Patient Demographics **Date** _____

First Name _____ **Middle Initial** ____ **Last Name** _____

Address _____

City _____ **State** _____ **Zip Code** _____

Home Phone (____) _____-_____ **Work Phone** (____) _____-_____

Cell Phone (____) _____-_____ **Email** _____

Date of Birth _____/_____/_____ **Sex:** ☐ Male ☐ Female

Social Security Number: _____-_____-_____ **Marital Status:** ☐ Single ☐ Married ☐ Widowed

Employment Status: ☐ Employed ☐ Unemployed ☐ FT Student ☐ PT Student ☐ Other_____

Spouse Information

First Name _____ **Middle Initial** _____ **Last Name** _____

Home Phone (____) _____-_____ **Work Phone** (____) _____-_____

Employer Information

Name _____

Your Occupation _____ **Your Job Description** _____

Address _____

City _____ **State** _____ **Zip Code** _____

Emergency Contact

Contact Name _____ **Relationship to Patient** _____

Contact Home Phone (____) _____-_____ **Cell Phone** (____) _____-_____

SMITH WELLNESS

Patient Name _____ **Date** _____

Referring Physician: _____

Referring Physician Number: _____

Primary Care Physician: _____

Do You Have an Attorney? __Yes __No

Name of Attorney if Yes: _____

Payment/Insurance Information:

Who is responsible for your bill? Self Health Insurance Spouse Worker's Comp
Auto Insur. Medicare Other _____

Personal Health Insurance Carrier: _____ Insur. Card ID # _____

Policy Holder's Name: _____ Group # _____

Policy Holder's Date of Birth _____ / _____ / _____ Primary Care Physician _____

Are your symptoms a result of: (If Yes please notify the receptionist) Motor Vehicle Accident
Work related Accident Other_____

Worker's Compensation Injury

Have you filed an injury report with your employer? **(If Yes please notify the receptionist)** Yes No
Date of injury: ____/____/____

SMITH WELLNESS

How did you hear about our office? _____

Medical Conditions: (Check all that apply to you)

☐ Arthritis	☐ Cancer	☐ Diabetes	☐ Heart Disease
☐ Hypertension	☐ Psychiatric Illness	☐ Skin Disorder	☐ Stroke
☐ Other _____			

Surgeries: (Check all that apply to you)

☐ Appendectomy	☐ Cardiovascular procedure	☐Cervical spine	☐ Hysterectomy
☐ Joint Replacement	☐ Prostate	☐ Lumbar spine	☐ Gall Bladder
☐ Brain	☐ Shoulder	☐ Thoracic spine	☐ Knee
☐ Carpal Tunnel	☐ Gastro-intestinal	☐ Uro-genital	☐ Hernia
☐ Other _____			

Allergies: (Check all that apply to you)

☐ Eggs	☐ Fish and Shellfish	☐ Milk or Lactose	☐ Peanuts
☐ Soy	☐ Sulfites	☐ Wheat/Glutens	☐ Other _____

Social History: (Check all that apply to you)

Caffeine use:	☐ occasional	☐ often	☐ never
Drink Alcohol:	☐ occasional	☐ often	☐ never
Exercise:	☐ occasional	☐ often	☐ never
Chew Tobacco:	☐ occasional	☐ often	☐ never
Cigarettes:	☐<1 pack/day	☐ >1 pack/day	☐ never
Wear Seat Belts:	☐ occasional	☐ always	☐ never

Other _____

Family History: (Check all that apply)

Arthritis:	☐ Parent	☐ Sibling
Cancer:	☐ Parent	☐ Sibling
Diabetes:	☐ Parent	☐ Sibling
Heart Disease	☐ Parent	☐ Sibling
Hypertension	☐ Parent	☐ Sibling
Stroke	☐ Parent	☐ Sibling
Thyroid	☐ Parent	☐ Sibling

Other _____

Occupational Activities: (Check one that best describes your job description)

☐ Administration	☐ Business Owner	☐ Clerical/Secretary	☐ Computer User
☐ Heavy Equipment operator	☐ Daycare/Childcare	☐ Construction	☐ Health Care
☐ Food Service Industry	☐ Medium Manual Labor	☐ Manufacturing	☐ Home Services
☐ Heavy Manual Labor	☐ Light Manual Labor	☐ Executive/Legal	☐ Housekeeper
☐ Other _____			

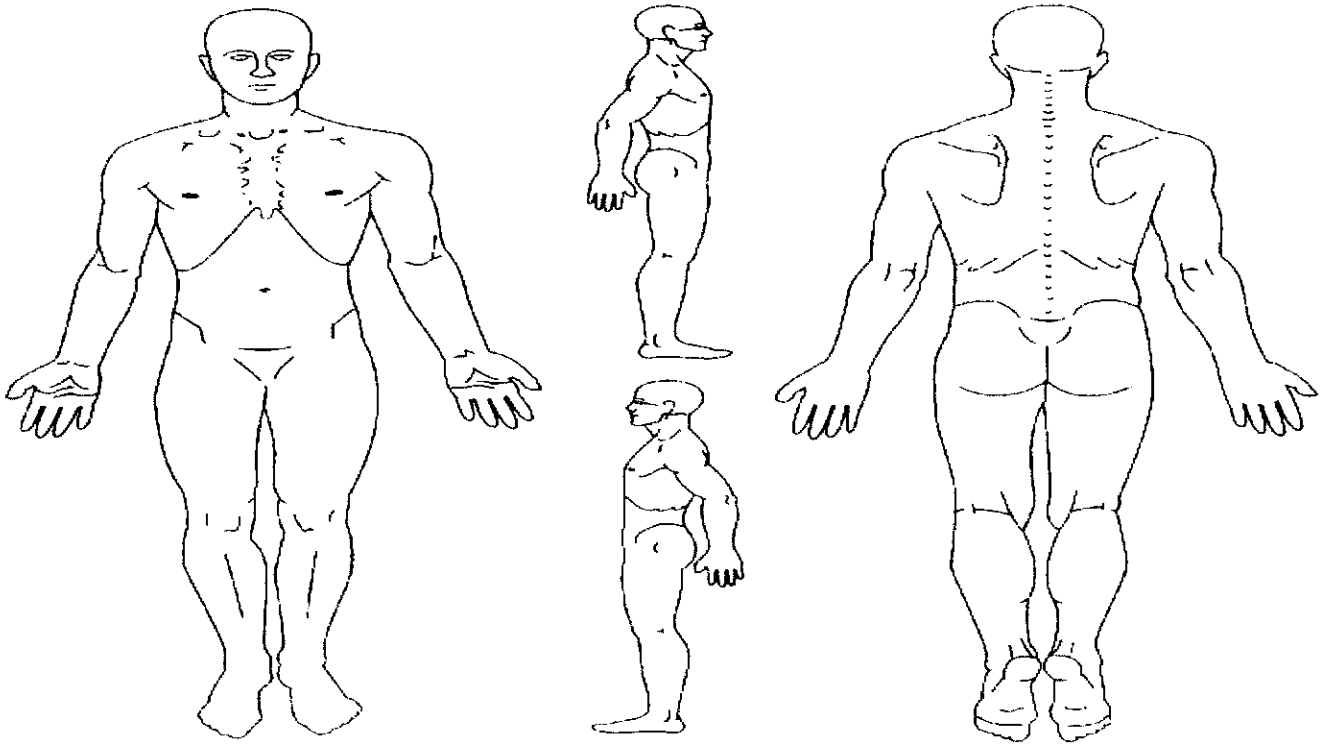
Doctor's Signature _____

SMITH WELLNESS

Patient Name _____ **Date** _____

By Using the key below, indicate on the body diagram where you are experiencing the following symptoms:

N=Numbness **B=Burning** **S=Stabbing** **T=Tingling** **A=Dull Ache**



On a scale of 1 to 10, with 10 being the most severe, how would you rate your current level of discomfort

None										Unbearable
0	1	2	3	4	5	6	7	8	9	10

Describe your symptoms in order of severity, with worse symptom being #1: _____

_____

_____

_____

When did your symptoms begin? **Month**_____ **Day**_____**Year** _____

How did your symptoms begin? _____

_____

How often do you experience your symptoms?

Constantly	Frequently	Occasionally	Intermittently
(76-100% of the day)	(51-75% of the day)	(26-50% of the day)	(0-25% of the day)

What describes the nature of your symptoms?

Sharp	Dull ache	Numb	Shooting
Burning	Tingling	Stabbing	Other _____

Please list any medications or supplements you are taking

Name: Dosage: Times a day:

_____

_____

_____

_____

_____

_____

_____

○ Attached Medication List

Family History

Mother	Living	Illness	Deceased
Father	Living	Illness	Deceased

SMITH WELLNESS

Woman's Health **Name:** **Date:**

Are you pregnant? _____Yes _____No

Are you nursing? _____Yes _____No

Are you taking birth control? _____Yes _____No

Do you experience painful periods? _____Yes _____No

Do you have irregular cycles? _____Yes _____No

Do you have breast implants? _____Yes _____No

Do you perform a regular self-breast examination? _____Yes _____No

Do you take Hormone Replacement Therapy? _____Yes _____No

Do you take oral contraceptives? _____Yes _____No

When was your last PAP/pelvic exam? _____Yes _____No

When was your last mammogram? _____

What was the date of your last menstrual period? (only answer if still menstruating) _____

SMITH WELLNESS

Men's Health **Name:** **Date:**

Do you have pain or a lump in your scrotum or testicles? ___Yes__No

Do you have an impaired libido (sex drive)? ___Yes__No

Do you have discharge from your penis? ___Yes__No

Do you have prostate issues? ___Yes__No

When was your last prostate exam?

___Within the past year
___Between 1-4 years
___Greater than 5 years
___Never had a prostate exam
___Prefers not to answer or don't know

When was your most recent PSA (Prostate-Specific Antigen) blood test?

___Within the past year r Between 1-4 years
___Greater than 5 years
___Never had a PSA blood test
___Prefers not to answer or don't know

What was your PSA (Prostate-Specific Antigen) level on your latest test?

___Normal__Low__Moderate__High
___Never had a PSA level done
___Prefers not to answer or don't know

Roland-Morris Low Back Pain and Disability Questionnaire (RMQ)

Instructions

Patient name:_____ File #:_____ Date:_____

Please read instructions: When your back hurts, you may find it difficult to do some of the things you normally do. Mark only the sentences that describe you today.

- ☐ I stay at home most of the time because of my back.
- ☐ I change position frequently to try to get my back comfortable.
- ☐ I walk more slowly than usual because of my back.
- ☐ Because of my back, I am not doing any jobs that I usually do around the house.
- ☐ Because of my back, I use a handrail to get upstairs.
- ☐ Because of my back, I lie down to rest more often.
- ☐ Because of my back, I have to hold on to something to get out of an easy chair.
- ☐ Because of my back, I try to get other people to do things for me.
- ☐ I get dressed more slowly than usual because of my back.
- ☐ I only stand up for short periods of time because of my back.
- ☐ Because of my back, I try not to bend or kneel down.
- ☐ I find it difficult to get out of a chair because of my back.
- ☐ My back is painful almost all of the time.
- ☐ I find it difficult to turn over in bed because of my back.
- ☐ My appetite is not very good because of my back.
- ☐ I have trouble putting on my socks (or stockings) because of the pain in my back.
- ☐ I can only walk short distances because of my back pain.
- ☐ I sleep less well because of my back.
- ☐ Because of my back pain, I get dressed with the help of someone else.
- ☐ I sit down for most of the day because of my back.
- ☐ I avoid heavy jobs around the house because of my back.
- ☐ Because of back pain, I am more irritable and bad tempered with people than usual.
- ☐ Because of my back, I go upstairs more slowly than usual.
- ☐ I stay in bed most of the time because of my back.

NECK DISABILITY INDEX

THIS QUESTIONNAIRE IS DESIGNED TO HELP US BETTER UNDERSTAND HOW YOUR NECK PAIN AFFECTS YOUR ABILITY TO MANAGE EVERYDAY -LIFE ACTIVITIES. PLEASE MARK IN EACH SECTION THE **ONE BOX** THAT APPLIES TO YOU. ALTHOUGH YOU MAY CONSIDER THAT TWO OF THE STATEMENTS IN ANY ONE SECTION RELATE TO YOU, PLEASE MARK THE BOX THAT **MOST CLOSELY** DESCRIBES YOUR PRESENT -DAY SITUATION.

SECTION 1 - PAIN INTENSITY

- ❑ I have no pain at the moment.
- ❑ The pain is very mild at the moment.
- ❑ The pain is moderate at the moment.
- ❑ The pain is fairly severe at the moment.
- ❑ The pain is very severe at the moment.
- ❑ The pain is the worst imaginable at the moment.

SECTION 2 - PERSONAL CARE

- ❑ I can look after myself normally without causing extra pain.
- ❑ I can look after myself normally, but it causes extra pain.
- ❑ It is painful to look after myself, and I am slow and careful.
- ❑ I need some help but manage most of my personal care.
- ❑ I need help every day in most aspects of self -care.
- ❑ I do not get dressed. I wash with difficulty and stay in bed.

SECTION 3 – LIFTING

- ❑ I can lift heavy weights without causing extra pain.
- ❑ I can lift heavy weights, but it gives me extra pain.
- ❑ Pain prevents me from lifting heavy weights off the floor but I can manage if items are conveniently positioned, ie. on a table.
- ❑ Pain prevents me from lifting heavy weights, but I can manage light weights if they are conveniently positioned.
- ❑ I can lift only very light weights.
- ❑ I cannot lift or carry anything at all.

SECTION 4 – WORK

- ❑ I can do as much work as I want.
- ❑ I can only do my usual work, but no more.
- ❑ I can do most of my usual work, but no more.
- ❑ I can't do my usual work.
- ❑ I can hardly do any work at all.
- ❑ I can't do any work at all.

SECTION 5 – HEADACHES

- ❑ I have no headaches at all.
- ❑ I have slight headaches that come infrequently.
- ❑ I have moderate headaches that come infrequently.
- ❑ I have moderate headaches that come frequently.
- ❑ I have severe headaches that come frequently.
- ❑ I have headaches almost all the time.

SECTION 6 – CONCENTRATION

- ❑ I can concentrate fully without difficulty.
- ❑ I can concentrate fully with slight difficulty.
- ❑ I have a fair degree of difficulty concentrating.
- ❑ I have a lot of difficulty concentrating.
- ❑ I have a great deal of difficulty concentrating.
- ❑ I can't concentrate at all.

SECTION 7 – SLEEPING

- ❑ I have no trouble sleeping.
- ❑ My sleep is slightly disturbed for less than 1 hour.
- ❑ My sleep is mildly disturbed for up to 1-2 hours.
- ❑ My sleep is moderately disturbed for up to 2-3 hours.
- ❑ My sleep is greatly disturbed for up to 3-5 hours.
- ❑ My sleep is completely disturbed for up to 5-7 hours.

SECTION 8 – DRIVING

- ❑ I can drive my car without neck pain.
- ❑ I can drive as long as I want with slight neck pain.
- ❑ I can drive as long as I want with moderate neck pain.
- ❑ I can't drive as long as I want because of moderate neck pain.
- ❑ I can hardly drive at all because of severe neck pain.
- ❑ I can't drive my care at all because of neck pain.

SECTION 9 – READING

- ❑ I can read as much as I want with no neck pain.
- ❑ I can read as much as I want with slight neck pain.
- ❑ I can read as much as I want with moderate neck pain.
- ❑ I can't read as much as I want because of moderate neck pain.
- ❑ I can't read as much as I want because of severe neck pain.
- ❑ I can't read at all.

SECTION 10 – RECREATION

- ❑ I have no neck pain during all recreational activities.
- ❑ I have some neck pain with all recreational activities.
- ❑ I have some neck pain with a few recreational activities.
- ❑ I have neck pain with most recreational activities.
- ❑ I can hardly do recreational activities due to neck pain.
- ❑ I can't do any recreational activities due to neck pain.

PATIENT NAME _____ **DATE** _____

SCORE _____ **[50]** **BENCHMARK -5 =** _____

SMITH WELLNESS

Massage Cancellation Policy

Smith Wellness is implementing a no-show or late cancellation fee for all cash massages. If you have not canceled or rescheduled your massage within a 24-hour time period of your scheduled appointment, you will be charged 30% of the scheduled service.

If you are receiving a medical massage and are more than 10 minutes late for your scheduled appointment we will have to reschedule.

This policy is in place to help assure staff and patients that slots are being scheduled appropriately. We thank you for your support and understanding.

_____ _____

Signature Date

SMITH WELLNESS

2415 S Telshor Blvd, Las Cruces NM 88011* Phone (575)288-1982 * Fax (575)377-8178

Financial Policy

- It is our office policy that, with limited exceptions described below, payment for services rendered is ultimately the responsibility of the patient, whether or not you have third party assistance with your financial obligation. We are happy to extend a payment plan to you so that you can follow through with all the care you may require.

Patients Without Insurance Who Are Not Covered by a Government Health Plan

- For patients who are not covered by insurance or a government health plan like Medicare or Medicaid, all patient fees are expected at the time of service or according to a preset payment plan or program. Personal balances may not exceed $150 unless on a pre-arranged payment plan. Payment plans are available to ensure you are able to receive all the care you may require.
- For your convenience, this office accepts cash, and the following credit cards:
Visa, MasterCard, American Express, Discover
- This office participates in a discount medical plan organization (DMPO) and offers discounted fees to uninsured, underinsured, or partially insured patients who are members. We will assist you in learning more about this should you wish to access these discounted fees.
- Any balance left unpaid after a period of 90 days will be assessed an interest charge of 1 percent per month.

Patients Who Have Health Insurance That is Not A Government Health Plan

- For patients who have health insurance and are not beneficiaries of a government health plan, as a courtesy to our patients, this office will bill third party payers, accept assignment, and wait to be paid for some portion of our patients' financial responsibility. Copayments or deductibles are due at the time of service or according to a present payment plan or program.
- The privilege of insurance assignment begins when our office receives and verifies your insurance information. Until that time, you are considered a "cash" patient and payment is expected at the time of service. As a courtesy to you, our office will pre-qualify your Insurance coverage, in an effort to help you determine what coverage is available to you under your policy. We will help you make the best estimate of your coverage for the recommended services. This service Is a courtesy to you and is not a guarantee of coverage.
- No one can predict what an Insurance company will pay for the usual and customary charges for services rendered. If we participate on your plan, you will not encounter balance billing above the stated fee schedule. If we do not participate, we will work with you to determine the amount of coverage and help estimate your responsibility.

SMITH WELLNESS

2415 S Telshor Blvd, Las Cruces NM 88011* Phone (575)288-1982 * Fax (575)377-8178

- If your insurance has not paid on an assigned bill within 60 days, you will be notified. Since we do not own your policy, we ask that you stay in communication with our office and take action with your insurance company at that time. If it remains unpaid within 60 days, the balance becomes due and payable Immediately and your assignment is revoked.
- All patients whose treatment visitation schedule is once per month or longer will no longer be eligible for insurance assignment as this level of care is rarely covered by insurance. Our office offers numerous payment options to allow you to continue maintenance, wellness, or supportive care.

Patients Who Are Beneficiaries of Government Health Plans (Medicare, Medicaid, Tricare, etc.)

- This office will bill your government health plan for services covered by the plan. Patients will be responsible for any co-insurance, co-payment, or deductible, which will be due at the time service is rendered. If you request a service that is never covered by your plan, you will be considered a "cash" patient and payment is expected at the time of service. We will advise you before the service is provided if your government health plan does not cover the service. If your plan requires it, we will give you written notice. If you request a service that is usually covered by your plan, but may not be covered this time, for example because there is a limit in your plan on the amount of treatments you may have in a given time period, the office will provide you with a written notice (sometimes called an Advance Beneficiary Notice of Noncoverage) advising you that your plan may not cover the service and listing the amount you will be required to pay if the plan does not cover the service. You may either sign the notice acknowledging responsibility for payment if your plan does not pay or decline the service. If you accept the services and your plan does not pay, the office will bill you for the services in the amount listed on the written notice.

All Patients

- Should you discontinue care for any reason, other than discharge by the doctor, any and all balances for which you are responsible will become due and payable at that time. If you are on a predetermined payment plan, that plan will continue to be in effect until your balance Is zero.

Signed: _____ Date: _____

Witness: _____ Date: _____

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Consent To Treat

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

I hereby request and consent to the performance of osteopathic and/or chiropractic manipulation and manual therapy techniques and other osteopathic and/or chiropractic procedures, including various modes of physical therapeutic modalities and procedures, where warranted, on me (or on the patient named below, for whom I am legally responsible) by the doctors of Osteopathic Medicine and Chiropractic, and/or other licensed doctors of Osteopathic Medicine and Chiropractic and Medical practitioners who now or in the future work at the clinic.

I have had an opportunity to discuss with the doctor of Chiropractic or doctor of Osteopathic Medicine the nature and purpose of osteopathic and/or 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 and Osteopathic Manipulative Medicine there are some risks to treatment and diagnostic services including but not limited to:

Manipulation: increased pain or discomfort, fractures, disc injuries, strokes, dislocations, and sprains.

Therapeutic Modalities and procedures: additional pain and discomfort. Endurance exercise may cause increased risk of acute Myocardial Infarction (heart attack) in patients with known or possible cardiac conditions.

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 procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest. The doctor has additionally explained the risks associated with my refusal of treatment.

I have read, or have had read to me, the above consent 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.

Smith Wellness may disclose any information regarding my health care to the following:

Name: _____ **Relationship:**_____ **Contact #:** _____

Name: _____ **Relationship:**_____ **Contact #:** _____

_____ _____ _____

Patient Signature Parent or Guardian Signature Date

SMITH WELLNESS

2415 S. Telshor Blvd. Las Cruces, NM 88011* Phone (575)288-1982 * Fax (575)377-8178

Notice of Patient Information Practices

Smith Wellness is required by law to protect the privacy of your PHI, provide this notice about our information practices and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION – Smith Wellness uses your PHI primarily for treatment; obtaining payment for treatment; conducting internal administrative actives and evaluating the quality of care that we provide. For example, Smith Wellness may use your PHI to provide appointment reminders, information about treatment alternatives, or other health related benefits that could be of interest.

Smith Wellness may also use or disclose your PHI without prior authorization for auditing purposes, for research studies and for emergencies. We also provide information when required by law.

In any other situation, Smith Wellness' policy is to obtain your written authorization before disclosing your PHI. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

Smith Wellness may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS – You have the right to review to obtain a copy of your PHI at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request of list of instances where we have disclosed your PHI for reasons other than treatment, payment or other related administrative purposes. You may also request in writing that we not use or disclose your PHI for treatment, payment and administrative purposes except when specifically authorized by you. When required by law or in emergency circumstances, Smith Wellness will consider all such requests on a case by case basis, but the practice is not legally required to accept those requests.

QUESTIONS AND CONCERNS – If you are concerned that Smith Wellness may have violated your privacy rights or if you disagree with any decision we have made regarding access or disclosure of your PHI, please contact our practice manager at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on Smith Wellness' health information practices or if you have a complaint, please contact our Office Manager at 2415 S Telshor Blvd, Las Cruces NM 88011. Phone (575)288-1982.

ACKNOWLEDGEMENT- I have read and fully understand Smith Wellness' Notice of Information Practices. I understand that Smith Wellness may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my PHI is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that Smith Wellness will consider requests for restriction on a case by case basis but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my PHI for purposes as noted in Smith Wellness' Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

Patient/Guardian Signature_____ Date _____

SMITH WELLNESS

Authorization to Release Medical Records

Today's Date _____

Patient (printed) Name _____ Date of Birth _____

I hereby authorize Smith Wellness to ☐ **OBTAIN** or ☐ **RELEASE** requested records from the following:

Doctor Name _____ **Practice Name** _____

Practice Address _____

City _____ **State** ____ **Zip** _____ **Phone Number** _____ **Fax Number** _____

Reason for Request: ☐Continued Care ☐ Insurance ☐ Legal Purposes ☐ Second Opinion ☐ Personal

Dates of Service Requested: _____ to _____

Information Requested: ☐ X-rays/MRI/CT ☐ Office Notes ☐ Entire Record

The individual signing this form agrees and acknowledges as follows:

Signature Authorization:

I have read this form and agree to the uses and disclosure of the information as described. I authorize Smith Wellness to release all health records necessary for my treatment and/or evaluation.

Patient or Parent/ Legal Guardian Signature _____ Date _____

SMITH WELLNESS
2415 S. Telshor Blvd
Las Cruces, N.M. 88011
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