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

Returning Established Patient Health Evaluation

Name ____ Birthdate ______/______/________ Sex M / F

Address ____ City ______________________

State ___________ Zip _______________ Primary Language ____

Email (print) ____ Home/Cell Phone ____________________

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

Name of Spouse, Significant Other or Partner ____

Occupation __________________________________ Employer ___________________________________

Current Status (Check one) ___ Employed ___ Unemployed ___ Retired ___ In School ___ Other ________

Work Phone __________________________________

How do you prefer we contact you? ____

Primary Care Physician ____ Phone ______________________

Insurance Provider ____________________________________ Subscriber I.D. _______________________

On a scale of 0-10, how intense is your pain TODAY?

0 1 2 3 4 5 6 7 8 9 10

No Pain Moderate Pain Unbearable Pain

How often are your symptoms present?

___ 0-25% ___ 26-50% ___ 51-75% ____76-100%

(Occasional) (Constant)

In the past week, how much has your pain interfered with your daily activities (work, social activities, or household chores)?

0 1 2 3 4 5 6 7 8 9 10

No Interference Unable to carry on any activities

Mark an "X" where symptoms are present

Date ____________

Korman Relief & Wellness Center

Returning Established Patient Health Evaluation

PATIENT CONDITION

Overall Health (Circle One) Excellent / Very Good / Good / Fair / Poor / Other ____________________

Chief Complaint / Reason you are here ____

____

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? ____

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

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

Patient Name ____ Date ___________

Korman Relief & Wellness Center

Returning Established Patient Health Evaluation

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

Please check below all that apply to your personal health.

- ☐ Recent Fever
- ☐ Corticosteroid Use (Cortisone, etc.)
- ☐ Birth Control Pills
- ☐ Dizziness / Fainting
- ☐ Visual Disturbances
- ☐ Numbness in Groin / Buttocks
- ☐ Prostate Problems
- ☐ Menstrual Problems
- ☐ Currently Pregnant, # Weeks ________________
- ☐ Abnormal Weight Gain
- ☐ Abnormal Weight Loss
- ☐ Marked Morning Pain / Stiffness
- ☐ Pain Unrelieved by Position or Rest
- ☐ Pain at Night
- ☐ Osteoporosis
- ☐ Epilepsy/Seizures
- ☐ Other Health Problem ______________________

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 __________________________________

Patient Name ____ Date ______________________

Korman Relief & Wellness Center

Returning Established Patient Health Evaluation

LIST ALL INJURIES **DATES**

______________________________________ ______________

______________________________________ ______________

______________________________________ ______________

LIST ALL SURGERIES **DATES**

______________________________________ ______________

______________________________________ ______________

______________________________________ ______________

LIST ALL HOSPITALIZATIONS **DATES**

______________________________________ ______________

______________________________________ ______________

______________________________________ ______________

LIST IMMUNIZATIONS **FLU SHOT?** ______________ **DATES**

______________________________________ ______________

______________________________________ ______________

CURRENT MEDICATIONS

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

LIST ANY SUPPLEMENTS, VITAMINS, ETC.

____

____

____

LIST ALLERGIES **ALLERGIC REACTION**

____

____

____

I certify, to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this practitioner, I understand that I am liable for all charges for services rendered, and I agree to notify this practitioner immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my chiropractor may need to contact my physician if my condition needs to be co-managed. Therefore, I give authorization to my chiropractor to contact my physician if necessary.

Patient 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:**______________

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 ______________________