DR. SCOTT SPENCER CCSP, CERT. MDT
205 W. Randolph, Ste 1205, Chicago, IL

CONFIDENTIAL REGISTRATION FORM

(Please Print)

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name: First: Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	Home phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

Chose clinic because/Referred to clinic by (please check one box):	❑ Dr.	❑ Insurance Plan	❑ Hospital

❑ Family	❑ Friend	❑ Close to home/work	❑ Internet

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance	❑ BCBS	❑ Cigna	❑ United Health	❑ PHCS	❑ Medicare

❑ Other	❑ Auto	❑ WC		

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	ID.:	Co-payment: $

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

I understand and authorize the staff to perform such services as deemed necessary by the physician to diagnose and treat my condition(s). Further, I authorize the assignment of my insurance rights and benefits directly to this provider and also authorize the release of such information as is needed to process insurance claims by provider or agent. I understand that I am responsible for all charges, which may include legal fees, collection fees or other expenses incurred by the provider in collecting my account. I hereby order all parties to accept a copy of this release and assignment in lieu of the original. This shall remain in effect until revoked by me in writing.

Patient/Guardian signature *Date*

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ABOUT YOUR CONDITION

In general, would you say your overall health right now is: Excellent / Very Good / Good / Fair / Poor

How would you describe your chief complaint at this time? _____

_____

How long have you had your symptoms? _____ **Are they changing?** Better / Worse / No change

Symptoms began due to? _____

Have you had these symptoms before? Yes / No **If so, how many episodes?** 1-5 6-10 11+

What makes your symptoms worse? _____

What makes your symptoms better? _____

How often do you experience your symptoms?

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

Average Pain Intensity	**None**										**Unbearable**
Last 24hrs	0	1	2	3	4	5	6	7	8	9	10
Past Week	0	1	2	3	4	5	6	7	8	9	10

How much have your symptoms interfered with your usual daily activities? (Both work and home life)

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

Previous Treatments: _____

Have you had special imaging for your symptoms? Yes No

If yes: Xray / MRI / CT / US / Other:_____ When:_____

Are your symptoms a result of an accident? Yes No

If Yes please explain: _____

SOCIAL HISTORY

Habits:

❑ Smoking ____pack(s) a day for ____ years

❑ Alcohol ____drinks per week

❑ Caffeine ____cups per day

❑ High stress _____

Exercise level within the last 6 months?

❑ None Type:_____

❑ 1-2 times per week

❑ 3-5 times per week

❑ Daily

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What is your activity level? (circle best)

1. Sedentary (Office worker getting little to no exercise)
2. Moderately Active (eg. Construction worker or person running one hour daily)
3. Vigorously Active (eg. Agricultural worker (non-mechanized) or person swimming two hours daily)
4. Extremely Active (Competitive athlete)

FAMILY HISTORY

Do any medical conditions run in your family? _____

_____

Have any relatives ever suffered a stroke? _____

PAST MEDICAL HISTORY

Please tell us about any hospitalizations / serious illness or surgeries:_____

_____

Please list any auto accidents or trauma (fractures / injuries / dislocations) _____

_____

Please list your prescribed medications, over the counter medications, herbs, vitamins

Name	Dosage	Reason

_____

_____

_____

_____

_____

Please provide details of any known allergies.

_____

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1. Patient specific functional scale:

We would like to know what 3 activities in your life you are unable to do or are having the most difficulty with as a result of your chief complaint. Please list your 3 activities on the left and rate them on the right.

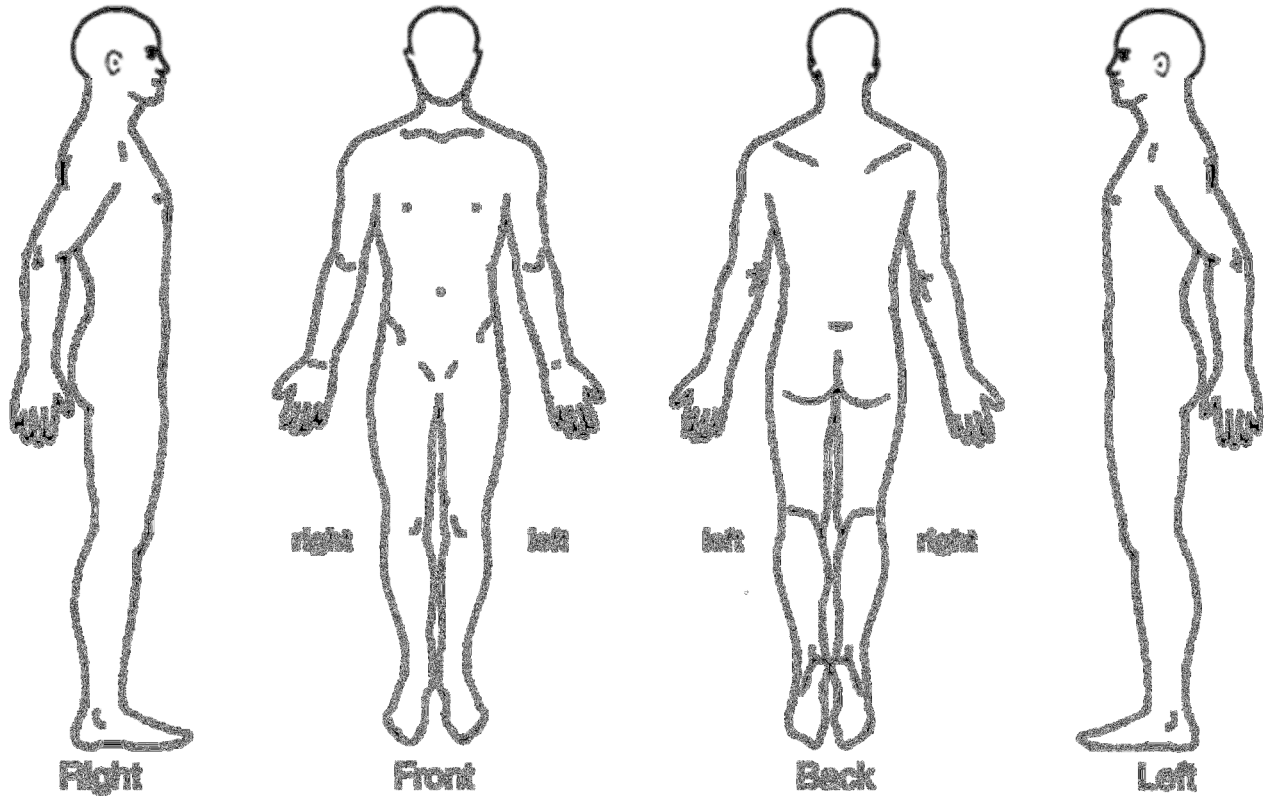
	Unable to perform activity										Able to perform with no problem
1._____	0	1	2	3	4	5	6	7	8	9	10
2._____	0	1	2	3	4	5	6	7	8	9	10
3._____	0	1	2	3	4	5	6	7	8	9	10

2. Pain Diagram:

please mark the areas on the picture below that correspond to the areas of your body where you feel the described sensations. Use appropriate symbols. Mark the areas of radiation (traveling pain).

Do not simply circle the area of involvement.

Numbness ----- Pins and Needles 00000 Burning xxxxxx Aching ***** Stabbing /////



3. Pain Scale:

Please indicate the average intensity of your symptoms.

None Unbearable

0

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Informed Consent to Physical Medicine, Joint Manipulation and Manual Therapy

Please read this entire document prior to signing. It is important that you understand the information it contains. Please feel free to ask question and to review any information if anything is unclear.

- **As part of the analysis, examination and treatment you are consenting to the following procedures.**

Spinal Manipulative Therapy	Muscle Strength Testing	Muscular Palpation
SASTM/Myofascial Release Therapy	Trigger Point Therapy	Massage Therapy
McKenzie Evaluation/Treatment	Extremity Joint Manipulation	Orthopedic Testing
Range of Motion/Neurological Testing	Electrical Stimulation Therapy	Kinesio Taping Therapy
Intersegmental Traction	Hot/Cold Packs	Postural Analysis
Stretching/Strengthening Exercises	Ultrasound Therapy	Vital Signs

- **The material risk inherent in Instrument-Assisted Soft Tissue Mobilization (SASTM)/Myofascial Release Therapy**

Instrument-Assisted Soft Tissue Mobilization is a soft tissue treatment method that utilizes instruments that enables clinicians to effectively detect and treat scar tissue and restrictions that affect normal function. You will often physically move the region of the body getting worked on through active ranges of motion. SASTM may be uncomfortable in some regions of the body (like the burn experienced while lifting weights) and may produce soreness and bruising post-treatment for up to 1-3 days.

- **The material risk inherent in McKenzie Mechanical Diagnosis and Therapy**

McKenzie Mechanical Diagnosis and Therapy is a diagnostic and therapeutic system used to identify and treat spinal and extremity conditions based on identifying the patient's initial baselines (symptoms, Mechanical and neurological deficits) and then introducing progressive and specific load to the area in question and observing any changes made to the initial baselines. Through observation and testing, reductive movement/load testing procedures patients may experience temporary stiffness and strain while performing some of the specific loading strategies that commonly last 10-15 minutes but can last up to 1-2 days.

- **The nature of spinal/extremity joint manipulation**

After full evaluation of your condition, the doctor may make the decision that manipulative therapy would be beneficial to assist your recovery. If joint manipulation is used, the doctor would use his hands in such a way as to move your joints to restore range of motion, proper function and reduce the perception of pain. You may feel click or pop, similar to someone cracking their knuckles, and you may feel movement of the joint.

- **The material risk inherent in joint manipulative therapy and ancillary procedures**

As with any health care procedure, there are certain complications which may arise following joint manipulation therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscular strain or cervical myelopathy. Some types of manipulation of the neck have been associated with injuries to the arteries of the neck leading to or contributing to serious complications including stroke. Some patients will feel some soreness and stiffness following the first twenty four to forty eight hours following their first and/or second treatment utilizing joint manipulation. Your doctor will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to his attention, it is your responsibility to inform him.

- **The probability of those risks occurring**

Fractures are rare occurrences and generally result from some underlying weakness of the bone which is checked for during the taking of your history and during examination and x-ray. Stroke has been a subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical manipulations. The other complications are also described as rare.

- **The availability and nature of the treatment options**

Other treatment options for your condition may include: Self-administered, over –the-counter analgesics and rest, Medical care a prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; Hospitalization or Surgery. If you choose to use one of the other treatment options, you should be aware that there are risks and benefits of such options and you may wish to discuss those with your primary care physician or specialist.

- **Procedures you would like excluded from you treatment**

If there are any procedures previously listed that you would explicitly request not to be employed in your treatment please list these below. We will gladly employ other treatment options in an attempt to reach the same results.

➢ THE RISK OF AND DANGERS OF REMAINING UNTREATED

Remaining untreated may allow the formation of adhesions and reduced mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

Patient Signature: Date: