

**PATIENT CONDITION:**

Reason for Visit:

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When did your symptoms appear:

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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: \_\_\_\_\_

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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: \_\_\_\_\_

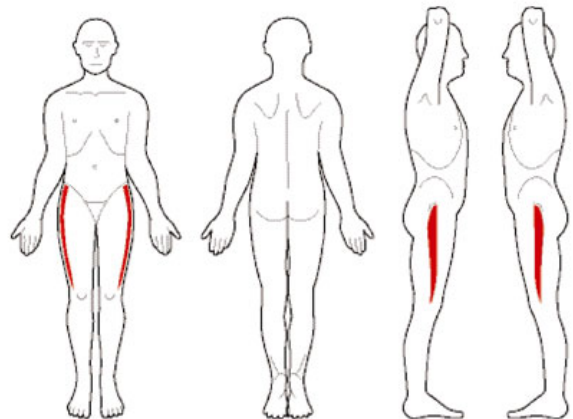
Comments: \_\_\_\_\_

**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: \_\_\_\_\_

Patient \_\_\_\_\_

Address \_\_\_\_\_

Apartment/Unit/Suite Number \_\_\_\_\_

City/ZipCode: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**Please CIRCLE ONE:** Female Male Transgender

**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 \_\_\_\_\_

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:

<b>Exercise</b>	<b>Work Activity</b>	<b>Habits</b>	
None	Sitting	Smoking	Packs/Day _____
Moderate	Standing	Alcohol	Drinks/Week _____
Daily	Light Labor	Coffee/Caffeine Drinks	Cups/Day _____
Heavy	Heavy Labor	High Stress Level	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: \_\_\_\_\_

