RUSSEAU | Team HealthCare Ltd.

ABOUT YOU:

Today's Date: ___/___/___*Name*: _____

How would you like to be addressed by our staff? _____

Current Address: _____City: _____State: _____Zip: _____

Permanent Address: _____City: _____State: _____Zip: _____
(If different from current address)

Home Phone #:(_____)_____-_____ Mobile Phone#:(_____)_____-_____ Daytime Phone#:(_____)_____-_____

Occupation:_____ Employer:_____

Referred by:_____ Your primary care (*medical physician*) is:_____

Phone # (physician)(_____)_____-_____ May we send a report to him/her about your examination and treatment? ☐Yes ☐No

Social Security #:_____-_____-_____ DOB:_____/_____/_____ Age:_____ Sex: ☐Male ☐Female

Hand Dominance: ☐Right ☐Left ☐Ambidextrous

Race: ☐ White/Caucasian ☐ Hispanic/Latino ☐ Black/African American
☐ Asian ☐ Hawaiian/Pacific Islander ☐ American Indian/Alaskan Native
☐ I prefer not to answer

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ I prefer not to answer

What is your complaint? _____

Is your complaint related to a car accident or work injury? ☐ Yes ☐ No **If yes, date of injury?** _____

PLEASE CHECK EITHER "NONE" OR "YES" IN THE SPACES PROVIDED BELOW:

Surgeries: ☐ **None** ☐ Yes – ***Please list on blank spaces below with approximate year (if known)***

Surgery	Year Performed	Surgery	Year Performed
Example: *Gall bladder removed*	1992		

Previous Illness or Diseases (i.e. Cancer): ☐ **None** ☐ Yes ***Please list with approximate year of diagnosis:***

Disease/Disorder	Year Diagnosed	Disease/Disorder	Year Diagnosed
Example. *Diabetes*	1992		

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Name: _____

Past/Present Injuries: ☐ None ☐ Yes *Please describe with approximate date* (may include injury for which you are here today)

Injury	Approx. Date	Injury	Approx. Date
Example: Car Accident	1980		

List below any FRACTURES, along with the date/year of the injury: ☐ None ☐ Yes

INJURY	DATE	INJURY	DATE

Past Treatments for ***current*** condition: ☐ NONE ☐ Chiropractic ☐ Physical Therapy ☐ Medications ☐ Acupuncture ☐ Massage ☐ Trigger Point Injections ☐ Epidural Injections ☐ Surgery ☐ Herbal or homeopathic remedies

Family History of Health Problems: Please indicate Paternal (Father's side) or Maternal (Mother's side)

Family Member	Maternal or Paternal	Disease *(and date or year of onset)*	Deceased?
Example: Grandpa	*Maternal*	*Prostate Cancer-1983*	*Yes*

Exercise:
☐ None ☐ Frequent & Heavy ☐ Occasional ☐ Infrequent
☐ Regular ☐ Avoid Due to Pain ☐ Stopped After Therapy
☐ Aerobic Activities ☐ Sports Activities

Work environment:
☐ Stressful ☐ Requires Constant sitting
☐ Requires constant standing
☐ Requires heavy typing or data entry ☐ Requires lifting
☐ Phone usage
☐ Use headset for phone

Family Status:
☐ Married ☐ Single ☐ Divorced ☐ Widowed
☐ Children - How many do you have?:_____
☐ Are you currently expecting? (Check for yes)

Substance Usage (check all that apply):
Tobacco: ☐ Never ☐ Lives with a former smoker ☐ Former Smoker/Time since quit:_____years
☐ Chews-Pouches per week_____ ☐ Cigarettes-Packs per day_____ ☐ Cigar-Amount per day_____
☐ Dips-Cans per week_____ ☐ Pipe-Pipefuls per day_____

Alcohol: ☐ None ☐ Social Drinker ☐ Rarely ☐ Moderately ☐ Lightly ☐ Heavily ☐ Frequently ☐ Recovering alcoholic

Please check the box/boxes below if you have experienced any of the following:

QUESTION	YES	QUESTION	YES	QUESTION	YES
Open sore that does not heal	☐	Headaches	☐	Ringing in the ears	☐
Difficulty swallowing	☐	Family history of stroke	☐	Loss of consciousness or momentary black	☐
Nagging hoarseness	☐	Pain wakes me from a deep sleep	☐	Temporary loss of understanding	☐
Vertigo, dizziness or lightheadedness	☐	Loss of bladder or bowel control	☐	Problems with balance, gait or coordination	☐
Night Sweats	☐	Loss of weight without trying	☐	Sensation problems – i.e. numbness	☐
Coughing up blood or noticing it in your stools	☐	Weakness or strength loss	☐	Problems or changes in vision	☐

Current Medications: ☐ **None** ***Please List (include dosage per day):*** _____
_____
_____
_____

Allergies: ☐ **None** ***Please List:*** _____
_____

Vaccinations: ☐ Received no immunizations/vaccinations ☐ Received typical childhood immunizations ☐ Unknown
If Over 65: Did you have a Pneumonia Shot? Date:_____

Women over 40: When was your last mammogram? Date:_____

DOCTOR NOTES:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

I understand the above information and guarantee this form was completed correctly to the best of my knowledge. I understand it is my responsibility to inform this office of any changes in my medical status. Medications and allergies will be noted in my records based on the information I have provided and specific brands or dosages will be estimated if not given. I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also understand that no guarantee or assurance has been made as to the results that may be obtained.

Signature of Patient (parent/guardian if minor)_____**Date**___/___/___

Print Name_____ ☐Keyed Initials_____

How would you like to receive your appointment reminders?
☐ Text (Mobile Service Provider: ☐AT&T ☐Cricket ☐Sprint ☐T-Mobile ☐US Cellular ☐Verizon ☐Virgin Mobile)
☐ E-mail Address *_____
☐ Phone Call
- ☐ Home
- ☐ Mobile
- ☐ Daytime

* If you supply us with your email address, you will receive an email notification of a care document being available to you. A care document includes some basic information from your exam. The email will include directions on how to access the document. If you would like a unique PIN number, please inform our front desk staff. If you do not want to receive these emails, please choose a method other than emails for your appointment reminders.

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PI History Form

Patient Name:_____ **Date:**_____

Date of Collision:_____/_____/_____

Were you the: ☐ Driver ☐ Front passenger
☐ Rear passenger - driver side ☐ Rear passenger – passenger side

Describe the collision:_____

_____

_____

Cost/estimate for repair of vehicle you were in: $_____

After impact, did your vehicle strike any object or vehicle as a result of the impact? ☐ Yes ☐ No

If so, please describe**:** _____

Description of the vehicle you were in at the time of the collision:
Year, make, and model:_____

Description of other vehicle:
Year, make and model:_____

At the time of the accident:

Yes	No	
☐	☐	Were you wearing a seatbelt?
☐	☐	Did the police come to the scene of the accident?
☐	☐	Did the police make a report?
☐	☐	Did the paramedics come to the scene of the accident?
☐	☐	Were you taken to a hospital via ambulance? If yes, which hospital? _____
☐	☐	Were you aware of the impending collision?
☐	☐	Did you lose consciousness? If yes, for how long? _____
☐	☐	Did the airbags deploy?
☐	☐	Did your body strike anything within the vehicle as a result of the collision?
☐	☐	Was the position of your body, torso, and head straight or turned at the time of impact?

If turned, please describe: _____

Have you lost any time at work as a result of the collision? ☐ Yes ☐ No
If yes, how many days have you missed: _____

Pain and Medical care:

When did you first begin to notice symptoms associated with the accident?
☐ Immediately ☐_____Hours after collision ☐_____Days after collision

If you went to the emergency room, please answer the following:

Yes	No	
☐	☐	Did you go via ambulance from the scene of the accident? If not, when did you go? _____
☐	☐	Was any diagnostic imaging performed (x-rays, MRI, CT scan)?
		If so, what body part: _____
☐	☐	Were you given medication at the hospital?
☐	☐	Was medication prescribed for home?
☐	☐	Did you have any cuts?
☐	☐	Did you require any stitches for cuts?

Patient Name: _____

Have you seen any other healthcare providers (other than the emergency room) concerning complaints related to this accident?

☐ **Yes** ☐ **No**

If yes, whom have you seen?

_____

_____

What treatment was provided/recommended?

_____

_____

If you did not see a doctor within the first week following your collision, why:

☐ No pain was noticed
☐ No transportation
☐ I thought the pain would go away
☐ I self-treated with over-the-counter medication
☐ No appointment available
☐ Work/home schedule conflicts
☐ I had no insurance or money
☐ I took a hot shower, used ice, heat
☐ Other: _____

_____

By signing this form I attest that the above provided information is true and accurate to the best of my knowledge.

X_____ _____

Signature Date

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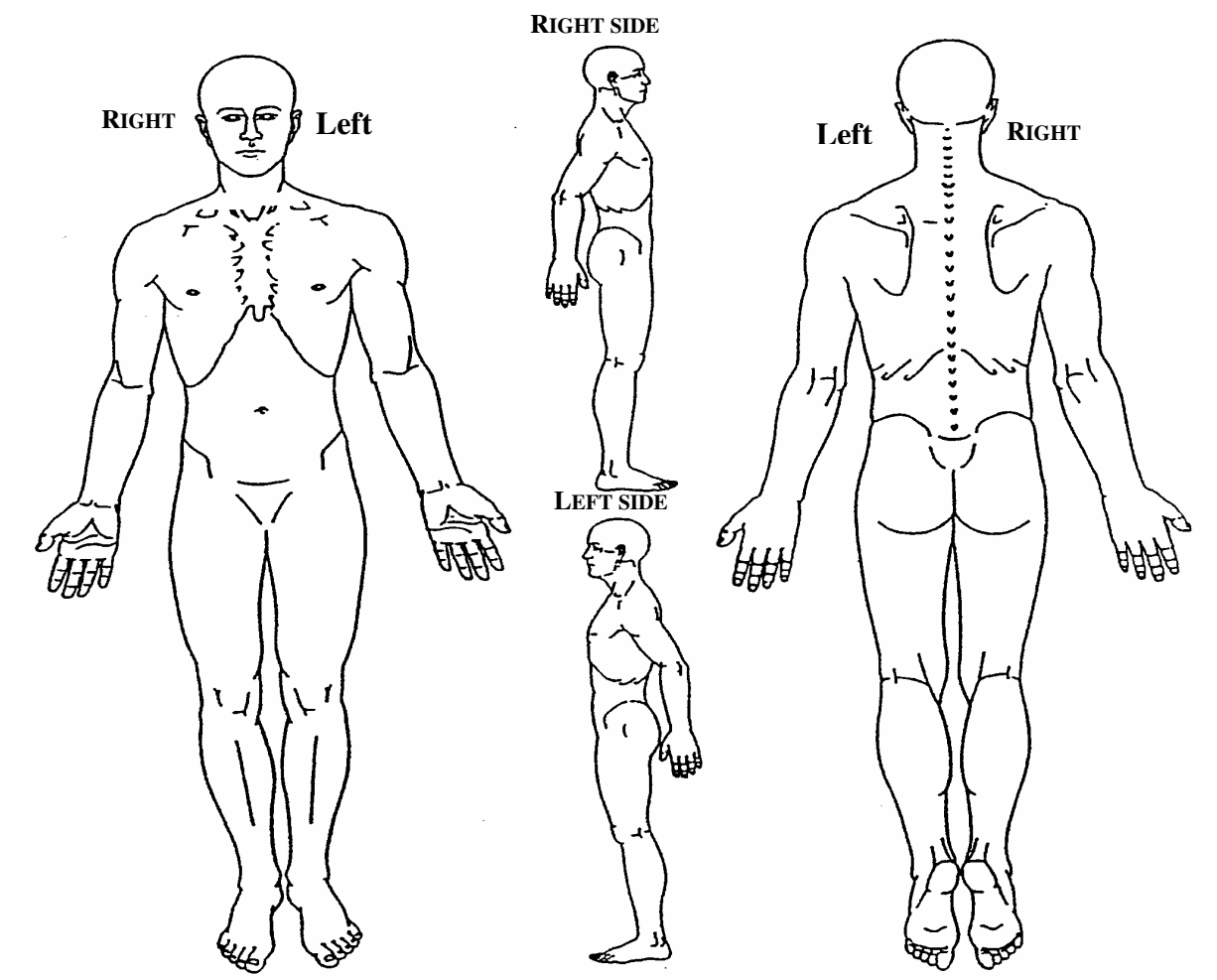
Patient Name _____

Instructions: Use the symbols in the "key" below to indicate the type and location of the discomfort AS IT FEELS TODAY. Place the letters on the part of the body that you feel the discomfort.

KEY

A = ACHE	**B = BURNING**	**C = STABBING**
N = NUMBING	**P = PINS & NEEDLES**	**O = OTHER**
S = SORE	**T = TIGHT**	**ST = STIFF**



Patient Signature _____Date_____

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Patient Name

_____

INSTRUCTIONS: **Please circle the number that best describes the question being asked. Please indicate your pain level right now, average pain, and pain at its best and worst.**

NOTE: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint.

EXAMPLE:

Headache Neck Low Back

No Pain _____ Worst Possible Pain

0 1 (2) 3 (4) 5 6 7 8 (9) 10

---

1 – What is your pain RIGHT NOW?

No Pain _____ Worst Possible Pain

0 1 2 3 4 5 6 7 8 9 10

---

2 – What is your TYPICAL or AVERAGE pain?

No Pain _____ Worst Possible Pain

0 1 2 3 4 5 6 7 8 9 10

---

3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best?)?

No Pain _____ Worst Possible Pain

0 1 2 3 4 5 6 7 8 9 10

---

4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst?)?

No Pain _____ Worst Possible Pain

0 1 2 3 4 5 6 7 8 9 10

OTHER COMMENTS:

Patient signature **Date**

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

Patient Name:_____ Date:_____

I have received a copy of the Russeau Team Healthcare, Ltd. Notice of Privacy Practices. I understand that Russeau Team Healthcare, Ltd. has the right to change its Notice of Privacy Practices from time to time and that I may contact Russeau Team Healthcare, Ltd. at any time to obtain a current copy of the Notice of Privacy Practices.

Please list any persons with whom we MAY share details about your healthcare, or check the box below.

☐ **I do not want my records shared with anyone else.**

Name	Relationship

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice to Russeau Team Healthcare, Ltd. I also understand that I will not be able to revoke this consent in cases where Russeau Team Healthcare, Ltd has already relied on it to use or disclose my health information. Written revocation of consent must be sent to Russeau Team Healthcare, Ltd.

Patient's Signature: _____ **Date:**_____

Legal Representative: _____ **Date:**_____

Relationship: _____

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