SKYLIMIT

New Patient Questionnaire

SECTION I **PATIENT INFORMATION** **DATE**_____

Name:_____ **I prefer to be called:** _____

"X" Appropriate Boxes: ☐Male ☐Female ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Address:_____ **#**_____ **City:**_____ **State:**_____ **Zip**_____

Phone (_____)_____ **Work Phone** (_____) _____ **Cell Phone** (_____)_____

The best time to contact me is:_____ ☐ A.M. ☐ P.M. On my ☐ Home phone ☐ Work phone ☐ Cell phone

Date of Birth:_____ **Age**_____ **Social Security Number:**_____-_____-_____

If Student, Name of School_____ **City/State**_____ ☐ FT ☐ PT

Spouse or Parent's Name:_____**Employer**_____ **Work Phone**_____

Whom may we thank for referring you? _____

If you were not referred, how did you hear about us?_____

Person to contact in case of emergency_____ **Phone**_____

Name of local primary physician_____**May we contact them?**_____

Email Address_____**May we contact you via email?** ☐ Yes ☐ No

MOBILE PROVIDER_____ **We will use this information to send you automatic text appointment reminders.**

**We will not sell or distribute your email address to any 3rd parties. Email address is used for newsletter and patient communication regarding special events and announcements.

TELL US ABOUT YOUR PAST HEALTH:

Y	N	Lower Back Pain	Y	N	Diabetes (A1C=_____)	Y	N	High Cholesterol
Y	N	Leg/Foot Pain/Numbness	Y	N	Hand Problems	Y	N	Shingles
Y	N	Prior Spinal Surgeries	Y	N	Neuropathy	Y	N	Knee Surgery
Y	N	Spinal Fractures	Y	N	Heart Attack	Y	N	Kidney Issues/Dialysis
Y	N	Spinal Stenosis	Y	N	Heart Problems	Y	N	Gout
Y	N	Spinal Arthritis	Y	N	High/Low Blood Pressure	Y	N	Hip Surgery
Y	N	Sciatica	Y	N	Vascular Leg Problems	Y	N	Leg Fractures
Y	N	Neck Pain	Y	N	Vascular Surgery _____	Y	N	Joint Replacement
Y	N	Herniated Disc	Y	N	Stroke	Y	N	Foot Surgery

SECTION III CURRENT/CHIEF COMPLAINT(S)

Main Complaint_____ **Location:** ☐Left ☐Right ☐Middle

How long? ☐____Days ☐____Weeks ☐____Months ☐____Years

How often? ☐Constant ☐Frequent ☐Intermittent ☐Occasional

What do you think may have caused this problem? _____

If auto accident – Date of Accident_____

SECTION III continued

Does the pain radiate? ☐Yes ☐No **If yes, where?** _____

Associated Symptoms? ☐Inflexibility ☐Stiffness ☐Spasms ☐Cramps ☐Other_____

DESCRIBE THE PAIN/SYMPTOMS ("X" ALL THAT APPLY)?

☐Dull	☐Sharp	☐Numb	☐Weak	☐Prickly
☐Aching	☐Crawling	☐Itching	☐Tingling	☐Shooting
☐Stinging	☐Stabbing	☐Hurting	☐Burning	☐Throbbing
☐Pounding	☐Pulsating	☐Deadness	☐Excruciating	☐Pins & Needles

☐Other_____

WHAT AGGRAVATES THE PAIN/SYMPTOMS?

☐Flashing lights	☐Coughing	☐Sneezing	☐Standing	☐Sitting
☐Getting up	☐Carrying	☐Pushing	☐Pulling	☐Depression
☐Straining at BM	☐Lifting	☐Stooping	☐Stress	☐Emotional upset
☐Climbing stairs	☐Exercising	☐Looking side/side	☐Driving	☐Walking
☐Walking uphill/downhill	☐Looking up/down	☐Repetitive movement	☐Getting in/out of car	☐Anger

☐Other_____

WHAT RELIEVES THE PAIN/SYMPTOMS?

☐Resting	☐Shower	☐Sleeping	☐Sitting	☐Standing
☐Lifting	☐Stooping	☐Exercising	☐Turning head	☐Looking up/down
☐Tylenol	☐Advil	☐Aspirin	☐Icy Hot	☐Lying Down
☐Fetal position	☐Bending forward	☐Leaning backward		

☐Other_____

HAVE YOU SEEN ANYONE ELSE FOR THIS CONDITION? ☐Yes ☐No

IF YES, WHOM? _____ **WHEN?**_____

How would you describe your average back/leg pain over the past week?

No Pain _____ Worst possible pain

0 1 2 3 4 5 6 7 8 9 10

Please indicate what you consider to be an acceptable level of pain after completion of the treatment, if you have to accept some pain?

No Pain Worst possible pain

0 1 2 3 4 5 6 7 8 9 10

SECTION IV HEALTH HISTORY

Please "X" All That Apply – Past or Present

☐AIDS/HIV	☐Allergy Shots	☐Anemia	☐Anorexia	☐Appendicitis	☐Arthritis	☐Asthma
☐Bleeding	☐Breast Lump	☐Bronchitis	☐Bulimia	☐Cancer	☐Cataracts	☐Chicken Pox
☐Depression	☐Diabetes	☐Emphysema	☐Epilepsy	☐Fibromyalgia	☐Fractures	☐Glaucoma
☐Goiter	☐Gonorrhea	☐Gout	☐Heart Disease	☐Hepatitis	☐Hernia	☐Herniated Disc
☐Herpes	☐High Cholesterol	☐Kidney Disease	☐ Liver Disease	☐Measles	☐Migraines	☐Miscarriage
☐Mono	☐M.S.	☐Mumps	☐Osteoporosis	☐Pacemaker	☐Parkinson's	☐Pneumonia
☐Polio	☐Prostate	☐Prosthesis	☐Implants	☐Rheumatoid	☐Stroke	☐Thyroid
☐Tonsillitis	☐Tuberculosis	☐Tumors	☐Typhoid	☐Ulcers	☐V.D.	
☐Chronic Fatigue	☐Whooping Cough	☐High Blood Pressure		☐Other_____		

PREVIOUS SURGERIES & DATES: _____

_____

Please List Any Medications You Are Taking: _____

_____

_____

_____

SECTION IV Continued

LIST ALL SUPPLEMENTS YOU ARE CURRENTLY TAKING: _____

_____

YOU HAVE A PACEMAKER? Yes No **HAVE YOU HAD PRIOR SPINAL SURGERY?** Yes No

_____ **WOMEN** _____

_____

DO YOU THINK YOU MIGHT BE PREGNANT? Yes No **ARE YOU PREGNANT?** Yes No

DATE OF LAST CYCLE: _____ NURSING? Yes No **BIRTH CONTROL?** Yes No

PATIENT HISTORY WAS OBTAINED FROM: Patient Father Mother Son Daughter Other_____

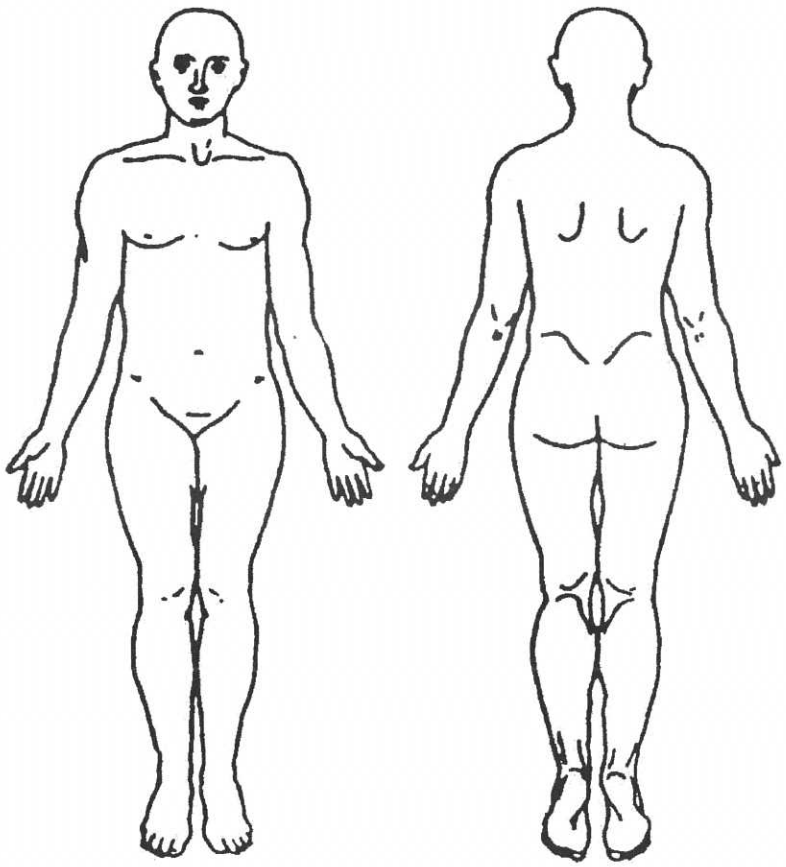
Please indicate on these drawings the body area(s) where you are currently experiencing symptoms:

Use the Following Symbols:

Pain = X

Numbness/Tingling = X

Stiffness = X



Walking Scale Questionnaire

For each statement please circle the one number that best describes your degree of limitation. Please check you have circled one number for each question. Please hand this to the doctor at the start of your consultation.

In the past 2 weeks how much has your knee pain...	Not at All	A Little	Moderately	Quite a Bit	Extremely
Limited your ability to walk?	1	2	3	4	5
Limited your ability to run?	1	2	3	4	5
Limited your ability to climb up/down stairs?	1	2	3	4	5
Made standing when doing things more difficult?	1	2	3	4	5
Limited your balance when standing/walking?	1	2	3	4	5
Limited how far you are able to walk?	1	2	3	4	5
Increased the effort needed for you to walk?	1	2	3	4	5
Made it necessary for you to use support when walking indoors? E.G. – Holding onto furniture, using a cane, etc.	1	2	3	4	5
Made it necessary for you to use support when walking outdoors? E.G. – Holding onto furniture, using a cane, etc.	1	2	3	4	5
Slowed down your walking?	1	2	3	4	5
Affected how smoothly you walk?	1	2	3	4	5
Made you concentrate on your walking?	1	2	3	4	5

WALKING SCALE DISABILITY SCORE: <NORMAL, 13-27 MILD, 28-45 MODERATE, >63 SEVERE DISABILITY

Subjective Peripheral Neuropathy Screen Questionnaire

Please take a few minutes to answer the following questions about the feeling in your legs and feet. Circle **YES** or **NO** based on how you usually feel.

1. Do you ever have legs and/or feet that feel numb?	YES	NO
2. Do you ever have any burning pain in your legs and/or feet?	YES	NO
3. Are your feet too sensitive to touch?	YES	NO
4. Do you get muscle cramps in your legs and/or feet?	YES	NO
5. Do you ever have any prickling or tingling feelings in your legs or feet?	YES	NO
6. Does it hurt at night or when the covers touch your skin?	YES	NO
7. When you get into the tub or shower, are you <u>unable</u> to tell the hot water from the cold water with your feet?	YES	NO
8. Do you ever have any sharp, stabbing, shooting pain in your feet or legs?	YES	NO
9. Have you experienced an asleep feeling or loss of sensation in your legs or feet?	YES	NO
10. Do you feel weak when you walk?	YES	NO
11. Are your symptoms worse at night?	YES	NO
12. Do your legs and/or feet hurt when you walk?	YES	NO
13. Are you unable to sense your feet when you walk?	YES	NO
14. Is the skin on your feet so dry that it cracks open?	YES	NO
15. Have you ever had electric shock-like pain in your feet or legs?	YES	NO

SKYLIMIT™
Integrated Wellness Solutions

Dr. Urvashi Mehta M.D.

Dr. Mark A. Bentley D.C.

Nicki Gatton MSN,APN,FNP-BC

Informed Consent and Authorization for Medical Treatment

I understand that medical practice is an inexact science and that the risk of injury is present whenever diagnosis and treatment are undergone. I acknowledge that no guarantees have been made to me as a result of my participation in examination and treatment by the above named physician.

I have been informed of the nature and risk involved in the proposed treatment, possible alternative methods of treatment, and possible consequences or complications arising from treatment. I have had ample opportunity to ask questions of the doctor in order to find out as much as I can about the proposed treatment(s) and my other options. Equipped with this knowledge, I freely consent to care and treatment, and by signing this form attest that I do so under no coercion.

I have read and understood the above paragraphs and am aware that no claims or therapeutic guarantees have been made.

I understand that information revealed in my record may be used for research purposes, and that I will never be personally identified in the course of such use of my medical record.

I agree to permit the physician's above to discuss my case with medical colleagues and allied health professionals in his efforts to obtain other professional opinions about treatment course and treatment options.

Patient Name (Print): _____

Patient Signature: _____

HIPAA DECLARATION

This Notice is in effect as of 10/27/2014

The Practice:
(a) Is required by federal law to maintain the privacy of your Protected Health Information and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your Protected Health Information.
(b) Under the Privacy Rule, may be required by state law to grant greater access or maintain greater restrictions on the use or release of your Protected Health Information than that which is provided for under federal law.
(c) Is required to abide by the terms of the Privacy Notice.
(d) Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for all of your Protected Health Information that it maintains.
(e) Will distribute any revised Privacy Notice to you prior to implementation.
(f) Will not retaliate against you for filing a complaint.

PATIENT ACKNOWLEDGMENT

By subscribing my name below, I acknowledge receipt of this notice, and my understanding and my agreement to its terms.

_____ _____

Signature of Patient/Guardian Date

FOR PRACTICE USE ONLY

Practice Documentation of Good Faith Effort to Obtain Patient's acknowledgment of this Notice could not be obtained because:

☐ Patient refused to sign ☐ Communication barriers prohibited obtaining acknowledgment
☐ Emergency circumstances ☐ Other

_____ _____

Signature of Practice Date

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

The undersigned patient and/or responsible party, in addition to continuing personal responsibility, and in consideration of treatment rendered or to be rendered assigns to SKYLIMIT INTEGRATED WELLNESS SOLUTIONS OF THE CAROLINAS , the following rights, power and authority:

RELEASE OF INFORMATION: You are authorized to release information concerning my condition and treatment to my insurance company, attorney or insurance adjuster for purposes of processing my claim for benefits and payment of services rendered to me.

IRREVOCABLE ASSIGNMENT OF RIGHTS: You are assigned the exclusive, irrevocable right to any cause of action that exists in my favor against any insurance company for the terms of the policy, including the exclusive, irrevocable right to receive payment for such services, make demand in my name for payment, and prosecute and receive penalties, interest, court loss, or other legally compensable amounts owed by an insurance company to cooperate, provide information as needed, and appear as needed, wherever to assist in the prosecution of such claims for benefits upon request.

DEMAND FOR PAYMENT: To any insurance company providing benefits of any kind to us for treatment rendered by the physician/facility named above, you are hereby tendered demand to pay in full the bill for services rendered by the physician/facility named above within 30/45 days following your receipt of such bill for services to the extent such bills are payable under the terms of the policy.

THIRD PARTY LIABILITY: If my injuries are the result of negligence from a third party, then I instruct the Liability carrier to cut a separate draft to pay in full all services rendered, payable directly to the physician/facility named above.

STATUTE OF LIMITATIONS: I waive my rights to claim any statute of limitations regarding claims for services rendered by the physician/facility named above, in addition to reasonable cost of collection, including attorney fees and court cost incurred.

LIMITED POWER OF ATTORNEY: I hereby grant to the physician/facility named above the power to endorse my name upon any checks, drafts, or other negotiable instrument representing payment from any insurance company representing payment for treatment and healthcare rendered by the physician/facility named above. I agree that any insurance payment representing an amount in excess of the charges for treatment rendered will be credited to my/our account or forwarded to my/our address upon request in writing to the physician/facility named above.

TERMINATION OF CARE: I hereby acknowledge and understand that if I do not keep appointments as recommended to me by my caring doctor at this clinic, he/she has full and complete right to terminate responsibility for my care and relinquish any disability granted me within a reasonable period of time. If during the course of my care, my insurance company requires me to take an examination from any other doctor; I will notify this physician/facility immediately. I understand that failure to do so may jeopardize my case.

_____ _____

Signature of Insured/Guardian Date

SECTION VII CONSENT TO EVALUATE AND TREAT A MINOR CHILD

I,_____, being the parent or legal guardian of _____, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

_____ _____

Signature Date

SECTION VIII FINANCIAL AGREEMENT

Please remember that insurance is considered a method of reimbursing the patient for fees put to the doctor and is NOT A SUBSTITUTE FOR PAYMENT. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance.

IN ORDER TO CONTROL YOUR OUTSTANDING BALANCE, IT IS OUR POLICY TO COLLECT COPAYS, COINSURANCE AND DEDUCTIBLE AT TIME OF SERVICE.

If this account is assigned to any attorney/outside agency for collection and/or suit, SKYLIMIT INTEGRATED WELLNESS SOLUTIONS OF THE CAROLINAS shall be entitled to reasonable attorney's fees and for cost of collection. I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim.

_____ _____ _____

Patient Signature Insured's Signature Date

SECTION IX TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral or extremity subluxation. Our chiropractic method of correction is by specific adjustment of the spine and/or extremities.

Health: A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express itself to its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral and/or extremity subluxations. Other methods of treatment such as physical therapy modalities, rehabilitation, and/or manual therapy techniques may be employed as well to assist in the prevention of exacerbations of the condition as the nerve interference is being removed by specific adjustments of the spine and/or extremities.

I, _____, have read and fully understand the above statements.
(print name)

I, therefore, accept chiropractic care on this basis.

_____ _____
Signature Date

SKYLIMIT™
Integrated Wellness Solutions

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Dr. Mark Bentley, D.C. Dr. Urvashi Mehta, M. D. Nicki Gatton, FNP

NAME: _____ DOB: _____

SS#: _____ ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

PHONE: _____

RELEASE MY MEDICAL RECORDS FROM:

NAME: _____

TEL: _____

FAX: _____

PLEASE SEND MEDICAL RECORDS NO LATER THAN _____

Please release a copy of all medical records, including but not limited to, progress notes, operative notes, laboratory results and diagnostic tests.

BY MY SIGNATURE I AUTHORIZE RELEASE OF MEDICAL RECORDS

PATIENT: _____ DATE: _____