

Utah Sports and Wellness - Dr. Michael J. Cerami

1550 East 3300 South | Salt Lake City, UT 84106 | 801-486-1818

Medical History

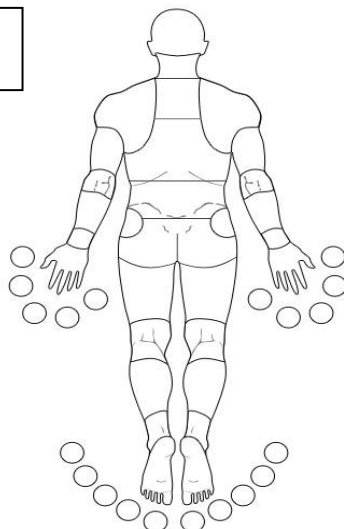
FOR YOUR FIRST APPOINTMENT: Please wear loose fitting clothes. If you have a shoulder injury, wear a tank top or sports bra. If a leg injury, please wear shorts. Bring all paperwork and arrive 10 minutes early.

Last Name:		First Name:	
Email:		Birth date:	Age: Sex:
Address:		City:	State & ZIP:
Best Phone #:	Alternative phone #:	Referred By:	
Occupation:	Employer:		
Have you received chiropractic care?		Date of last visit or examination:	
Name of Chiropractor:			
Your weight	Your shoe size	Height:	
WOMEN ONLY			
Is there ANY chance you might be pregnant?: <input type="checkbox"/> No <input type="checkbox"/> Yes		Are you on birth control?: <input type="checkbox"/> No <input type="checkbox"/> Yes	
What is (are) your specific concern(s)? : _____			

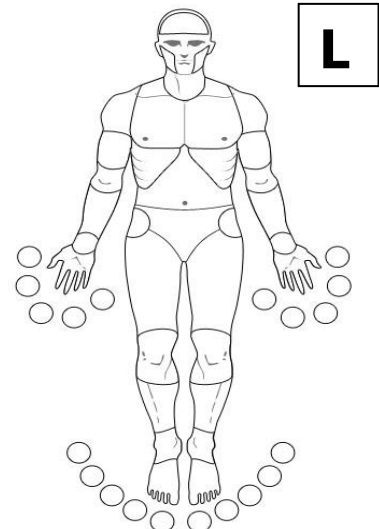
Did you sustain an injury? <input type="checkbox"/> No <input type="checkbox"/> Yes If so, when? _____			
During what activity? _____			
Date symptoms began: _____ Is condition Better: - AM/PM Worse - AM/PM			
Activities that make condition better: _____			
Activities that make condition worse: _____			

Please use these diagrams to mark the location of the pain you have.

L



R



L

How long do you expect the repair process to take?

Are you on a special diet? Yes No If requested, will you keep a 2 week food diary?: No Yes

Please circle your treatment goal (circle all that apply): RELIEF STABILIZATION CORRECTION MAINTENANCE

Once we get rid of your pain, would like us to give you rehab exercises and home care stretches?: YES NO

If yes, please circle which of the following you have access to (at home or your gym):

THERA-BANDS STABILITY BALL YOGA MAT FOAM ROLLER LIGHT WEIGHTS (1-10 LB DUMBBELLS) THE STICK

PATIENT CONDITION INFORMATION (limitations):

- | | | | |
|-----------------------------------|----------------------------------|-----------------------------------|--------------------------------------|
| <input type="checkbox"/> Bending | <input type="checkbox"/> Lifting | <input type="checkbox"/> Running | <input type="checkbox"/> Sitting |
| <input type="checkbox"/> Standing | <input type="checkbox"/> Stairs | <input type="checkbox"/> Walking | <input type="checkbox"/> Biking |
| <input type="checkbox"/> Swimming | <input type="checkbox"/> Driving | <input type="checkbox"/> Twisting | <input type="checkbox"/> Other _____ |

INTERFERES WITH:

- | | | | | |
|-------------------------------|----------------------------------|--------------------------------|-----------------------------------|----------------------------------|
| <input type="checkbox"/> Work | <input type="checkbox"/> Routine | <input type="checkbox"/> Sleep | <input type="checkbox"/> Exercise | <input type="checkbox"/> Lifting |
|-------------------------------|----------------------------------|--------------------------------|-----------------------------------|----------------------------------|

PRESENT/PAST MEDIAL HISTORY (please check all that apply):

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Prostate disease | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Cervical spine disorder |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Bowel disease | <input type="checkbox"/> Severe headaches | <input type="checkbox"/> Lumbar spine disorder |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Cancer (past or present) | <input type="checkbox"/> Tuberculosis/TB | <input type="checkbox"/> Muscle disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Anemia | <input type="checkbox"/> Mental health problem | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Blood clots/DVT | <input type="checkbox"/> Depression | <input type="checkbox"/> Chronic skin disease |
| <input type="checkbox"/> Stomach disease | <input type="checkbox"/> Bleeding tendency | <input type="checkbox"/> Stroke | <input type="checkbox"/> Nerve impairment |
| <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Bladder disease | <input type="checkbox"/> Seizures | <input type="checkbox"/> Other _____ |

PERTINENT FAMILY MEDICAL HISTORY (cancer, heart disease, hypertension, etc):

HOPITALIZATION and SURGERIES (last 10 years):

Approximate Date Purpose

CURRENT MEDICATION (includes non-prescription products)

<u>Drug</u>	<u>Dose</u>	<u>Frequency</u>	<u>Drug</u>	<u>Dose</u>	<u>Frequency</u>
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1. _____ 2. _____

3. _____ 4. _____

SPECIAL CONSIDERATIONS:

- | | |
|---|--|
| <input type="checkbox"/> Spinal fusion (neck, low back) | <input type="checkbox"/> Prefer "low-force" chiropractic adjustments |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Smoker ____ packs per day: _____ |
| <input type="checkbox"/> Attempted pregnancy | Other: _____ |
| <input type="checkbox"/> Substance abuse or addiction | Describe: _____ |

ACTIVITY LEVEL:

- | | | |
|--|---|--|
| <input type="checkbox"/> Competitive athlete | <input type="checkbox"/> Well-trained/frequent sports | <input type="checkbox"/> Occasional sports |
|--|---|--|

What would you like your physician to accomplish today? (Please check all that apply)

- | | | |
|---|--|---|
| <input type="checkbox"/> Chiropractic treatment | <input type="checkbox"/> Sports injury treatment | <input type="checkbox"/> Accurate diagnosis |
| <input type="checkbox"/> Nutrition plan | <input type="checkbox"/> Healthy exercise plan | <input type="checkbox"/> Other _____ |

Print Name: _____

Signature: _____

Date: _____



Terms of Acceptance

When a practice member seeks chiropractic health care, and when a chiropractor accepts a patient for such care, it is essential that they both are seeking and working for the same goals.

New patients, or as we call them, practice members; usually want to get rid of whatever ailments or conditions are bothering them. In our opinion, most symptoms are an extension or an effect of other underlying problems that may have been present "below the surface" for some time. Our work is designed to find these dysfunctional patterns and interferences and correct them as quickly as possible. One common type of distortion pattern is spinal stress: this interferes with the function of nerve pathway and can stretch, pull and twist the spinal cord and associated muscles and bony structures. Unless these and other patterns are corrected, the patient may never achieve long-standing balance and symmetry and therefore never get to the level of improvement they expect. This is an example of why we take care of the entire body and not just focus on the symptomatic presentation.

With bio-mechanical correction and restored muscle integrity proper energy flow and health usually improves. Sometimes the changes are slow or not present. Dr. Cerami cannot guarantee results in your case or in anyone's care. He will provide you options for treatment, let you decide how you would like to proceed and then give you his best advice and clinical care based on his experience and within his scope of practice.

Informed Consent Document

Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment

The primary treatment we use as a Doctor of Chiropractic is spinal manipulative therapy (SMT). We will use this procedure to treat you. We may use our hands or a mechanical instrument upon your body in such a way as you move your joints. That may cause an audible "pop" or "click", much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis/Examination/Treatment

As part of the analysis, examination, and treatment, you are consenting to the following procedures:

- | | | | |
|-------------------------------|-----------------------------|---------------------------|---------------------------|
| --Spinal manipulative therapy | --Palpation | --Vital Signs | --Range of motion testing |
| --Orthopedic testing | --Neurological testing | --Muscle strength testing | --Postural analysis |
| --EMS | --Radiographic studies | --Hot/cold therapy | --AMIT |
| --Stretching | --Massage therapy | --Exercise rehabilitation | --Microcurrent |
| --Low level laser therapy | --Hyperbaric Oxygen therapy | | |

The material risks inherent in chiropractic care

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and physiotherapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strains, ligament sprains, cervical myelopathy, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to complications including stroke (CVA). Some patients will feel some stiffness and soreness following the first few days of treatment. I 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 my attention, it is your responsibility to inform me.

The probability of those risks occurring

Statistically, Chiropractic Care has been demonstrated to be one of the safest of all healthcare practices. Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and examination. CVA has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in a million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options

Other treatment options for your condition may include:

- Self administered, over-the-counter (OTC) analgesics, ice, head or rest.
- Medical care and prescription drugs such as anti-inflammatories, muscle relaxants and pain killers.
- Hospitalization/Surgery

If you choose to use on of the above noted "other treatment" options, you should be aware that there are severe risks associated with these treatments. Many patients taking OTC NSAID's such as Ibuprofen and Acetaminophen are not aware that every year there are thousands of deaths associated with their use. No medicine should ever be taken without discussing their side effects and inherent statistical danger with their primary care physician or pharmacist. The PDR is also a good reference regarding pharmaceutical use.

Utah Sports and Wellness Mutual Agreement

- 1) Utah Sports and Wellness consists of, and is limited to, surveying the spine, body, and joints to identify any area of nerve energy distortion and muscle imbalance. Dr. Cerami uses his hands and other tools to correct these problems.
- 2) Utah Sports and Wellness specifically represents to the patient that we cannot guarantee that the services rendered can prevent or cure any illness, injury or disease.

Patient Consent and Authorization

ALL patients initial at 1, 2, 3 – IF necessary initial at 4 or 5

- 1. ___ (Initials) **Consent for Treatment:** I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such position.
- 2. ___ (Initials) **Resolution of Disputes:** In the rare circumstances that a dispute arises regarding any matter connected with this office, I agree that independent arbitration will be entered into and completed before any legal action can be taken. I further understand that if I am not satisfied with results of arbitration, I am free to pursue any other legal remedy at that time.
- 3. ___ (Initials) **(Female Patients Only) Verification on Non-Pregnancy:** By signing on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed, at this particular time.
- 4. ___ (Initials) **Permission to Evaluate and treat a Minor Child/Dependent Adult:** I authorize Dr. Cerami to evaluate and treat:

Office Financial Policy

Considerable care has been taken in setting our fees. We want to assure you that our charges accurately reflect the complexity and expertise required of the care rendered to you. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees bearing no relationship to the current standard of care in this area.

Our policy requires payment at time of service unless specified arrangements have been made in advance. You are financially responsible for services you receive; payment to our office is not contingent upon payment by your insurance company. If you wish to file your own insurance claims we will provide you with the necessary itemized statements to file for reimbursement.

New Patient Examinations: Are required by law for any patients new to our office in addition to any previous patients out of care for **more than three (3) years**. This procedure is necessitated for patient safety and legal reasons which hold the doctor accountable for recording and responding to any changes in the patient’s health.

Reactivation Examinations: Any patient who has been out of care for **more than 1 year** will require a brief exam before receiving additional care. This procedure is necessitated for patient safety and legal reasons which hold the doctor accountable for recording and responding to any changes in the patient’s health.

Missed Appointments: We charge **\$25 for ‘no-shows’ or missed appointments** cancelled with less than 24-hours’ notice from the scheduled visit. Additionally, AMIT visit(s) cancelled with less than 24 hours’ notice will incur **a 50% fee of the scheduled visit amount**. We reserve the right to determine when an appointment has been missed.

Scheduled Appointments: Please be on time for each appointment you book. If you are late you may be required to wait up to 30 minutes for the next available opening.

___ (Initials) **Office Visit Fees:** Office visits vary depending on the amount of clinical work that needs to be performed. **Regular visits are \$60. AMIT visits cost between \$165.00 and \$285.00** Extended office visits (new patient exams, reactivation exams, and private consultations) have separate fee schedules. **All charges are due at time of service. We do not carry any patient balances.**

___ (Initials) **Past Due Accounts:** A finance charge of 1.5% per month will be charged on the unpaid balances of past due accounts. In the event that this account is submitted to a collection agency, customer will pay all attorney fees, court costs, filing fees, and all collection costs.

___ (Initials) **Insurance:** Insurance companies, such as HMO’s, PPO’s and others, create their own guidelines and are not required to cover chiropractic or nutritional services. Your individual policy may cover all or none of our care as we are not affiliated with any insurance carriers and considered “out of network”. If chiropractic services are covered, the amount and type of reimbursement varies according to the policy that has been purchased by you or by your employer. There will a \$60.00 charge if any additional forms are required.

I have read the above, understand it completely, and agree to undertake care at Utah Sports and Wellness by its terms.

Name (Please Print): _____

Signature: _____

Date: _____

Parent/Guardian’s Signature (If patient is under 18 years old): _____