Date _____

Personal History Form

The following is a confidential questionnaire which will help us determine the best possible course of treatment for you. Please take your time and complete the information accurately. Thank you!

Name _____ S.S.# _____

Address _____ City _____ State _____ Zip _____

Home phone _____ Business phone _____

Cell phone _____ e-mail address _____

Gender: Male Female Birth Date _____ Age _____

Employer _____ Occupation _____

Employment address _____

In case of emergency contact _____ Phone _____

Referred by _____ Have you ever been treated by a chiropractor before? Yes No

How would you describe your chief complaint at this time?

_____

_____

When did it start? _____
(Include month and year, day if known)

What makes the pain worse? _____

What makes the pain better? _____

How would you describe your pain? _____

At what time of the day or week is your pain worse? _____

The pain is: Intermittent Constant

Have you had this problem in the past? _____ If so, how often? _____

Is your pain the result of a motor vehicle accident? _____

Have you filed a legal suit? _____

Is your pain the result of a work related injury? _____

If so, have you filed a worker's compensation claim? _____

Please list accidents, injuries, surgeries, and hospitalizations you have had.

_____ Date or Age _____

_____ Date or Age _____

_____ Date or Age _____

Do you or other family members have a history of any of the following?

Arthritis	Self	Family member _____
Asthma	Self	Family member _____
Cancer	Self	Family member _____
Diabetes	Self	Family member _____
Heart Disease	Self	Family member _____
Hypertension	Self	Family member _____
Hypoglycemia	Self	Family member _____
Kidney Disease	Self	Family member _____
Depression	Self	Family member _____
Mental Illness	Self	Family member _____

Do you drink coffee or black tea? _____ If so, how much per day? _____

Do you smoke tobacco? _____ If so, how much per day? _____

Do you drink alcohol? _____ If so, how often? _____

What medications, vitamins, supplements, herbs do you take?

Name	**Reason**

Please list any allergies that you have.

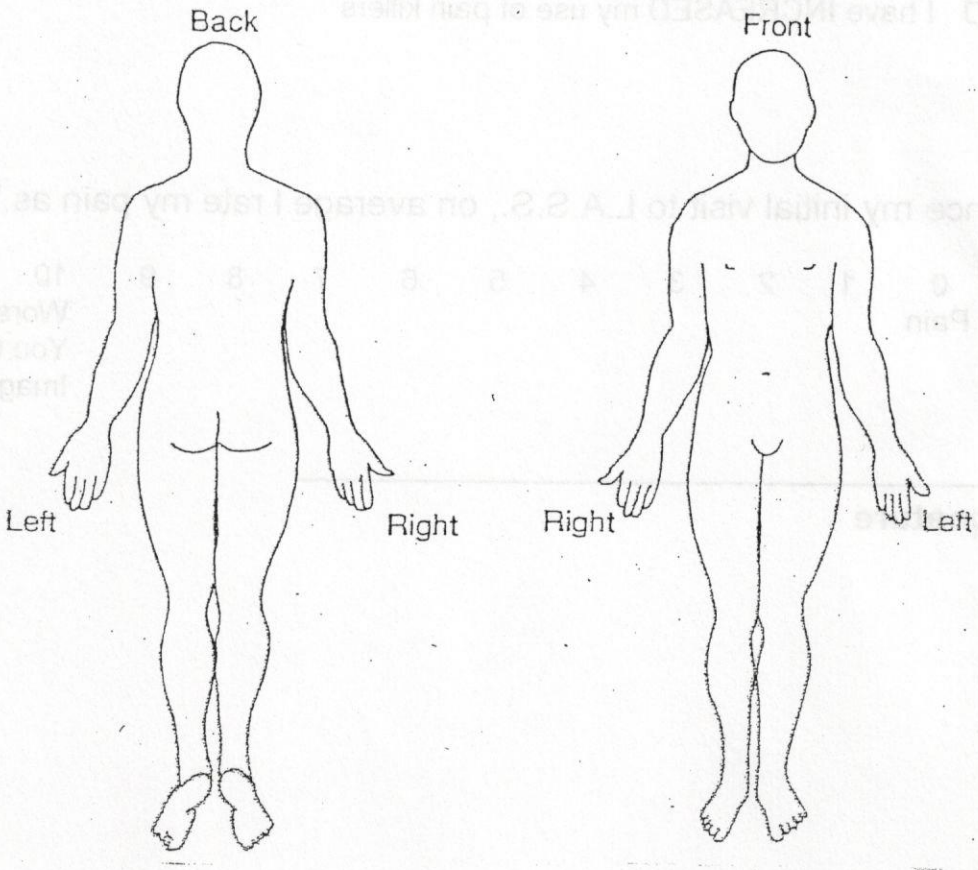
_____

Pain Drawing

Date: _____ Name: _____

Draw location of your pain on body outlines

Ache	Burning	Numbness	Pins and Needles	Stabbing	Other
ʌʌʌ	= = = =	ooo	.....	//////	XXXXX
ʌ	= = = =	oo	....	////	XXX



Name _____ Date_____

My Chief Complaint is _____ My Secondary Complaint is _____

When did it start _____ _____

I) CURRENT STATUS -

1. Since my most recent episode of pain, my overall status is:

□ Very Much (80%) better

□ Much (50%) better

□ Minimally (20%) better

□ No Change

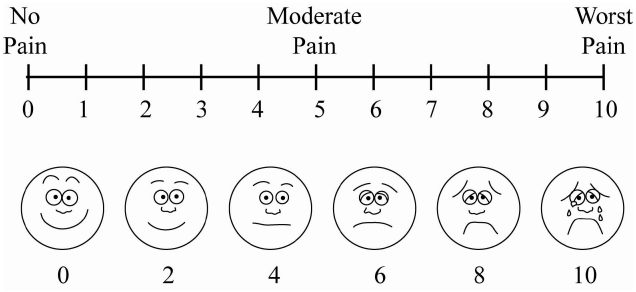
□ Minimally (20%) Worse

□ Much (50%) Worse

□ Very Much (80%) Worse

II) PAIN -

2. Please indicate your usual level of pain & worst pain during the past week:



No pain 0 1 2 3 4 5 6 7 8 9 10 Worst possible pain

3a. Are you taking any MEDICATION (PAIN KILLERS) for your symptoms? (pick ONE)

□ Never □ Rarely □ Sometimes □ Every day

SKIP 3b. if the answer to 3a. was Never

3b. If you are taking any MEDICATION (PAIN KILLERS) pick ONE:

□ I have ⬇️ them □ I am taking about the SAME amount □ I have ⬆️ them

4. If you had to spend the rest of your life with your <u>condition as it is right now</u>, how would you feel about it?

Delighted 0 1 2 3 4 5 6 7 8 9 10 Terrible

III) ACTIVITY TOLERANCE -

5. On a scale of 0 to 10, how certain (confident) are you that you will be doing normal activities or working in <u>six months</u>?

Very certain 0 1 2 3 4 5 6 7 8 9 10 Not certain at all

6. How confident are you that you are moving in the right direction?

Very confident 0 1 2 3 4 5 6 7 8 9 10 Not confident at all

7. Physical activity (in general) makes my pain worse?

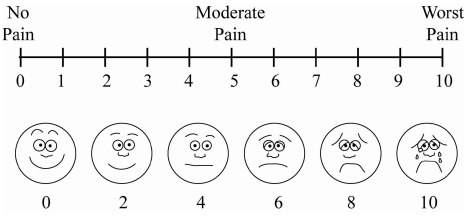
Completely disagree 0 1 2 3 4 5 6 7 8 9 10 Completely agree

8. What specific daily tasks give you the most problems, & rate the pain (0-10) of each?

1:_____ Pain:_____

2:_____ Pain:_____

3:_____ Pain:_____



IV) FITNESS -

9. List your 3 most strenuous weekly activities or workouts - time (min), level of exertion (RPE), frequency/week

Activity 1:_____

Avg. Duration of Activity:_____ Min.

RPE:_____Days/week _____

Activity 2:_____

Avg. Duration of Activity:_____ Min.

RPE:_____Days/week _____

Activity 3:_____

Avg. Duration of Activity:_____ Min.

RPE:_____Days/week _____

_____

Signature

LA Sports & Spine
10474 Santa Monica blvd. Suite 304
Los Angeles CA 90025

Financial Policy

Dear Valued Patient,

We recognize the need for a definite understanding between the patient and his/her doctor regarding financial arrangements for chiropractic care.

Please be aware that Dr. Liebenson is ***NOT*** an in-network provider for **ANY** insurance carrier, including Medicare. Payment in full is required at the time of service. We are required only to bill Medicare plans and they will send reimbursement directly to the beneficiary as well as forward the claim to your secondary. For a non-medicare insurance, a superbill will be provided upon request that you may submit to your insurance or medical savings plan for out-of-network reimbursement. Some insurance policies have a maximum on how many dollars they will reimburse for or limit the number of sessions they allow you to use. ***YOU are responsible for understanding your own coverage for non-network providers.***

At the time of your first visit we will take your credit card information for billing, which includes any broken appointments not canceled at least 24 hours in advance, excluding weekends (Monday appointments must be canceled by Friday by 5:00pm), and within business hours only. Certain things may not be covered by your reimbursement such as additional time spent during the appointment, supplies, and cancellation charges.

Any outstanding balances that are greater than 30 days past due will be charged interest of 1.5% per month (18% annual).

I have read and fully understand all of the above information and hereby agree to comply as outlined above.

_____ _____

Patient/responsible party signature Date

LA SPORTS & SPINE
10474 SM Blvd, # 304, LA, CA 90025

Credit Card Authorization Form

All information will remain confidential.

Cardholder Name:_____

Billing Address: _____

_____

Credit Card Type: _____ Visa _____ MasterCard ____ Discover

Credit Card Number: _____**exp**_____

Security Code: (3 digits): _____

Amount to Charge**: $450** (initial visit up to 90 mins) / **$180** (subsequent visits up to 45 mins, or broken appointments without 24 hr **business day** notice).

Initial consultation or follow-up visits that extend beyond the normal time are charged at a prorated amount of $50 per 15 minute increment.

I authorize __**L.A. Sports & Spine**__ to charge the agreed amount listed above to my credit card provided herein. I agree that I will pay for this purchase in accordance with the issuing bank cardholder agreement.

Cardholder – Print Name, Sign and Date Below:

Signed: _____

Dated: _____

Name: _____

Once signed, this authorization represents an acknowledgment of patient responsibility for the office charges listed above, for any missed or canceled appointments outside of the 24 hours notice policy. We reserve all rights to modify or waive this or any other fee when appropriate for any office visit, re-examination, broken appointments or discounts.

_____

Signature of responsible party

L.A. Sport & Spine
10474 Santa Monica Blvd. #304
Los Angeles, CA 90025
310-470-2909

Informed Consent

The determination of an appropriate plan of chiropractic/physical rehabilitation management for neuromusculoskeletal conditions may involve or include the utilization of orthopedic, neurological and physical performance testing and physical, manipulative and exercise/rehabilitative therapies. Should these procedures be deemed appropriate in your case, you will be evaluated by a doctor/therapist to determine if you have any conditions that indicate you should not engage in any particular test or therapeutic procedure.

I understand that, as with any form of physical activity or exercise, orthopedic, neurological, and physical performance testing and physical, manipulative and exercise/rehabilitative therapies carry with them a small inherent risk of injury which includes but is not limited to minor strains, inter vertebral disc compromise, and compression fractures. Additionally, as is the case with most health care interventions, there is a certain (albeit rare) inherent risk of complications associated with chiropractic and rehabilitative procedures. These complications include but are not limited to muscle strains, dislocations, skin irritations, costovertebral sprains, fractures, disc trauma, and cardiovascular accidents. I understand my doctor/therapist will not be able to anticipate all potential complications, but elect to rely on his/her clinical expertise and judgment to determine courses of clinical action, based upon known facts, which are considered to be in my best interest. I understand that results are not guaranteed and that I have the opportunity to discuss the purposes and risks associated with all recommended evaluation and treatment procedures at any time.

We may use your de-identified medical information for research purposes. I have read and understand the preceding statements and hereby consent to voluntarily participate I orthopedic, neurological and physical performance testing and physical, manipulative and exercise/rehabilitative therapies as deemed appropriate by my doctor/therapist. If at any time I decide that I am unwilling to engage in these procedures, I reserve the right to inform my doctor/therapist of such and not participate in these forms of evaluation or treatments.

Responsible Party's Signature_____Date_____

L.A. Sports & Spine
10474 Santa Monica blvd. #304
Los Angeles, CA 90025
310-470-2909

My signature acknowledges that I have read and agreed to the office policy for broken or missed appointments. We require at least 24 hours notice (Friday within business hours for a Monday appointment) for any appointment changes in days or time slot, and will charge $180 for each occurrence. Messages outside of business hours do not count for 24 hours notice, one day prior to appointment.

_____

NAME DATE

I have read these terms and understand my financial responsibility. I will receive a copy of this policy upon request.

Physical Activity Readiness
Questionnaire - PAR-Q
(revised 2002)

PAR-Q & YOU

(A Questionnaire for People Aged 15 to 69)

Regular physical activity is fun and healthy, and increasingly more people are starting to become more active every day. Being more active is very safe for most people. However, some people should check with their doctor before they start becoming much more physically active.

If you are planning to become much more physically active than you are now, start by answering the seven questions in the box below. If you are between the ages of 15 and 69, the PAR-Q will tell you if you should check with your doctor before you start. If you are over 69 years of age, and you are not used to being very active, check with your doctor.

Common sense is your best guide when you answer these questions. Please read the questions carefully and answer each one honestly: check YES or NO.

YES	NO		
☐	☐	1.	**Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor?**
☐	☐	2.	**Do you feel pain in your chest when you do physical activity?**
☐	☐	3.	**In the past month, have you had chest pain when you were not doing physical activity?**
☐	☐	4.	**Do you lose your balance because of dizziness or do you ever lose consciousness?**
☐	☐	5.	**Do you have a bone or joint problem (for example, back, knee or hip) that could be made worse by a change in your physical activity?**
☐	☐	6.	**Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heart condition?**
☐	☐	7.	**Do you know of any other reason why you should not do physical activity?**

If you answered YES to one or more questions

Talk with your doctor by phone or in person BEFORE you start becoming much more physically active or BEFORE you have a fitness appraisal. Tell your doctor about the PAR-Q and which questions you answered YES.

- You may be able to do any activity you want — as long as you start slowly and build up gradually. Or, you may need to restrict your activities to those which are safe for you. Talk with your doctor about the kinds of activities you wish to participate in and follow his/her advice.
- Find out which community programs are safe and helpful for you.

NO to all questions

If you answered NO honestly to all PAR-Q questions, you can be reasonably sure that you can:

- start becoming much more physically active – begin slowly and build up gradually. This is the safest and easiest way to go.
- take part in a fitness appraisal – this is an excellent way to determine your basic fitness so that you can plan the best way for you to live actively. It is also highly recommended that you have your blood pressure evaluated. If your reading is over 144/94, talk with your doctor before you start becoming much more physically active.

DELAY BECOMING MUCH MORE ACTIVE:

- if you are not feeling well because of a temporary illness such as a cold or a fever – wait until you feel better; or
- if you are or may be pregnant – talk to your doctor before you start becoming more active.

PLEASE NOTE: If your health changes so that you then answer YES to any of the above questions, tell your fitness or health professional. Ask whether you should change your physical activity plan.

Informed Use of the PAR-Q: The Canadian Society for Exercise Physiology, Health Canada, and their agents assume no liability for persons who undertake physical activity, and if in doubt after completing this questionnaire, consult your doctor prior to physical activity.

No changes permitted. You are encouraged to photocopy the PAR-Q but only if you use the entire form.

NOTE: If the PAR-Q is being given to a person before he or she participates in a physical activity program or a fitness appraisal, this section may be used for legal or administrative purposes.

"I have read, understood and completed this questionnaire. Any questions I had were answered to my full satisfaction."

NAME _____

SIGNATURE _____ DATE _____

SIGNATURE OF PARENT _____ WITNESS _____
or GUARDIAN (for participants under the age of majority)

Note: This physical activity clearance is valid for a maximum of 12 months from the date it is completed and becomes invalid if your condition changes so that you would answer YES to any of the seven questions.

Requests for correspondence or documentation $130-150

• Letter writing, treatment summaries or documentation beyond customary expectations may be requested.
• Adequate notice is required to allow time to prepare documents.

_____

Signature Date

Consent for Purposes of Treatment, Payment & Healthcare Operations (3/03)

In this document, "I" and "my" refer to the patient,
and "Chiropractor" refers to Dr. Craig Liebenson.

I consent to the use or disclosure of my protected health information by Chiropractor for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Chiropractor. I understand that analysis, diagnosis or treatment of me by Chiropractor may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Chiropractor is not required to agree to the restrictions that I may request. However, if Chiropractor agrees to a restriction that I request, the restriction is binding on Chiropractor. I have the right to revoke this consent, in writing, at any time, except to the extent that Chiropractor has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have been provided with the opportunity to read and or have a copy of the Notice of Privacy Practices of Chiropractor prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Chiropractor. The Notice of Privacy Practices for Chiropractor is also posted in the waiting room. This Notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information.

Chiropractor reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of Chiropractor and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____

Signature of Patient or Personal Representative Date

Acknowledgement of Receipt of Notice of Privacy Practices from LA Sports and Spine

LA Sports and Spine reserves the right to modify or change the privacy practices outlined in this notice.

I, _____ (name) acknowledge that I have received a copy of the notice of privacy practices from LA Sports and Spine.

_____ signature

_____ date