



Patient Information

Last Name _____ First Name _____ M.I. _____
Phone Home _____ Cell _____ Work _____
Permission to leave a message on your voice mail: YES NO Date of Birth ____ / ____ / ____
Appointment Reminders: Email _____ or Text _____
Street Address _____ Apt. or PO Box _____
City _____ State _____ Zip Code _____
How did you hear about us? Physician Friend Website Other _____
Referring Physician _____ Physician Phone _____

Responsible Party/Emergency Contact Information

Last Name _____ First _____
Relationship _____ Day Phone _____ Night Phone _____

Release of Confidential Information for Billing

I, _____ authorize the following person/persons to discuss my medical account, including the procedure, diagnosis, insurance and balance on all services performed.

Name: _____ Relationship: _____
Name: _____ Relationship: _____

I have read the "Patient Responsibility and Release of Information" and "Consent to Treat" Forms provided at check-in:

Signature _____ Date _____

I have read the "HIPPA" Form (Notice of Privacy Practices and How your Medical Information will be used and disclosed) provided at check-in:

Signature _____ Date _____

Cancellation and Payment Policy

If you need to cancel an appointment, you must call our office one business day prior or you will be charged a \$30 cancellation fee. Missing an appointment without calling ("No Show") will also result in a \$30 fee on your account. These fees are not covered by your insurance and must be paid prior to your next appointment. All payments are due at the time of service. This includes copays, deductibles and estimated coinsurance.

Signature _____ Date _____



Name: _____ Date: _____

The purpose of this form is to assist you in identifying and clarifying your problem areas and discovering your present level of awareness of your body. It will also serve as a means to acknowledge and note what changes result from the treatments. Please be as complete and in-depth as possible. The privacy of your answers will be respected. The use of this form or the answering of any question is optional.

1. Present Condition: Pain or Tension

a. What are the present symptoms of the problem(s) for which you are seeking treatment?

Location:

Frequency:

Type:

b. Circle the number indicating your pain level:

Current: 0 1 2 3 4 5 6 7 8 9 10

Highest: 0 1 2 3 4 5 6 7 8 9 10

No pain

Unbearable pain

c. What makes your symptoms worse?

d. What makes your symptoms better?

e. Are you taking any medications? What? How much?

f. What does this pain keep you from doing?

g. What do you think initially caused your symptoms? When?

2. Please draw on the picture below any pain or symptoms you have using the following symbols:

A = ACHE

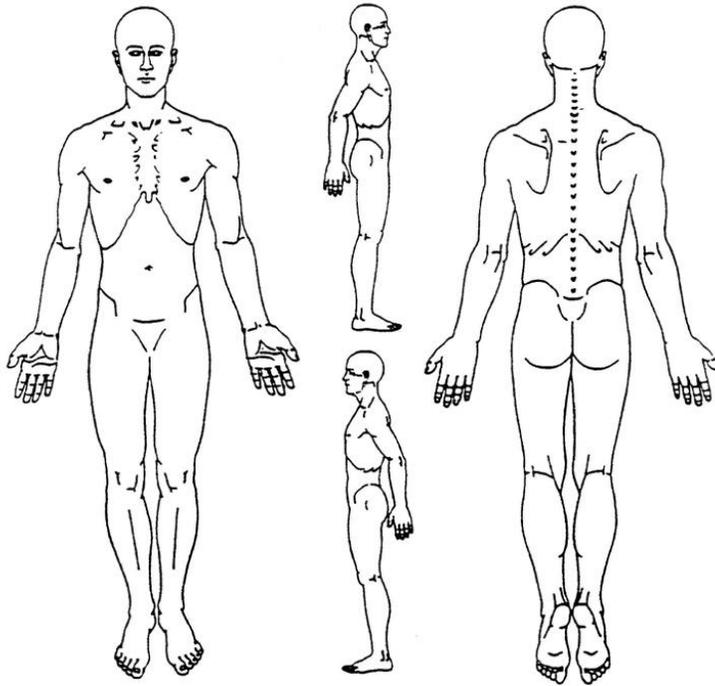
B = BURNING

O = OTHER

P = PINS & NEEDLES

N = NUMBNESS

R = RADIATING



Medical History

Existing or Relevant Previous Conditions

Allergies	<input type="radio"/> Yes <input type="radio"/> No	Dizzy Spells	<input type="radio"/> Yes <input type="radio"/> No	MRSA	<input type="radio"/> Yes <input type="radio"/> No
Anemia	<input type="radio"/> Yes <input type="radio"/> No	Emphysema/Bronchitis	<input type="radio"/> Yes <input type="radio"/> No	Multiple Sclerosis	<input type="radio"/> Yes <input type="radio"/> No
Anxiety	<input type="radio"/> Yes <input type="radio"/> No	Fibromyalgia	<input type="radio"/> Yes <input type="radio"/> No	Muscular Disease	<input type="radio"/> Yes <input type="radio"/> No
Arthritis	<input type="radio"/> Yes <input type="radio"/> No	Fractures	<input type="radio"/> Yes <input type="radio"/> No	Osteoporosis	<input type="radio"/> Yes <input type="radio"/> No
Asthma	<input type="radio"/> Yes <input type="radio"/> No	Gallbladder Problems	<input type="radio"/> Yes <input type="radio"/> No	Parkinson's	<input type="radio"/> Yes <input type="radio"/> No
Autoimmune Disorder	<input type="radio"/> Yes <input type="radio"/> No	Headaches	<input type="radio"/> Yes <input type="radio"/> No	Rheumatoid Arthritis	<input type="radio"/> Yes <input type="radio"/> No
Cancer	<input type="radio"/> Yes <input type="radio"/> No	Hearing Impairment	<input type="radio"/> Yes <input type="radio"/> No	Seizures	<input type="radio"/> Yes <input type="radio"/> No
Cardiac Conditions	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis	<input type="radio"/> Yes <input type="radio"/> No	Smoking	<input type="radio"/> Yes <input type="radio"/> No
Cardiac Pacemaker	<input type="radio"/> Yes <input type="radio"/> No	High Cholesterol	<input type="radio"/> Yes <input type="radio"/> No	Speech Problems	<input type="radio"/> Yes <input type="radio"/> No
Chemical Dependency	<input type="radio"/> Yes <input type="radio"/> No	High/Low Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	Strokes	<input type="radio"/> Yes <input type="radio"/> No
Circulation Problems	<input type="radio"/> Yes <input type="radio"/> No	HIV/AIDS	<input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease	<input type="radio"/> Yes <input type="radio"/> No
Currently Pregnant	<input type="radio"/> Yes <input type="radio"/> No	Incontinence	<input type="radio"/> Yes <input type="radio"/> No	Tuberculosis	<input type="radio"/> Yes <input type="radio"/> No
Depression	<input type="radio"/> Yes <input type="radio"/> No	Kidney Problems	<input type="radio"/> Yes <input type="radio"/> No	Tuberculosis	<input type="radio"/> Yes <input type="radio"/> No
Diabetes	<input type="radio"/> Yes <input type="radio"/> No	Metal Implants	<input type="radio"/> Yes <input type="radio"/> No		<input type="radio"/> Yes <input type="radio"/> No



Describe any other conditions

If "Yes" to any of the above, please explain and give approximate dates/Describe any other Conditions

Fall History

Injury as a result of a fall in the past year? Yes No Height: _____
Two or more falls in the last year? Yes No Weight: _____
Patient is at risk for falls? Yes No

Surgical History

Body Region: _____ Surgery Type: _____ Date: _____
Body Region: _____ Surgery Type: _____ Date: _____
Body Region: _____ Surgery Type: _____ Date: _____
Body Region: _____ Surgery Type: _____ Date: _____

Current Medications

Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason Taking: _____
Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason Taking: _____
Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason Taking: _____
Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason Taking: _____
 Currently not taking any medications