Ethos Medical New Patient Consultation Information

How were you referred to Dr. Black? ☐ Google Search ☐ Doctor Referral ☐ Social Media ☐ Attorney
☐ Friend/Family (who?): _____ ☐ Other: _____

First Name: _____ Last Name:_____

DOB: ___ / ___ /_____ Sex: ☐ Male ☐ Female Preferred Method of Contact: ☐ Phone ☐ Text ☐ E-Mail

Home Address _____ APT# ___ City: _____ State:____ Zip Code: _____

Cell Phone: _____ E-Mail: _____

Marital Status: ☐ Single ☐ Married ☐ Other Number of Children: ___ Your Occupation: _____

Emergency Contact Name: _____ Relationship to Patient: _____

Emergency Contact Info: Cell Phone: _____ E-Mail: _____

What is the number one condition you want evaluated, so we can determine a diagnosis and whether we can move forward with care?
_____

When did the complaint FIRST begin? _____ What do you believe caused the problem: _____

How would you describe the pain or discomfort? Dull, Numb, Sharp, Other: _____

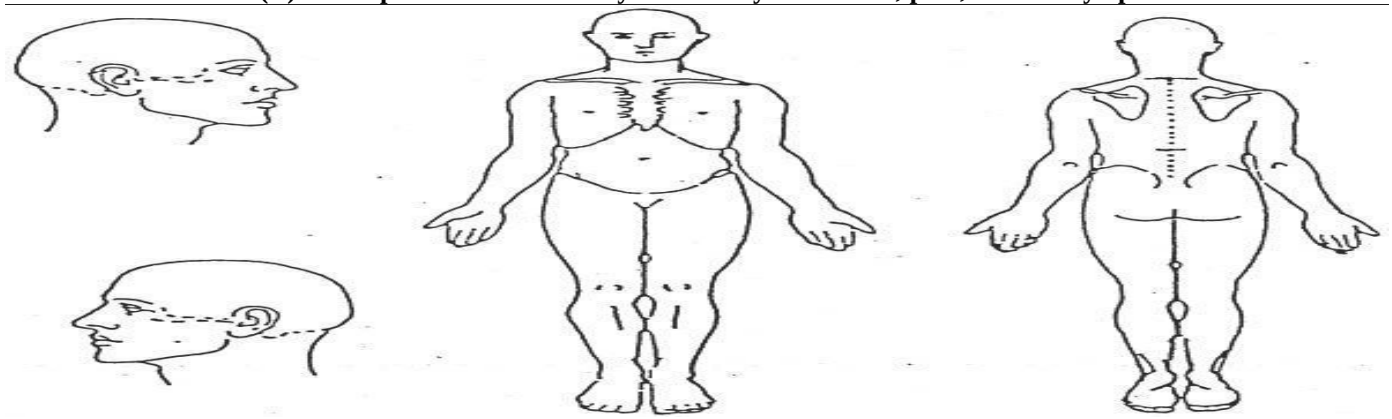
Do the Symptoms travel, radiate, move around, OR stay in one place? Describe: _____

On a scale of 1-10, (10 = Severe) where is your pain/discomfort level today? # _____

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

What time of day is it the worst? Waking / Daytime / Bedtime: _____

Mark (X) on the picture below where you have any discomfort, pain, or other symptoms:



Have you ever had any Imaging for these complaints? ☐ U/S ☐ X-Ray ☐ CT ☐ MRI Date(s): ____ / ____ / ____

Have you ever consulted another Provider, Hospital, or Urgent Care for help? ☐ No ☐ Yes Date: ____ / ____ / _____

IF YES: Diagnosis and Recommendations for Treatment? _____

IF Injury/Accident: ☐ Motor Vehicle Accident ☐ Work Injury ☐ Sports Injury Date: ____ / ____ / _____

Are you represented by an attorney for this injury? ☐ No ☐ Yes Firm Name & Contact: _____

Please mark any of the following that may suffer or are more difficult/less enjoyable because of your complaints:

☐ Quality Family Time ☐ Productivity/Focus/Work ☐ Sitting/Driving ☐ Focus/Mood ☐ Hobbies ☐ Standing
☐ Sleep Quality ☐ Housework ☐ Self-Care/Bathing ☐ Travel/Vacation/Leisure ☐ Exercise/Sports ☐ Walking

Please mark below what you have tried in the past that has NOT fixed your complaints:

☐ Medications ☐ Acupuncture ☐ Homeopathy/Herbal ☐ Personal Training ☐ Exercise ☐ Heat/Ice
☐ Injections ☐ Physical Therapy ☐ Chiropractic ☐ Massage Therapy ☐ Surgery ☐ Supplements ☐ Other_____

Ethos provides care to meet your unique goals. Indicate the types of care you would like the Doctor to discuss, check all that apply:

☐ Relief: Temporary symptom management, providing short-term relief only.
☐ Corrective Care: Identify and address the underlying root causes of your symptoms, for lasting improvements to your life & health.
☐ Wellness & Prevention: Improve my health with focus on: Diet, exercise, supplements, lab work, peptides, & hormones.

Rate where you feel your overall Quality of Life is *today* on a scale of 1-10? (10= best possible)
Energy: ____ Focus: _____ Productivity: _____ Mood: ____ Sleep Quality: ____
Digestion: ____ Immune System: ____ Motivation to be healthy: ____ Family & Relationships: ____

How would you rate your current Level of OVERALL HEALTH, Wellness & Happiness? (1-10): #_____
Where do you want it to be after treatment, if you're accepted as a patient? (rate: 1-10) # _____
How important is taking action towards improving your health to you right now? (rate: 1-10) # _____

What concerns you the most about your quality of life in your current condition? _____
If this problem stayed exactly the same for the next 2 years, how would your quality of life be impacted? _____
What made you decide to seek help now instead of waiting longer? _____

If your care is successful, what would you most like to be able to do again? (Check all that apply)
☐ Sleep through the night ☐ Play with kids/grandkids ☐ Working out ☐ Lift weights ☐ Running ☐ Golf
☐ Tennis ☐ Pickleball ☐ Travel ☐ Work comfortably ☐ Sit comfortably ☐ Stand comfortably ☐ Gardening
☐ Household chores ☐ Other: _____

In addition to addressing the causes of your symptoms, which of these areas would you like to improve? (Check all that apply)
☐ Mobility & Flexibility ☐ Strength & Stability ☐ Energy ☐ Sleep ☐ Weight Management ☐ Nutrition
☐ Longevity & Healthy Aging ☐ Hormone Optimization ☐ Athletic Performance ☐ Stress Resilience

Prior Chiropractic Experience: Doctor/Clinic Name: _____

Have you seen a Chiropractor in the past? ☐ Yes ☐ No Was there an detailed Exam, X-Rays & a Clear Diagnosis ☐ Yes ☐ No
What CONDITION/Complaint were you treated for: _____
What Year(s): _____. How frequently did you go: _____ How long did you receive care: _____
Rate your experience, 1-10 #_____ What would you have changed: _____

Medications & Health History:
Primary Care Physician & Contact Info: _____
Other Specialist you currently are treating with: _____

Have you ever been diagnosed with, or do you currently have, any of the following? (Mark all that apply)
☐ Cancer (type/year: _____) ☐ Osteoporosis/Osteopenia ☐ Stroke/TIA ☐ Heart Condition ☐ Diabetes ☐ Blood Thinners/Anticoagulants ☐ Pacemaker/Implants ☐ Unexplained Weight Loss ☐ Numbness in Groin
☐ Bowel/Bladder Changes ☐ None of the above

Any Allergies (medications, latex, adhesives, other)? ☐ No ☐ Yes: _____

Any Broken/Dislocated Joints or Bones? ☐ No ☐ Yes *If Yes*, List the Areas and Dates: _____

Surgeries (including cosmetic, aesthetic, weight loss, etc.)? ☐ No ☐ Yes Procedures & Dates:
_____

List ALL Medications that you take regularly *(prescribed, OTC):* _____
_____

List all Supplements/ Herbs that you are taking: _____
_____

Are you open to taking specific medical-grade supplements and dietary changes, if appropriate for your diagnosis? ☐ Yes ☐ No

FEMALE PATIENTS: *(Patient Initials*: ___) Are you pregnant, or is there any possibility of pregnancy? ☐ No ☐ Yes
Date of Last Menstrual cycle: _____ HRT Therapy ☐ Yes ☐ No

INFORMED CONSENT TO CHIROPRACTIC CARE

Chiropractic care, including spinal adjustments, therapeutic procedures, and rehabilitative exercises, is generally safe and effective. As with any healthcare procedure, there are potential risks, which may include temporary soreness or stiffness, temporary aggravation of symptoms, and, uncommonly, muscle or soft-tissue strain or rib injury. Rare cases of injury to the arteries of the neck have been reported in temporal association with cervical adjustments; current research suggests this association may reflect patients seeking care for symptoms of an artery injury already in progress, rather than being caused by the adjustment itself, and the reported occurrence is extremely rare. I have had the opportunity to ask questions about the nature and purpose of my care, its risks and benefits, and alternatives (including no treatment). I consent to the examination and treatment recommended by my provider. **Initials: _____**

PRIVACY PRACTICES (HIPAA)

I acknowledge I have been offered the opportunity to review this practice's Notice of Privacy Practices. I understand my protected health information may be used and disclosed for treatment, payment, and healthcare operations as permitted by HIPAA; that I may request restrictions on such uses (which the practice is not required to accept); and that I may revoke this consent in writing at any time, effective going forward. The practice may contact me by phone, mail, or email regarding my care and office updates, will not otherwise share my information, and reserves the right to amend its privacy policy as allowed by law.

I authorize Ethos Regenerative Medical Group, PLLC to discuss my condition with: *(name & relationship)*

_____ **Initials: _____**

TEACHING CLINIC ACKNOWLEDGMENT — Parker University CBI Program

Ethos Regenerative Medical Group, PLLC is a clinical teaching facility participating in the Parker University Clinic-Based Internship (CBI) Program. I acknowledge that this practice functions as a supervised clinical training site; that a CBI chiropractic intern may observe, assist, evaluate, or provide treatment under direct supervision; and that all care is overseen and directed by a licensed chiropractor. **Initials: _____**

MEDIA & EDUCATIONAL USE AUTHORIZATION

I authorize Ethos Regenerative Medical Group, PLLC to use photographs, videos, audio recordings, and/or written testimonials of me for educational, training, promotional, or marketing purposes, including on websites, social media, and in printed materials. I understand that no compensation will be provided; that this authorization is optional and my care is NOT contingent upon granting it; and that I may revoke it in writing at any time, though materials already published may not be retractable. **Initials: _____**

TEXT/SMS COMMUNICATIONS

☐ YES, I consent to receive text messages from Ethos Regenerative Medical Group, PLLC at the cell number provided, including appointment reminders and occasional promotional offers. Message frequency varies; message & data rates may apply. Reply STOP to opt out at any time. Consent is not a condition of receiving care. **Initials: _____**

EXAMINATION FEE DISCLOSURE

Your consultation today is complimentary. If, following your consultation, the Doctor recommends and you elect to proceed with a comprehensive examination (including any indicated X-rays), the patient portion for the examination, any necessary x-rays, vitals, posture assessment followed by a discussion of your diagnosis & recommendations is $300, due at the time of service. **Initials: _____**

ASSIGNMENT OF INSURANCE BENEFITS

Your Insurance Company: _____. We will verify your insurance before your exam. We will discuss any insurance coverage, along with any expected contributions towards our Providers' recommendations for the Testing, Exam required to get a diagnosis, along with any prescribed treatment. As a courtesy, we will file directly to your insurance company for your exam and any recommended treatment. All fees for today's exam, scans, and any x-rays will be due in full today. All fees will be discussed with you *prior to any services being performed* today.

The undersigned patient and/or responsible party, in addition to continuing personal responsibility and consideration of treatments rendered, assigns to Ethos Regenerative Medical Group, PLLC the following rights: **Initials: _____**

RELEASE OF INFORMATION

You are authorized to release information concerning my condition and treatment to my insurance company or insurance adjuster, for purposes of processing/appealing my claim for benefits and payment of services.

ALL PAYMENTS FOR SERVICES WILL BE MADE PAYABLE TO: ETHOS REGENERATIVE MEDICAL GROUP

I hereby grant Ethos Regenerative Medical Group, PLLC, the power to endorse my name upon any checks, drafts, or other negotiable instruments representing payment from any insurance group, company representing payment for treatment, consultations, and all health care rendered. **Initials: _____**

By signing below, I confirm that I have read, understood, and initialed the acknowledgments, consents, and authorizations in this packet, and that the information I have provided is accurate and complete to the best of my knowledge.

Printed Name *Signature of the Patient, Parent or Guardian* *Date*

If signing for a minor — Relationship to patient: _____