

Registration & History
Renato Hess, L. P.T.

Patient _____

Address _____

Apartment/Unit/Suite Number _____

City/ZipCode: _____

Social Security #: _____

Date of Birth: _____

PATIENT CONTACT INFORMATION

Email _____

Cell _____

Home _____

Work _____

Best time to reach you _____

Please Circle One:

Married Partnered Single Divorced Widowed Separated

Partners Name _____

Partners DOB _____

EMERGENCY CONTACT INFORMATION

Name _____

Relationship _____

Phone _____

INSURANCE INFORMATION

Insurance Company _____

Provider Phone _____

EMPLOYER INFORMATION

Occupation _____

Employer _____

Employer Address _____

Employer Number _____

PATIENT CONDITION:

Reason for Visit:

When did your symptoms appear:

Is this condition getting progressively worse?

Yes _____ No _____

Comments: _____

Rate the severity of your pain on a scale from

1 (least pain) to 10 (severe pain) _____

Comments: _____

How often do you have this pain? _____

Is it constant or does it come and go? _____

What does the pain interfere with (ex. Work) _____

Type of Pain (Please circle all that apply):

Sharp Pain Dull Throbbing Stiffness

Numbness Aching Burning Swelling

Shooting Tingling Cramps Other:

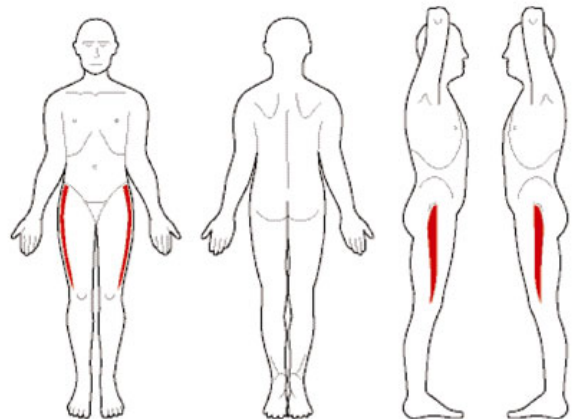
Comments: _____

Activities or movements that are painful to perform:

(Please circle all that apply)

Sitting Standing Walking Bending Lying Down

***Mark an X on the picture where you experience pain:**



Comments: _____

Personal History

(PLEASE PRINT)

Date: _____

HAVE YOU HAD? (circle choice)	Yes	N0	HAVE YOU HAD? (circle choice)	Yes	N0
Recurrent Headache			Epilepsy		
Eye Problem			Seizures		
Ear Problem			Dizziness		
Nose Problem			Fainting with exercise		
Throat Problem			Head Injury		
Thyroid Disorder			Concussion		
Heart Murmur			Bone Injuries		
Heart Disease			Joint Injuries		
Heart Palpitations			Stomach Problems		
High Blood Pressure			Intestinal Problems		
Low Blood Pressure			Diabetes		
Anemia			Eating Disorder		
Sickle Cell			ADD		
Bleeding Disorders: Hemophilia/Other			ADHD		
Hepatitis			Chicken Pox Vaccine		
Kidney Disorders			Chicken Pox Illness		
Bladder Disorders			Mononucleosis		
Pneumonia			Alcoholism		
Bronchitis			Drug Abuse		
Tuberculosis			Sexual Assault		
Seasonal Allergies/Hay Fever			Victim of Violence		
Asthma			Emotional Problems-Specify below:		
Surgeries:			Pregnancies:		
Hospitalizations:					

Briefly describe the history of your present Accident, Injury, Illness or Condition:

Onset Date: _____ Description: _____

Please list any special concerns, questions or expectations: _____

Have you fallen in the past year? _____ If so, how many times?: _____

If so, did you sustain an injury: _____

Please explain sustained injury: _____

Please list all medications: _____

Please list recent diagnostic studies (CAT scan, MRI, X-ray, Etc.) and where they were taken _____

Do you have METAL anywhere in your body (other than teeth), such as pins/plates, pacemakers, stints, etc.? _____

Please Describe: _____

Please list ALL surgeries you have had; please give procedures and dates, if possible: _____

Please circle one in each section:

Exercise

None

Moderate

Daily

Heavy

Work Activity

Sitting

Standing

Light Labor

Heavy Labor

Habits

Smoking

Alcohol

Coffee/Caffeine Drinks

High Stress Level

Packs/Day _____

Drinks/Week _____

Cups/Day _____

Reason _____

***If patient is a minor please provide us with the following:**

Parent/Guardian Name: _____

Social Security #: _____

Parent/Guardian Employer: _____

Work #: _____

Please Check Method of Payment:

Cash Private Insurance Medicare Flex Spending Workers Comp

If you have Medicare, do you have secondary insurance? Yes No

Please Provide us with a copy of your insurance card:

Name of Insurance: _____ PPO HMO ID #: _____

Customer Service/Provider Phone Number: _____

Primary Holder's Name: _____ Group #: _____

Was this a motor vehicle accident? Yes No *(If your answer is yes, please fill in the following)*

Name of Motor Vehicle Insurance: _____ Phone: _____

Adjusters Name: _____ Claim #: _____

Name of Insured: _____ Do you have an attorney? Yes No

If Yes, Name of Attorney: _____ Phone: _____

Please Initial the Following:

____: I hereby authorize the office of Balance Health + Wellness to provide treatment as prescribed by my physician.

____: I hereby assign all insurance benefits for services rendered to which I am entitled to be paid directly Renato G. Hess, L. P.T. at the office of Balance Health + Wellness. I understand that if my insurance company/third party payer denies payment or makes partial payment, that I am responsible for the balance.

____: I hereby authorize the release of medical records to Renato G. Hess at the office of Balance Health + Wellness and any pertinent information concerning the patient for the provision of care and for obtaining insurance reimbursement.

____: I understand that I am legally responsible for payment of all services rendered by Renato G. Hess at the office of Balance Health + Wellness. If my insurance is being billed, I will be responsible for paying deductible amounts. I understand that co-payments are due at the time of service. (This does not apply to worker's compensation patients.)

Signature of Patient/Guardian: _____ Date: _____

Witness Signature: _____ Date: _____

