PATIENT INITIAL PAPERWORK

NAME: ____ AGE: _____________ SEX: M / F

ADDRESS:____

CITY: ____ STATE: __________ ZIP: _____________

CELL PHONE: ________________________________ BIRTHDATE: __________________________

REFERRED BY:

□ Family / Friend □ Company □ Online Search □ Insurance Provider □ Other:_________

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.

Insurance Company: ____

ID / Subscriber #:_________________________________ Group #:____________________________

Patient Signature:____ Date: _________________________

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, phone or postcards.
3. I understand that if I revoke this consent at any time, the practice has the right to refuse treatment.
4. I authorize the release of my medical information to the following person(s): ___________________

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? ___________________________

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 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?____

What did they do/response?____

What is your goal of care (select all that apply)?

□ Pain Relief □ Improved Athletic Performance □ Injury Prevention

LIFESTYLE:

WATER INTAKE: How many ounces per day?____

ALCOHOL INTAKE: Amount & Frequency? ____

TOBACCO USE: How much?____

LIST MEDICATIONS: ____

LIST VITAMINS / SUPPLEMENTS: ____

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

Cervical Region (Neck) -

□ Neck Pain □ Headaches / Migraines □ Pain in shoulders/arms/hands □ Dizziness □ TMJ pain/clicking □ Numb/Tingle in arms/hands

Thoracic Region (Upper & Mid Back) -

□ Upper back pain □ Mid back pain □ Pain in ribs/chest

Lumbar & Pelvis Region (Low Back & Hips) -

□ Low back pain □ Pain in hips/legs/feet □ Sciatica into legs/feet

List all surgeries:____

List any other health conditions:____