical picture to make an appropriate diagnosis & treatment plan. Please sign below authorizing that the information in this form has been read and filled out completely & accurately to the best of your understanding. Also, understand that the information in this form is considered confidential and for use by your doctor at Mountain View Pain Center LLC. Any disclosure is outlined in our privacy policies.

Patient's Signature (*or guardian's signature*):_____Date:_____

Doctor's Notes: _____