PIONEER
SPORTS & PAIN CENTER
SPINE & ORTHOPEDIC REHAB SPECIALISTS

S. Kyle Burtenshaw, DC
Dustin D, Elliott, DC
Ashley Hall, FNP
Cara Carpenter, DPT

We believe in empowering patients to make informed decisions as your partner in health

Dear New Patient:

We would like to take this opportunity to welcome you to Pioneer Sports & Pain Center!

We are pleased that you have chosen our team of healthcare professionals to care for you. It is our pleasure to provide you with the highest quality healthcare and service. Our doctors and therapists work together and collaborate to provide the best outcomes and patient focused care in the valley. We take a very holistic and comprehensive approach. Our practices are progressive and evidence based. We promise to give you our best, to treat you like a person and do all in our power to give you the best chance of living your best life.

We combine the best practices in sports and regenerative medicine, evidence based chiropractic rehabilitation along with Spine & Orthopedic Physical Therapy. We take the most comprehensive approach available to care for your acute and chronic pain. If we can't resolve your condition we refer out as needed.

As part of your contract with your insurance company, we are legally required to collect all co-pays and/or deductibles from you at the time of service. We ask that you are prepared to pay your co-pay and/or deductibles at the time of service. We conveniently accept the following methods of payment: Cash, Check, Visa, Mastercard, Discover and American Express. We also offer patient financing through Care Credit and other vendors upon request.

We are innovators and progressive physical medicine and rehab specialists. As our name Pioneer implies, we are committed to patient focused, data driven outcomes based on a progressive & compassionate health care delivery system. It is our privilege to earn your trust as your partner in health.

Again, thank you for allowing us to assist you with your healthcare needs.

Sincerely,

The Healthcare Team at Pioneer Sports & Pain Center

PIONEER
SPORTS & PAIN CENTER
SPINE & ORTHOPEDIC REHAB SPECIALISTS

PATIENT INFORMATION

Last Name:	First Name:	M.I.:	DOB:
Mailing Address:		City/State/Zip:	
Home Phone:	Cell Phone:	Work Phone:	
SSN:	Sex (circle one): ◯ MALE / ◯ FEMALE	Marital Status: Single / Married / Divorce / Widowed	
Employer:		Occupation:	
Primary Care Provider:		How did you hear about us?	
Email (parent/guardian email if patient is a minor):			

RESPONSIBLE PARTY (If patient is a minor please fill out parent/guardian)

Last Name:	First Name:	M.I.:	DOB:
Mailing Address:		City/State/Zip:	
Home Phone:	Cell Phone:	Work Phone:	
SSN:	Sex (circle one): ◯ MALE / ◯ FEMALE	Relationship to Patient:	

ADDITIONAL INFORMATION

Emergency Contact:	Phone:	Relationship to Patient:

PRIMARY INSURANCE	SECONDARY INSURANCE
Company:	Company:
Policy Holder:	Policy Holder:
Policy Holder DOB:	Policy Holder DOB:
Relationship to Patient:	Relationship to Patient:

THIRD PARTY LIABILITY ** If this is a 3rd party liability insurance for an auto claim, we request all patients to consult with an attorney to understand how benefits work**

WORKERS COMPENSATION

Claim Number:	Date of Injury:
Insurance Name:	Phone Number:
Adjuster Name:	Adjuster Phone:
Employer Name:	Phone Number:
Address:	City/State/Zip:

MOTOR VEHICLE ACCIDENT

Claim Number:	Date of Injury:
Insurance Name:	Phone Number:
Adjuster Name:	Adjuster Phone:

Patient/Guardian Signature: _____ Date: _____

Personal Health History

Please list all physicians that you see. (Please include Mental Health Professionals)

Name:	Address:	Specialty, or condition that is being treated:

Please list any complementary and/or alternative practitioners you see or have seen in the past (i.e., chiropractor, acupuncturist, naturopath, massage therapist, spiritual healer, etc.).

Approximate Date(s) of Treatment	Name of Therapist or Treatment Facility	Type of Treatment (e.g. Reiki, Qi Gong, Sand Tray)	Reason for Treatment	Beneficial Experience?

What health issues do you want to focus on during this visit?

Current Medical Problems: (e.g. diabetes, heart disease, hypertension, etc.)

1.	4.	7.
2.	5.	8.
3.	6.	9.

Past Medical History: List any major past illnesses, hospitalizations (include year or date if known).

	Date		Date

Past Gyn/Obstetrical History: List any past pregnancies.

Vaginal Births		Miscarriage/ Still births	
Caesarian Sections		Pregnancy Terminations	
Abnormal PAP tests		Other GYN Procedures	

Family History: Have your close relatives (parent, brother or sister, child, grandparent) had the following?

	Yes	No	If yes, which relative	Age at Diagnosis
Heart attack, angina				
Stroke				
High blood pressure				
High Cholesterol				
Diabetes				
Thyroid disease				
Breast cancer				
Other Cancer--what type?				
Kidney Disease				
Osteoporosis				
Rheumatoid Arthritis				
Asthma				
Mental Health disorder				
Substance Abuse				

Pharmaceuticals and Supplements:

Do you have Medication allergies? ○ Yes ○ No If yes, please list:

Medication	Reaction	Medication	Reaction

Please outline your use of the following, past or present:

Product:	Current Use? Yes/No	Quantity Per Day	Quantity Per Week	Past Use? Yes/No	Do others have concern about your usage?
Tobacco					
Alcohol					
Recreational Drugs					
Caffeine:					

Please list all prescribed and over-the-counter medications you take regularly. Please include all supplements, vitamins or herbal products.

Medicine/ Supplement including Dose	Frequency	Dose	Frequency
1.		8.	
2.		9.	
3.		10.	
4.		11.	
5.		12.	
6.		13.	
7.		14.	

Preventive Health: Please provide the dates and documentation when possible

Do you routinely wear a seat belt? ❑ Yes ❑ No

	Date		Date
Pap/pelvic exam (females)		Tetanus vaccine (specify Td or Tdap)	
Mammogram (females)		Flu vaccine	
Colonoscopy		Pneumonia vaccine	
Test of stool for blood (Stool Guaiac)		Zoster (shingles) vaccine	
Rectal prostate exam (males)		Hepatitis A	
Prostate Specific Antigen (males)		Hepatitis B	
Bone Density (Dexa)		MMR	
Eye exam		Gardesil (HPV vaccine)	
Cardiovascular stress test		Other	

Trauma History: Have you ever been the victim of trauma or abuse (including sexual, emotional, physical abuse or neglect and/or being a victim of an accident, violent crime, or a natural disaster)? ○ Yes ○ No
If yes, is this an active issue in your life that you would like to address while you are here? ○ Yes ○ No

Movement, Exercise and Rest:

What forms of exercise and movement do you enjoy?

Please describe your physical activity:

Activity:	How often:	How long each time:

How many hours of sleep do you usually get each night?

Describe any issues you have with sleep.

Nutrition: Please list any food allergies or sensitivities:

Foods	Reaction	Foods	Reaction

Do you currently or have you ever had a problem with weight or eating? ❑ Yes ❑ No If yes, please describe:

Are you comfortable with your relationship with food? ❑ Yes ❑ No

Do you feel knowledgeable about your nutritional needs? ❑ Yes ❑ No

Who prepares your meals?

Personal and Professional Development:

Current or past occupation:

❑ Retired? ❑ Working at home? ❑ Care-taking? ❑ Disabled? ❑Unemployed?

Are you happy with your occupation? _ ○ Yes ○ No

Why?

Do you anticipate any work changes in the near future? Retirement, etc.

Do you have a Racial/Culture heritage that is important to you?

Relationships:

Relationship status: If married or partnered, what is your relationship length?

What are your living arrangements? Number of children and ages:

Are you sexually active? ❑ Yes ❑ Are you happy with your sexual life?

Which relationship(s) fulfill and/or empower you?

Who or what drains your energy?

Physical Environment:

Do you have specific health concerns about your current home or environment (Quality of air, water, etc.)?

Have you had hazardous environmental or occupational exposures? If yes, please describe.

What are your health goals? What are your overall goals for improving your health and your life?

Is there anything else that would be helpful for us to know about you?

Review of Symptoms: Please check no or yes for the following **current** symptoms (**within past 3 months**)

GENERAL	Yes	No		GASTROINTESTINAL	Yes	No
Fever	☐	☐		Diarrhea/Constipation	☐	☐
Sweats at night	☐	☐		Indigestion/heartburn	☐	☐
Hot flashes	☐	☐		Nausea	☐	☐
Temperature intolerance	☐	☐		Blood in stool	☐	☐
Excessive thirst	☐	☐		**GENITOURINARY**		
Fatigue	☐	☐		Pain or burning on urination	☐	☐
Sleep difficulties	☐	☐		Frequent urination	☐	☐
Daytime sleepiness	☐	☐		Waking to urinate more than once at night	☐	☐
Unplanned weight change	☐	☐		Excessive urination	☐	☐
SKIN				Difficulty emptying bladder	☐	☐
Rash	☐	☐		Urinary incontinence	☐	☐
New or changing moles	☐	☐		Decreased sexual desire	☐	☐
EYES				Pain with intercourse	☐	☐
Pain	☐	☐		Sexually Transmitted Diseases	☐	☐
Redness	☐	☐		Fertility issues	☐	☐
Vision change	☐	☐		**Men:**		
EAR, NOSE, THROAT				Erectile dysfunction	☐	☐
Hearing loss	☐	☐		**Women:**		
Ringing in ears	☐	☐		Heavy vaginal discharge	☐	☐
Dizziness or vertigo	☐	☐		Heavy menstrual bleeding	☐	☐
Bleeding gums	☐	☐		Painful menstrual periods	☐	☐
Nosebleeds	☐	☐		Irregular menstrual bleeding	☐	☐
BREAST				**MUSCULOSKELETAL**		
Breast Pain	☐	☐		Generalized or all-over pain	☐	☐
Masses and or Lumps	☐	☐		Joint pain	☐	☐
Nipple discharge	☐	☐		Stiffness	☐	☐
Skin changes	☐	☐		Joint swelling	☐	☐
CARDIOVASCULAR				Joint redness	☐	☐
Chest pain	☐	☐		Back or neck pain	☐	☐
Heart murmur	☐	☐		**NEUROLOGICAL**		
Irregular heart beat (palpitations)	☐	☐		Abnormal gait (Trouble Walking) or falls	☐	☐
Leg swelling or edema	☐	☐		Headache severe and/or frequent	☐	☐
PULMONARY				Seizures	☐	☐
Wheezing or shortness of breath	☐	☐		Muscle weakness, TIA or stroke	☐	☐
Chronic cough	☐	☐		Fainting or loss of consciousness	☐	☐
HEMATOPOIETIC				Localized numbness, tingling, neuropathy	☐	☐
Swollen lymph glands	☐	☐		**PSYCHOLOGICAL**		
Blood clots	☐	☐		Anxiety	☐	☐
Excessive bleeding	☐	☐		Depression	☐	☐
Anemia				Memory loss	☐	☐
				Mood swings	☐	☐

Consent for Treatment

Consent for Treatment: I authorize the staff at Pioneer Sports & Pain Center to undertake such treatment and procedures as deemed appropriate to improve my condition. It is recognized that the practice of medicine is not an exact science and, as such, no guarantees are made by the staff of Pioneer Sports & Pain Center as to the results of treatment or interventions performed. I am advised that I have the full right to a full explanation of any treatment or procedure utilized. I understand that I have the right to refuse treatment; but, in doing so, I also understand that the desired outcome of my treatment program may be affected. Persistent refusal to participate or cooperate in the recommended treatment program may result in my discharge from the program.

Release of information: Pioneer Sports & Pain Center may disclose all or any part of my records to any part or organization responsible for all or part of my therapy chargers. Pioneer Sports & Pain center may disclose all or part of my record to other healthcare providers including but not limited to, hospitals and physicians. I further agree that Pioneer Sports & Pain Center may release all or any part of my record to any federal, state, or local government body when, in the opinion of Pioneer Sports & Pain Center, such bodies may be liable for all or part of my charges in relation to my care and treatment pursuant to statute or rule.

Patient/Legal Guardian Signature: _____ **Date:** _____

Consent to Communicate

I understand that Pioneer Sports & Pain Center may send text messages, emails, or voice call reminders for my appointments. I also understand that I might receive on occasion messages and such that might inform me of any specials, upcoming events, or any other noteworthy information that may be pertinent to my care. If I no longer wish to receive messages from Pioneer Sports & Pain Center, I have the right to revoke this consent at any time.

Patient/Legal Guardian Signature: _____ **Date:** _____

Protected Health Information Release (patients 18 years and older)

Please note that by signing this release you are not authorizing us to release your physical records. This authorization is to verbally discuss your healthcare with the individuals you list below.

- ☐ Only release information to me personally.
- ☐ I authorize you to speak with my adult family members or other individuals about my medical care, test results, or billing as identified below.

Name (please print):_____ Name (please print):_____
Phone number: _____ Phone number: _____
Name (please print):_____ Name (please print):_____
Phone number: _____ Phone number: _____

Medical Records Release

Patient Name: _____ Date of Birth: _____ Phone Number: _____

I hereby request that a copy or summary of my records, including laboratory or x-ray reports that you may have which contains information relevant to my present and future diagnosis and/or treatment to be released from Pioneer Sports & Pain Center to the following Medical Office, Health Care Provider, or Person(s):

_____

_____

_____

HIPPA Privacy Act Acknowledgement

Pioneer Sports & Pain Center is concerned about the privacy of our patient's health care information. Our intent is to make you aware of the possible uses and disclosures of your privacy rights. The delivery of your health care service will in no way be conditioned upon your signature acknowledgement, we will continue to provide you treatment, and will use and disclose your protected health information for treatment, payment and health care operations when necessary.

I acknowledge that I have received this Notice of Privacy Practice for Pioneer Sports & Pain Center.

Patient/Legal Guardian Signature: _____ **Date:** _____

Completed by: _____ **If not patient, relationship to patient:** _____ **Date:** _____