PATIENT INITIAL PAPERWORK

GENERAL INFORMATION:

NAME: ____ AGE: ____________ SEX: M / F

ADDRESS:____

CITY: ____ STATE: __________ ZIP: _______

CELL PHONE: __________________________________ BIRTHDATE: __________________

EMAIL ADDRESS: ____

REFERRED BY: ▫ Friend ▫ Company ▫ Online Search ▫ Other:_____________________

Please Select Payment Option: ▫ Keep Card on File ▫ Paypal Invoice ▫ Time of Service

INSURANCE:

I clearly understand that all insurance coverage, whether accident, work related, or general coverage is an arrangement between my insurance carrier and myself. This office will provide any necessary reports or required information to aid in insurance reimbursement of services, but I understand that insurance carries may deny my claims and I am ultimately responsible for any unpaid balances.

Patient Signature:___________________________ Date:_____________________________

Insurance Company:____

ID /Policy #:______________________________ Group #:___________________________

CONSENT FOR CARE:

I give the doctors, therapists and staff permission and authority to care for me in accordance with testing, diagnosis, analysis and treatment. I am responsible to inform you of any symptoms, conditions, or issues which would otherwise not come to their attention.

Patient Signature: ___________________________________ Date:_________________________

HIPPA NOTICE:

I acknowledge and agree to the following:

1. The privacy notice is available to me now and at any time in the future.
2. Appointment reminders may be used by the practice via email, text, phone or postcards.
3. I understand that if I revoke this consent the practice has the right to refuse treatment.
4. I authorize the release of my medical information to: ___________________________________

Patient Signature: _____________________________________ Date:_________________________

WHAT BRINGS YOU IN TODAY?

What is your primary sport:_______________________ Secondary sport:_______________

Describe symptom/pain:____

What is the pain on average?_____ (1-10, 10=worse) At it's worst?_____ (1-10, 10=worse)

When/How did this begin?____

What aggravates symptoms?

Playing sport: Yes / No Lifting Weights: Yes / No Prolonged Sitting: Yes / No

Sleeping: Yes / No Other:____

What helps/relieves symptoms?

Rest/Immobility: Yes / No Kinesiotaping: Yes / No Soft Tissue Work: Yes / No

Dry Needling: Yes / No Other:____

Have you experienced these symptoms before? YES / NO

Who have you seen for this?____

How did you respond?____

What is your goal of your care? Pain Relief / Injury Prevention / Both

LIFESTYLE:

Do you smoke? YES / NO How much?_________________________

Do you drink alcohol? YES / NO How much/week?____________________

Do you drink caffeine? YES / NO How much/day?______________________

Do you take supplements? YES / NO List:_________________________________

Do you drink enough water? YES / NO How much/day?______________________

OVERALL HEALTH:

Please check any symptoms that you may be experiencing currently and up to 6 months ago.

Cervical Region -

▫ Neck Pain ▫ Headaches ▫ Pain in shoulders/arms/hands ▫ Numb/Tingle in arms/hands

Thoracic Region-

▫ Upper back pain ▫ Pain on deep breathing ▫ Mid back pain ▫ Pain in ribs/chest

Lumbar & Pelvis Region-

▫ Low Back Pain ▫ Pain in hips/legs/feet ▫ Weakness / Numbness in legs/feet

List all Surgeries:____

List any other Health Conditions not mentioned:__________________________________