Korman Relief & Wellness Center
Laura R. Korman, DC, DACBN
16954 Toledo Blade Blvd.
Port Charlotte, Fl. 33954
Phone: (941) 629-6700, Fax: (941) 629-6805

PATIENT INFORMATION

Please print clearly:

Name_____ Date_____ SS#_____

Address_____ Unit #_____

City_____ State_____ Zip_____

Date of Birth _____ Age _____ Sex M / F Primary Language _____

Home Phone _____ Cell Phone _____

Work Phone _____ Email Address (print)_____

What is your preferred method of contact? _____

Emergency Contact _____ Relationship _____

Home Phone _____ Alternate Phone _____

Your Race (check all that apply) ____ White _____ American Indian or Alaskan Native _____ Asian

_____ Black or African American _____ Hispanic or Latino _____ Native Hawaiian or Other Pacific Islander

Marital Status Single / Married / Divorced / Separated / Widowed / Significant Other / Partner

Spouse / Partner Name _____

Currently living with Spouse / Alone / Other _____

Describe health of spouse Excellent / Very Good / Good / Fair / Poor / Other _____

Number of Children _____

Name of Child	**Age**	**Sex**	**Any physical condition / concern?**
_____	_____	M / F	_____
_____	_____	M / F	_____
_____	_____	M / F	_____
_____	_____	M / F	_____
_____	_____	M / F	_____

Your Occupation_____ Employer_____ Status_____

How, or by whom, were you referred to our office? _____

Patient / Guardian Signature _____ **Date** _____

PATIENT CONDITION

Overall health: (circle one) Excellent / Good / Poor / Other_____

Chief complaint / reason you are here (use separate sheet if more room is needed) _____

_____

_____

Cause of complaint or how complaint began_____

What type of pain are you experiencing? (Circle all that apply) Sharp / Burning / Dull / Tingling / Throbbing / Cramps

Numbness / Stiffness / Aching / Swelling / Shooting / Other _____

When did your symptoms first appear? _____

Is this condition getting progressively worse? Yes / No

How often do you have this pain / condition? _____

Is it constant, or does it come and go? _____

Does it interfere with (circle all that apply) Work / Sleep / Daily Routine / Recreation / Activities

Are any of these movements painful to perform? Sitting / Standing / Walking / Bending / Lying Down

Previous treatment for this complaint? _____

Are you currently under the care of a physician or other health professional? Yes / No

If "yes", please give name and date of last visit _____

Have you had Spinal X-rays, MRI, or CT Scan for your area(s) of complaint? Yes / No

List recent imaging or tests _____

At what facility was imaging / testing done? _____

Are you pregnant? Yes / No How many weeks? _____

Is this condition due to an accident? Yes / No If "yes", date of accident? _____/_____/_____

What type of accident did you have? Auto / Work Related / Home / Other _____

To whom have you reported the accident? Auto Insurance / Employer / Work Comp / Other

HEALTH HISTORY

Please check-mark below any health issues YOU currently have or have ever had, leaving blank if the condition does not apply to you.
If a condition applies to a family member, please indicate which family member using the following abbreviations:

M = Mother | **F** = Father | **S** = Sister | **B** = Brother | **MGM** = Maternal Grandmother

MGF = Maternal Grandfather | **PGM** = Paternal Grandmother | **PGF** = Paternal Grandfather

YOU			FAMILY	YOU			FAMILY
Past	**Present**	**Issue**		**Past**	**Present**	**Issue**	
_____	_____	Anemia	_____	_____	_____	High Blood Pressure	_____
_____	_____	Cancer	_____	_____	_____	High Cholesterol	_____
_____	_____	Diabetes	_____	_____	_____	Kidney Disease	_____
_____	_____	Heart Disease	_____	_____	_____	Stroke (date _____)	_____
_____	_____	Heart Failure	_____	_____	_____	Thyroid	_____
_____	_____	Rheumatoid Arthritis	_____				

Patient / Guardian Signature _____ **Date** _____

Korman Relief & Wellness Center

REVIEW OF SYSTEMS

Please circle "Yes" or "No" if you CURRENTLY have problems with the following. If yes, describe.

Y / N Skin _____
Y / N Ears / Nose / Throat _____
Y / N Cardiovascular_____
Y / N Gastrointestinal_____
Y / N Neurological_____
Y / N Psychiatric _____
Y / N Endocrine / Metabolic _____
Y / N Pacemaker _____
Y / N Musculoskeletal_____
Y / N Respiratory _____
Y / N Blood / Glands_____
Y / N Urinary _____
Y / N Reproductive _____
Y / N Eyes _____
Y / N Other _____

LIST ALL INJURIES **DATES**

_____ _____
_____ _____
_____ _____

LIST ALL SURGERIES **DATES**

_____ _____
_____ _____
_____ _____

LIST ALL HOSPITALIZATIONS **DATES**

_____ _____
_____ _____
_____ _____

LIST IMMUNIZATIONS **FLU SHOT? Y / N** **DATE** _____ **DATES**

_____ _____
_____ _____

CURRENT MEDICATIONS

MEDICATION **STRENGTH (MG, ML, ETC)** **TIMES PER DAY** **DATE BEGAN**

_____
_____
_____
_____
_____
_____

NUTRITIONAL SUPPLEMENTS (vitamins, calcium, fish oil, etc.)

_____
_____
_____

LIST ALLERGIES **ALLERGIC REACTION**

_____
_____
_____

Patient / Guardian Signature _____ **Date** _____

Korman Relief & Wellness Center

SOCIAL HISTORY

(Please circle all that apply to you)

Smoking - Never / Former / Current # Packs per day _____

Alcohol - None / Casual / Moderate / Heavy / Beer Only / Wine Only / # Drinks per week _____

Coffee / Caffeinated Drinks - None / Less than 3 drinks per day / 3-6 drinks per day / More than 6 per day

Drug Use - None / Recreational / Current or Former Addiction

Exercise - Never / Daily / Weekly / Walk only / Run / Swim

COMMUNICATION

I give permission for the following person(s) to discuss my health information with staff and physicians at Korman Relief & Wellness Center.

Name _____ Relationship _____

Name _____ Relationship _____

I give permission to be contacted by the following methods regarding messages, appointments, etc., for myself or my minor children.

(circle all that apply) Home Phone / Work Phone / Cell Phone / Email Address / Text Message

My email address at this time is (print) _____

I give permission to: (Check all that apply.)

_____ Leave messages on answering machine

_____ Leave messages with family member

INSURANCE

Name of Insurance Company _____

Authorization and Release: I authorize payment of insurance benefits, directly to Korman Relief & Wellness Center. I authorize the doctor to release all information necessary and to communicate with my personal physicians and other healthcare providers, and payers, and to secure the payment of benefits. I understand that I am responsible for all costs of care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this office to use their Patient Health Information for the purpose of treatment, payment, health care operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA notice that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

Patient's Signature_____ **Date**_____

Guardian's Signature Authorizing Care_____**Date**_____

Korman Relief & Wellness Center

Exam Form

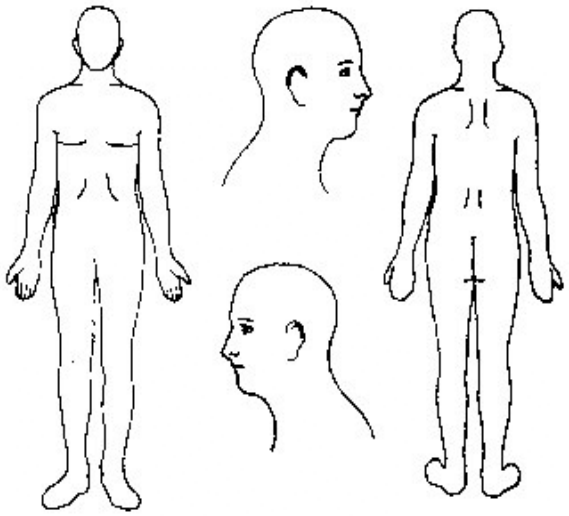
Date of Visit: ___/___/___ Patient: _____ Age: _____

What brought you here today?_____

_____

Place an "X" on the drawings below on areas causing you pain and include a letter (from box on right) describing the pain.

A = Ache
B = Burning
S = Stabbing
N = Numbness
P = Pins & Needles



PAIN SCALE

Please circle the number that best describes your pain.

0 1 2 3 4 5 6 7 8 9 10

NONE LITTLE MEDIUM SEVERE

Describe your past health history:

Prior Illness: _____

_____

Past Hospitalizations: _____

_____

Surgeries: _____

_____

Medications: _____

Patient Signature: X _____

PATIENT: DO NOT WRITE BELOW THIS LINE OR ON THE NEXT PAGE - PHYSICIAN USE ONLY

EXAMINATION

Range of Motion

Cervical	Normal		Pain
Flexion	50		
Extension	60		
Left Lat Flex	45		
Right Lat Flex	45		
Left Rotation	80		
Right Rotation	80		
Lumbar	**Normal**		**Pain**
Flexion	60		
Extension	25		
Left Lat Flex	25		
Right Lat Flex	25		
Left Rotation	30		
Right Rotation	30		

Health HX Notes:

_____

_____

_____

_____

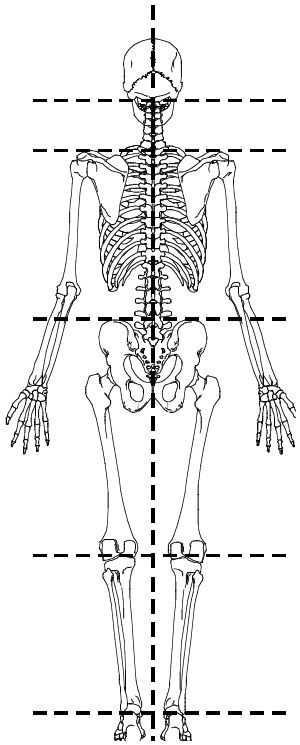
_____

_____

Asymmetry

C0
C1
C2
C3
C4
C5
C6
C7

L1
L2
L3
L4
L5
SAC
L-IL
R-IL

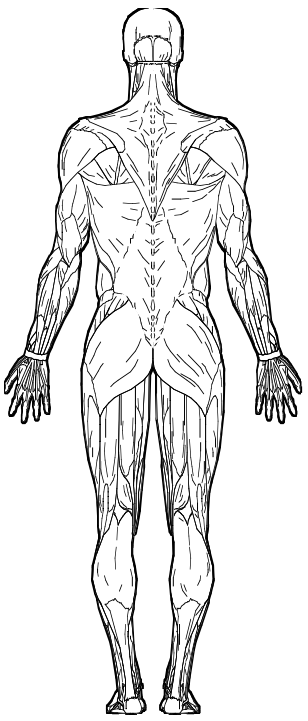


Using arrows (↑ ↓ → ←) mark the misaligned vertebrae

T1
T2
T3
T4
T5
T6
T7
T8
T9
T10
T11
T12

Using arrows (↑↓), mark postural asymmetry

Tissue



Mark tissue abnormalities
TP, LG, TN, SK, FS

TP=Trigger Points; LG=Ligaments (swollen or tender)
TN=Tendons; SK=Skin; FS=Fascial Restrictions

Korman Relief & Wellness Center **Patient Name** _____ **Date** _____

HISTORY OF PRESENT COMPLAINT

Complaint: _____

Qual & Chara: _____

On, Dur, Intens, Freq, Loc, Rad: _____

_____

_____

Better or worse: _____

_____

Prior TX, meds, other: _____

_____

EXAMINATION

Reflexes
(Wexler Scale)

Biceps ____
Triceps ____
Brac/rad____
Patella ____
Achilles ____

B/P: _____/_____ **L / R** **PULSE:** _____ **O2:** _____ **HT:** _____ **WT:** ____ **GRIP: (R)** ____ **(L)**___

Sensory: C5: _____ C6: _____ C7: _____ C8: _____ T1: _____
L3: _____ L4: _____ L5: _____ S1: _____

D= Deficit **N= Normal** **(R) or (L)**

General Orth/Neuro Examination:

Spinous Percus: _____ Valsalva: _____

Dejerine Triad: _____ Rhomberg: _____ **(+) or (-), (R) or (L)**

Notes: _____

Test	(+)	(-)	R	L	Indication
Distraction					nerve root compression
Jackson					nerve root compression
Max Cerv Rot Comp					nerve root compression
Cerv Comp					nerve root compression
Soto Hall					(cerv) (thor) vertebral trauma
Spurlings					nerve root irritation
Shoulder Depress					nerve root compression

Test	(+)	(-)	R	L	Indication
Libman's					(low) (normal) (high) pain threshold
Burn's Bench					(hysteria) (malingering)
Hoover's					(hysterical paralysis) (malingering)

Test	(+)	(-)	R	L	Indication
Bechterew					sciatic disc compression
Beevor's					abdominal muscle weakness
Minors Sign					radicular disc pain
Ely					upper lumbar lesion
Fajersztajn					intervertebral disc syndrome
Nachlas					upper lumbar lesion
Gluteal punch					spinal lesion
Goldthwaite					lumbar differentiation
Heel walk					5th lumbar motor deficit
Kemps					intervertebral disc rupture
Lasague					(muscle) (disc) (nerve) irritation
Braggards					lumbar antalgic spasm
Supported Adam's					lumbosacral differentiation

MUSCLE TESTS

Level	Muscle	Muscle Grade	
C5	Deltoids	L:	R:
C6	Biceps	L:	R:
	Wrist extensors	L:	R:
C7	Triceps	L:	R:
	Wrist flexors	L:	R:
	Finger extensors	L:	R:
C8	Finger flexors	L:	R:
T1	Finger abductors	L:	R:
L2-L3	Hip flexors	L:	R:
L4-L5	Hip extensors	L:	R:
L3-L4	Knee extensors	L:	R:
L5-S1	Knee flexors	L:	R:
L4-L5	Ankle extensors	L:	R:
S1-S2	Ankle flexors	L:	R:

TREATMENT PLAN

Initial TX on: ____ /___ /___

Level of Care: (include duration and frequency of visits)

_____

_____

_____

Specific Treatment Goals: _____

_____

Specific Objective Eval: _____

_____

_____

DIAGNOSIS: _____

_____

_____

Doctor Signature:_____ **Date:** ____ /___ /___

Korman Relief & Wellness Center
Laura R. Korman, DC, DACBN
16954 Toledo Blade Blvd.
Port Charlotte, FL 33954
941-629-6700

INFORMED CONSENT FOR THERAPY TREATMENT

Physicians and physical therapists who perform soft tissue therapies and spinal manipulations are required by law to obtain your informed consent before starting treatment.

I, _____, do hereby give my consent to the performance of conservative, non-invasive treatments to the joints and soft tissues. I understand that the procedures may consist of soft tissue and/or spinal manipulations involving movement of the joints and soft tissues.

Physiotherapies and exercises which may be used by this office include:

1. Class IV Deep Tissue Laser
2. Infrared Light Therapy
3. Vibration Plate and/or Whole Body Vibration
4. Back on Trac (Low Back Decompression and/or Cervical Decompression)
5. Knee Trac (Knee Decompression)
6. EMS
7. Ultrasound
8. Rebuilder
9. Specialized Myoneural Therapy

Although these treatments are considered to be safe for neuromuscular problems, I realize that there are possible risks and complications associated with these procedures, as follows:

- **Soreness:** I am aware that, like exercise, it is common to experience muscle and/or joint soreness after the first few treatments.
- **Physiotherapy Burns:** Some of the therapies used in this office generate heat and may rarely cause a burn. Despite precautions, if a burn is obtained, there will be a temporary increase of pain and possible blistering.
- **Bruising:** Mild bruising may occur as a result of the soft tissue therapies.
- **Joint Injury:** I further understand that, in isolated cases, underlying physical defects, deformities, or pathologies, such as weak bones from osteoporosis, may render a patient susceptible to injury. When osteoporosis, degenerative disc(s), or any other abnormality is detected, this office will proceed with caution.

TREATMENT RESULTS

I also understand there are beneficial effects associated with these treatment procedures, including decreased pain and inflammation, increased circulation, and mobility. However, I appreciate that there is no certainty that I will achieve these benefits.

I have read, or have had read to me, the above explanation of soft tissue treatment. Any questions have been answered to my satisfaction. I made this decision freely and voluntarily.

Signature_____ Date _____

Korman Relief and Wellness Center
Laura R. Korman, DC, DACBN
16954 Toledo Blade Blvd.
Port Charlotte, FL 33954
(941) 629-6700

OFFICE & PAYMENT POLICY INFORMATION

OUR GOAL:
We believe that a clear definition of our office policies will allow you, the patient, and us, the doctor, to concentrate on the big issue - REGAINING AND MAINTAINING YOUR HEALTH. It is the goal of this office to provide you with the finest quality healthcare available. If you have any questions regarding your healthcare, or any of our policies, please let us know. We welcome your referrals and look forward to a mutually rewarding doctor-patient relationship.

FINANCIAL POLICY:
Payments for Healthcare Services provided in this office are due the day that services are rendered, unless other arrangements have been made prior to seeing the doctor. Patients are personally responsible for all charges.

This office uses a collections service to collect on unpaid, past due charges. Past due accounts will receive a notice from our office before the account is sent to collections. Once sent to collections, there will be an assessed fee of $30 *minimum* added to the past due account. The account holder is responsible for total past due balance, in addition to the collections fees added.

INSURANCE POLICY:
I understand, and agree, that health and accident insurance policies are an arrangement between my insurance company and myself, and ***not*** between my insurance company and this office.

Assignment of Insurance benefits will be accepted upon proper verification of coverage and at the discretion of this office, however **benefits quoted are not a guarantee of payment.** Benefits are determined at the time of processing. In the event that an "Explanation of Benefits" comes back stating patient responsibility, the patient will be sent a bill.

This office does not file for, or accept assignment for, out-of-network or secondary insurance benefits. We will, however, provide you with documentation to assist you in collecting from your insurance carriers.

APPOINTMENT POLICY:
We want to thank you for choosing us as your healthcare provider. Please remember that we have reserved appointment times especially for you, and we attempt to honor all appointments at the scheduled time. Therefore, in the event you are unable to keep an appointment for any reason, we request that you call immediately to reschedule your visit. This will enable us to schedule other patients for that time.

When you cancel your appointment at the last minute, everyone loses - you, the doctor, and other patients who would like to have utilized your appointment time. ***In the event that you do not contact our office to cancel or reschedule your appointment, at least 2 hours prior to your scheduled time, you may be billed a $20 missed appointment fee. Failure to comply may result in dismissal of care.***

I have read and understand the above policies. Any questions I had have been answered to my satisfaction, and I understand my responsibility as a patient. I also understand that if my insurance does not respond within 90 days, or if I suspend or terminate my schedule of care as prescribed by Korman Relief & Wellness Center, all fees will be due and payable immediately.

Should there be any instance of a bounced or returned check, I acknowledge that I will be charged a fee of $36 **per bounced check.**

PATIENT SIGNATURE: _____ **DATE:**_____