Name: _____

Total Body Therapy & Wellness

ADULT PATIENT INFORMATION SHEET

FIRST NAME	LAST NAME	MIDDLE INITIAL	SSN

MALE / FEMALE	DATE OF BIRTH (MM/DD/YYYY)	MARTIAL STATUS	EMPLOYMENT	EMAIL ADDRESS
MALE FEMALE		SINGLE MARRIED SEPARATED DIVORCED WIDOWED	EMPLOYED UNEMPLOYED RETIRED STUDENT	

HOME PHONE (PRIMARY YES/NO)	CELLPHONE (PRIMARY YES/NO)	APPOINTMENT REMINDER PREFERENCE
_____	_____	_____TEXT MESSAGE _____EMAIL _____PHONE CALL

MAILING ADDRESS	APT #	CITY	STATE	ZIP CODE

WHY ARE YOU BEING SEEN TODAY? LEFT RIGHT BOTH	IS THIS A WORKER'S COMPENSATION CASE?	DO YOU HAVE A LAWYER REPRESENTING YOU FOR THIS INJURY?	ARE YOU RECEIVING HOME HEALTHCARE OF ANY KIND?	ARE YOU EXPERIENCING ANY FOOT RELATED ISSUES?
_____	YES NO	YES NO	YES NO	YES NO
WHEN DID YOUR SYMPTOMS BEGIN? _____		**IF SO, DO YOU HAVE HEALTH INSURANCE?** YES NO		

IS THIS INJURY A RESULT OF A MOTOR VEHICLE ACCIDENT? YES NO

IF YES…

WHAT STATE DID THE ACCIDENT OCCUR? _____

WHAT WAS THE DATE OF ACCIDENT? _____

WERE YOU HOSPITALIZED DUE TO THE ACCIDENT? YES NO **IF SO, WHAT DATES?** _____

WERE YOU UNABLE TO WORK DUE TO THE ACCIDENT? YES NO **IF SO, WHAT DATES?** _____

PRIMARY CARE PROVIDER:

_____

REFERRING PHYSICIAN:

_____

HOW DID YOU HEAR ABOUT TBTW?

WORKSHOP
REFERRAL
WALK-IN
REFERRAL.
INTERNET SEARCH
NEWSLETTER
OTHER: _____
FRIEND/FAMILY
FACEBOOK
PHYSICIAN
FORMER PATIENT
LAWYER

EMPLOYER: _____

EMPLOYER ADDRESS: _____

_____

EMPLOYER PHONE: _____

EMERGENCY CONTACT

RELATIONSHIP TO PATIENT	FIRST NAME	LAST NAME	PHONE NUMBER	EMAIL ADDRESS	THIS PERSON HAS PERMISSION TO DISCUSS MEDICAL RECORDS FOR THE PATIENT?
					YES NO

ADDRESS (IF DIFFERENT FROM PATIENT)	APT #	CITY	STATE	ZIP CODE

Name: _____

MEDICAL HISTORY

HEIGHT: _____
WEIGHT: _____

EXISTING OR RELEVANT PREVIOUS CONDITION (PLEASE CIRCLE APPROPRIATE ANSWER)								
ALLERGIES	**YES**	**NO**	DIFFICULTY EMPTYING BOWELS/CONSTIPATION	**YES**	**NO**	MRSA	**YES**	**NO**
ANEMIA	**YES**	**NO**	DIZZY SPELLS	**YES**	**NO**	MULTIPLE SCHLEROSIS	**YES**	**NO**
ANXIETY	**YES**	**NO**	EMPHYSEMA	**YES**	**NO**	MUSCULAR DISEASE	**YES**	**NO**
ARM/LEG SWELLING	**YES**	**NO**	EXCESSIVE FATIGUE	**YES**	**NO**	NUMBNESS/TINGLING	**YES**	**NO**
ARTHRITIS	**YES**	**NO**	EXCESSIVE WEAKNESS	**YES**	**NO**	OSTEOPOROSIS	**YES**	**NO**
ASTHMA	**YES**	**NO**	FIBROMYALGIA	**YES**	**NO**	PARKINSONS	**YES**	**NO**
AUTOIMMUNE DISORDER NAME: _____	**YES**	**NO**	FRACTURES	**YES**	**NO**	RHEUMATOID ARTHRITIS	**YES**	**NO**
BLOOD IN URINE OR STOOLS	**YES**	**NO**	FREQUENT URINATION	**YES**	**NO**	SEIZURES	**YES**	**NO**
BRUISE EASILY	**YES**	**NO**	GALLBLADDER PROBLEMS	**YES**	**NO**	SEXUAL DIFFICULTIES	**YES**	**NO**
CANCER	**YES**	**NO**	HEADACHES	**YES**	**NO**	SKIN RASH	**YES**	**NO**
CARDIAC CONDITIONS	**YES**	**NO**	HEARING IMPAIRMENT	**YES**	**NO**	SMOKING	**YES**	**NO**
CARDIAC PACEMAKER	**YES**	**NO**	HEPATITIS	**YES**	**NO**	SPEECH PROBLEMS	**YES**	**NO**
CHEMICAL DEPENDENCY	**YES**	**NO**	HIGH CHOLESTEROL	**YES**	**NO**	STRESS AT HOME OR WORK	**YES**	**NO**
CIRCULATION PROBLEMS	**YES**	**NO**	HIGH/LOW BLOOD PRESSURE	**YES**	**NO**	STROKES	**YES**	**NO**
CURRENTLY PREGNANT	**YES**	**NO**	HIV/AIDS	**YES**	**NO**	THYROID DISEASE	**YES**	**NO**
DEPRESSION	**YES**	**NO**	KIDNEY PROBLEMS	**YES**	**NO**	TREMORS	**YES**	**NO**
DIABETES	**YES**	**NO**	METAL IMPLANTS	**YES**	**NO**	URINE LEAKS OR INCONTINENCE?	**YES**	**NO**

DESCRIBE ANY OTHER CONDITIONS (IF "YES" TO ANY OF THE ABOVE, PLEASE EXPLAIN AND GIVE APPROXIMATE DATES):

FALL HISTORY:

INJURY AS A RESULT OF A FALL IN THE PAST YEAR?	**YES**	**NO**
TWO OR MORE FALLS IN THE LAST YEAR?	**YES**	**NO**
PATIENT IS AT RISK FOR FALLS?	**YES**	**NO**

SURGICAL HISTORY (PLEASE INCLUDE DATE OR BEST ESTIMATE):

Name: _____

PLEASE CHECK IF YOU HAVE BEEN DIAGNOSED WITH OR EXPERIENCED ANY OF THE FOLLOWING WITHIN THE PAST MONTH:

	LOW BACK AND RADIATING PAIN		ELBOW PAIN OR INSTABILITY		NUMBNESS, TINGLING, OR BURNING SENSATION IN THE ARMS OR HANDS
	NUMBNESS, TINGLING OR BURNING SENSATION IN THE LEGS OR FEET		BLURRED VISION		LOSS OF SENSATION IN HANDS/FEET
	WEAKNESS IN THE LEGS OR ARMS		DIZZINESS OR VERTIGO		DAILY ALCOHOL 3 GLASSES OR MORE
	YOU HAVE DIABETES OR NEUROPATHY		UNSTEADY GAIT		MUSCLE DISEASE/MUSCLE CRAMPING
	THYROID DYSFUNCTION		HYPERTENSION		SHOULDER PAIN OR INSTABILITY
	TENDINITIS/BURSITIS/ARTHRITIS		NECK PAIN AND RADIATION PAIN		ANKLE-FOOT PAIN OR INSTABILITY
	HEARING PROBLEMS		HEADACHES		HISTORY OF FALLS
	HYPOTENSION				

INFORMED CONSENT

LASER THERAPY IS A SAFE, NON-INVASIVE, FDA CLEARED MODALITY FOR THE TREATMENT OF PAIN AND THE TEMPORARY INCREASE OF MICROCIRCULATION. INCREASED MICROCIRCULATION CAN PROVIDE RELIEF FOR MANY ACUTE AND CHRONIC CONDITIONS. LASER THERAPY UTILIZES VISIBLE AND INVISIBLE LASER RADIATION; THEREFORE, APPROPRIATE EYE PROTECTION IS REQUIRED AT ALL TIMES DURING TREATMENT.

EFFECTS OF YOUR TREATMENT WILL CONTINUE FOR UP TO 18 HOURS. INDIVIDUALS RESPOND UNIQUELY TO TREATMENT; YOU MAY SEE IMMEDIATE RESULTS AFTER THE FIRST TREATMENT OR DEPENDING ON THE SEVERITY OF YOUR CONDITION YOU MAY REQUIRE SEVERAL TREATMENTS BEFORE YOU BEGIN TO FEEL RESULTS.

INCREASED SORENESS MAY OCCUR AFTER YOUR FIRST LASER SESSION. THIS IS A NORMAL HEALING PHENOMENON KNOWN AS RETRACING. MILD BRUISING MAY OCCUR FROM THE SOFT TISSUE MANUAL THERAPY ELEMENT OF YOUR TREATMENT PROGRAM.

DO YOU HAVE A PACEMAKER OR ANY OTHER IMPLATED DEVICES?	**YES NO**
ARE YOU PREGNANT?	**YES NO**
DO YOU HAVE CANCER?	**YES NO**
ARE YOU TAKING MEDICATIONS THAT INCREASE YOUR SENSITIVITY TO LIGHT?	**YES NO**
HAVE YOU HAD A STEROID INJECTION IN THE LAST 7 DAYS?	**YES NO**

*****BY SIGNING THIS CONSENT, I UNDERSTAND AND CONSENT TO TREATMENT. I UNDERSTAND THAT FAILING TO COMPLETE ANY PART OF MY TREATMENT PROGRAM WILL REDUCE MY CHANCES OF SUCCESS.**

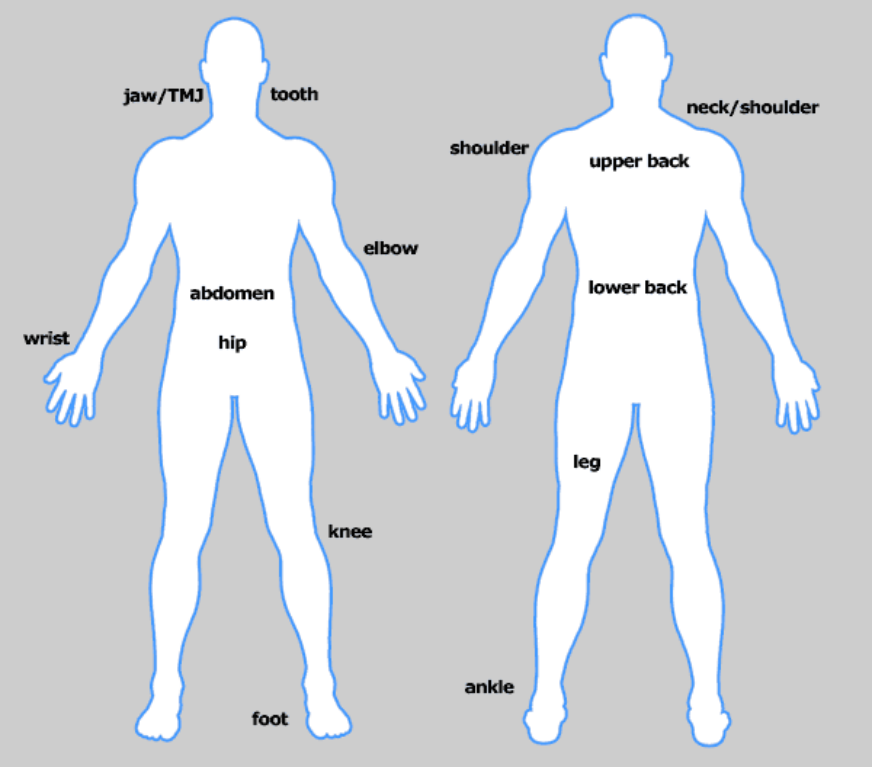
SIGNATURE:_____ **DATE:**_____

Name: _____

Patient Medication

PLEASE LIST ALL MEDICATIONS THAT YOU ARE CURRENTLY TAKING (PRESCRIBLED, VITAMINS, MINERALS, AND SUPPLEMENTS):

MEDICATION	DOSAGE	FREQUENCY TAKEN	ROUTE (ORAL, NASAL, ETC)
Circle your area(s) of pain:			



Please rank your pain level from 0-10
(0 = no pain 10= worst pain imaginable)

____ at worst in past week

____ at best

____ right now

I describe my pain as (circle all applicable):

Sharp	Shooting	Stabbing
Constant	Dull	Achy
Burning	Numb	Tingling

Other: _____

Total Body Therapy & Wellness

Name: _____

PATIENT RIGHTS DISCLOSURE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO INFORMATION. PLEASE READ IT CAREFULLY.

TOTAL BODY THERAPY AND WELLNESS'S LEGAL DUTY

TOTAL BODY THERAPY AND WELLNESS IS REQUIRED BY LAW TO PROTECT THE PRIVACY OF YOUR PERSONAL HEALTH INFORMATION, PROVIDE THIS NOTICE ABOUT OUR INFORMATION PRACTICES AND FOLLOW THE INFORMATION PRACTICES THAT ARE DESCRIBED HEREIN.

USES AND DISCLOSURES OF HEALTH INFORMATION

TOTAL BODY THERAPY AND WELLNESS USES YOUR PERSONAL HEALTH INFORMATION PRIMARILY FOR TREATMENT, OBTAINING PAYMENT FOR TREATMENT, CONDUCTING INTERNAL ADMINISTRATIVE AND EVALUATING THE QUALITY OF CARE THAT WE PROVIDE. SOME EXAMPLES OF USES OF YOUR PERSONAL HEALTH INFORMATION MAY INCLUDE, BUT ARE NOT LIMITED TO, THE FOLLOWING: (1) CONTACTING YOU BY TELEPHONE/MAIL/EMAIL AND LEAVING A MESSAGE IF NECESSARY TO PROVIDE OR OBTAIN INFORMATION REGARDING APPOINTMENTS, YOUR TREATMENT, YOUR PATIENT ACCOUNT, TREATMENT ALTERNATIVES OR OTHER HEALTH RELATED BENEFITS AND SERVICES THAT WE OFFER, AND/OR COMPANY NEWS; (2) OBTAINING INFORMATION FROM YOUR REFERRAL SOURCE IN ORDER TO SCHEDULE AN APPOINTMENT AND TO VERIFY/AUTHORIZE INSURANCE BENEFITS; (3) ANNOUNCING YOUR ARRIVAL TO THE THERAPIST IN AN AREA WHERE OTHERS MAY HEAR THE INFORMATION; (4) CALLING OUT YOUR NAME IN THE WAITING AREA; (5) TREATING YOU IN AN OPEN AREA WHERE CONVERSATIONS BETWEEN YOU AND YOUR THERAPIST MAY BE OVERHEARD BY OTHER PATIENTS AND STAFF; (6) SHARING INFORMATION AS NEEDED WITH OTHER HEALTH CARE PROVIDERS INVOLVED IN YOUR CARE; (7) PERFORMING QUALITY ASSURANCE TASKS SUCH AS CHART REVIEW AND OUTCOME ANALYSIS; (8) FORWARDING INFORMATION TO YOUR INSURANCE CARRIER IN ORDER TO RECEIVE PAYMENT ON CLAIMS (AFTER OBTAINING YOUR MEDICAL RECORDS RELEASE AND INSURANCE ASSIGNMENT), AND/OR (9) SHARING INFORMATION TO INSURERS AND OTHER ENTITIES INVOLVED IN YOUR WORKERS' COMPENSATION CASE AS AUTHORIZED BY LAW.

TOTAL BODY THERAPY AND WELLNESS MAY ALSO USE OR DISCLOSE YOUR PERSONAL HEALTH INFORMATION WITHOUT PRIOR AUTHORIZATION FOR PUBLIC HEALTH PURPOSES, FOR AUDITING PURPOSES, FOR RESEARCH STUDIES AND FOR EMERGENCIES. WE ALSO PROVIDE INFORMATION WHEN REQUIRED BY LAW.

IN ANY OTHER SITUATION, TOTAL BODY THERAPY & WELLNESS'S POLICY IS TO OBTAIN YOUR WRITTEN AUTHORIZATION BEFORE DISCLOSING YOUR PERSONAL HEALTH INFORMATION. IF YOU PROVIDE US WITH A WRITTEN AUTHORIZATION TO RELEASE INFORMATION FOR ANY REASON, YOU MAY LATER REVOKE THAT AUTHORIZATION TO STOP FUTURE DISCLOSURES AT ANY TIME.

PATIENT'S INDIVIDUAL RIGHTS

YOU HAVE THE RIGHT TO REVIEW OR OBTAIN A COPY OF YOUR PERSONAL HEALTH INFORMATION AT ANY TIME. YOU HAVE THE RIGHT TO REQUEST THAT WE CORRECT ANY INACCURATE OR INCOMPLETE INFORMATION IN YOUR RECORDS. YOU ALSO HAVE THE RIGHT TO REQUEST A LIST OF INSTANCES WHERE WE HAVE DISCLOSED YOUR PERSONAL HEALTH INFORMATION FOR REASONS OTHER THAN TREATMENT, PAYMENT OR OTHER RELATED ADMINISTRATIVE PURPOSES.

YOU MAY ALSO REQUEST IN WRITING THAT WE NOT USE OR DISCLOSE YOUR PERSONAL HEALTH INFORMATION FOR TREATMENT, PAYMENT OR ADMINISTRATIVE PURPOSES EXCEPT WHEN SPECIFICALLY AUTHORIZED BY YOU, WHEN REQUIRED BY LAW OR IN AN EMERGENCY CIRCUMSTANCE. TOTAL BODY THERAPY & WELLNESS WILL CONSIDER ALL SUCH REQUESTS ON A CASE-BY-CASE BASIS, BUT THE PRACTICE IS NOT LEGALLY REQUIRED TO ACCEPT THEM.

CONCERNS AND COMPLAINTS

IF YOU ARE CONCERNED THAT TOTAL BODY THERAPY & WELLNESS MAY HAVE VIOLATED YOUR PRIVACY RIGHTS OR IF YOU DISAGREE WITH ANY DECISION WE HAVE MADE REGARDING ACCESS OR DISCLOSURE OF YOUR PERSONAL HEALTH INFORMATION, PLEASE CONTACT OUR PRIVACY/SECURITY OFFICE AT THE ADDRESS BELOW. YOU MAY ALSO SEND A WRITTEN COMPLAINT TO THE US DEPARTMENT OF HEALTH AND HUMAN SERVICES. TOTAL BODY THERAPY & WELLNESS WILL NOT TOLERATE ANY RETALIATORY ACTS AGAINST ANYONE WHO FILES A COMPLAINT. FOR FURTHER INFORMATION ON TOTAL BODY THERAPY & WELLNESS HEALTH INFORMATION PRACTICES, OR IF YOU HAVE A COMPLAINT, CONTACT THE FOLLOWING PERSON: SARA MORRISON, TOTAL BODY THERAPY & WELLNESS, 2 THE SQUARE AT LILLINGTON, LILLINGTON, NC 27546, PHONE: (910) 893-2850, FAX: (910) 984-1515.

Signature _____ **Date:** _____

Name: _____

CONSENT TO TREAT

PLEASE READ AND INITIAL INDICATING THAT YOU ACKNOWLEDGE THE FOLLOWING POLICIES:

_____ THE INFORMATION ON THE PATIENT INTAKE FORM IS CORRECT TO THE BEST OF YOUR KNOWLEDGE. YOU AGREE THAT YOU WILL NOTIFY TBTW IMMEDIATELY OF ANY INSURANCE CHANGES OR CHANGES IN PERSONAL INFORMATION. FAILURE OF WHICH MAY RESULT IN DENIAL OF COVERAGE, THE FEES FOR WHICH YOU WILL BE RESPONSIBLE.

_____ CHARGES FOR SERVICE ARE DUE AT THE TIME OF SERVICE. PLEASE CHECK IN AND OUT TO MAKE SURE ALL CHARGES HAVE BEEN PAID BEFORE LEAVING CLINIC.

_____ ARRIVING LATE: LATE ARRIVALS MAY BE RESCHEDULED SO THAT OTHER PATIENTS MAY BE SEEN ON TIME. ARRIVING MORE THAN 15 MINUTES LATE MAY RESULT IN A $50.00 FEE.

_____ **CANCELLATIONS, RESCHEDULING OR NOT SHOWING FOR AN APPOINTMENT: WE REQUIRE A MINIMUM OF 24 HOURS NOTICE TO CANCEL OR RESCHEDULE APPPOINTMENTS. YOU MAY LEAVE A VOICEMAIL AS WE MAY BE AWAY FROM THE DESK OR ASSISTING ANOTHER PATIENT (ALL OF OUR VOICEMAILS ARE CHECKED AND TIME STAMPED). IF YOU FAIL TO SHOW FOR AN APPOINTMENT WITHOUT 24 HOURS NOTICE, YOU WILL BE CHARGED A $50.00 FEE THAT WILL NOT BE COVERED BY INSURANCE. ALL FUTURE APPOINTMENTS ARE SUBJECT TO CANCELLATION IF CONTACT IS NOT MADE WITH TBTW. CANCELLATION OF A DIAGNOSTIC TESTING APPOINTMENT WITH LESS THAN 24 HOURS NOTICE WILL RESULT IN A FEE OF $150. ALSO, CANCELLATION OF A DRY NEEDLING APPOINTMENT WITH LESS THAN 24 HOURS NOTICE WILL RESULT IN A $35 FEE.**

_____ I UNDERSTAND TBTW WILL NOT PERMIT ANY REFUNDS OR EXCHAGES FOR DME ITEMS, DEEP TISSUE LASER PACKAGES, OR DRY NEEDLING PACKAGES PURCHASED.

_____ I UNDERSTAND THAT ANY CREDIT ON MY ACCOUNT WILL GO TOWARDS MY BALANCE BEFORE BEING ISSUED A REFUND.

_____ APPOINTMENT REMINDERS: WE SEND APPOINTMENT REMINDERS VIA TEXT, PHONE, OR EMAIL. PLEASE LET US KNOW WHICH METHOD OF NOTIFICATION IS BEST FOR YOU.

_____ I UNDERSTAND AND AGREE THAT INSURANCE CLAIM FORMS WILL BE SUBMITTED TO MY INSURANCE COMPANY AS A MATTER OF CONVENIENCE ONLY, AND THAT I AM RESPONSIBLE FOR ALL CHARGES REGARDLESS OF MY EXISTING MEDICAL COVERAGE. I HEREBY GIVE AUTHORIZATION FOR PAYMENT OF INSURANCE BENEFITS TO BE MADE DIRECTLY TO TBTW FOR SERVICES RENDERED.
IN THE EVENT THAT MY INSURANCE COMPAY FORWARDS PAYMENT DIRECTLY TO ME INSTEAD OF TBTW, I WILL IMMEDIATELY DELIVER SAID PAYMENT TO TBTW.
AUTHORIZATION TO RELEASE INFORMATION: I AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY TO VERIFY BENEFITS/OBTAIN PAYMENT OR COMPLETE TREATMENT.

_____ I UNDERSTAND AND AGREE THAT I AM WHOLLY RESPONSIBLE AND LIABLE FOR PAYMENT AND ALL CHARGES ASSESSED FOR PROFESSIONAL SERVICES RENDERED AND WILL PAY ANY SUM DUE WHEN REQUESTED. I UNDERSTAND AND AGREE THAT IF NECESSARY, TO COMMENCE LEGAL ACTIONS FOR THE COLLECTION OF ANY OUTSTANDING CHARGES ON MY ACCOUNT, I WILL BE RESPONSIBLE FOR ANY COSTS AND/OR COURT FEES, IN ADDITION TO OUTSTANDING BALANCE.

_____ ASSIGNMENT OF BENEFITS/PROCEEDS: I HEREBY INSTRUCT AND DIRECT ALL PAYERS RESPONSIBILITY FOR MAKING PAYMENTS TOWARDS THE TREATMENT OF MY INJURIES TO PAY TBTW, 2 THE SQUARE AT LILLINGTON, LILLINGTON, NC 27546 FOR THE PROFESSIONAL OR MEDICAL BENEFITS/PROCEEDS ALLOWABLE, AND OTHERWISE PAYABLE TO ME AS PAYMENT TOWARD TOTAL CHARGES FOR THE PROFESSIONAL SERVES RENDERED. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS/PROCEEDS UNDER ANY APPLICABLE POLICIES/AGREEMENTS. I FURTHER INTEND FOR THIS ASSIGNMENT TO CREAT A SECURED INTEREST UNDER THE APPLICABLE UNIFORM COMMERCIAL CODE.

_____ CONSENT TO EVALUATION AND TREATMENT: I DO HEREBY CONSENT TO THE EVALUATION AND TREATMENT OF TBTW. I UNDERSTAND IT IS MY RIGHT TO ACCEPT OR REFUSE ANY TREATMENT OFFERED TO ME. I ACKNOWLEDGE AND UNDERSTAND THAT NO GUARANTEE HAS BEEN MADE TO ME AS TO THE RESULTS THAT MAY BE OBTAINED FROM SUCH TREATMENT. YOU WILL SEE MORE THAN ONE THERAPIST DURING YOUR TIME HERE AT TBTW.

_____ **WE OPERATE AS A TEAM TO ENSURE THE HIGHEST QUALITY OF CARE. ALL THERAPISTS HAVE DIFFERENT EXPERIENCES AND SPECIALITIES, WHICH ALL CONTRIBUTE TO HELPING TO ATTAIN OPTIMAL RESULTS FOR OUR PATIENTS. AS SUCH, OUR TEAM MEMBERS WILL WORK COLLABORATIVELY TO BEST ADDRESS YOUR NEEDS.**

_____ I ACKNOWLEDGE THAT I WILL REQUIRE A FORMAL DISCHARGE/GRADUATION APPOINTMENT IN ORDER TO END MY PHYSICAL THERAPY COURSE AT TBTW.

_____ I UNDERSTAND AND ACKNOWLEDGE THE RECEIPT OF TBTW'S NOTICE OF PATIENT INFORMATION PRACTICES AND PRIVACY POLICY.

_____ TBTW WANTS TO HELP EVERYONE GET BACK TO NORMAL WITHOUT MEDICATION, SHOTS OR SURGERY! IF YOU HAVE SUCCESS, PLEASE REFER A FRIEND TO HELP THEM ACHIEVE THEIR GOALS! BRING A FRIEND TO A WORKSHOP FOR A FREE DEEP TISSUE LASER CONSULTATION.

_____ **OPTIONAL:** I CONSENT FOR MY PICTURE AND ANY VIDEOS TAKEN OF ME, WITH MY KNOWLEDGE, TO BE USED FOR PROMOTIONAL PURPOSES.

ALL PATIENTS:

It is the patient's responsibility to understand their benefits. As a courtesy, TBTW will verify and file your insurance; however, there is not a guarantee of payment and all services rendered are subject to approval from the insurance company; making, the patient ultimately responsible for all remaining medical fees relating to care. TBTW will inform you in person or by invoice for payment of any monies owed or remaining that were not paid or covered.

Signature: Date:

Total Body Therapy & Wellness

Name: _____

ADULT (18 AND OLDER)

NAME:_____ **DATE:**_____

DEPRESSION SCREEN

HAVE YOU EVER BEEN DIAGNOSED WITH DEPRESSION OR BIPOLAR DISORDER? IF YES, SKIP THIS SURVEY. YES_____ NO_____

PLEASE CHECK THE ANSWER THAT MORE ACCURATELY DESCRIBES YOUR HEALTH AND FEELINGS (CHOOSE ONE):

QUESTION	YES, DESCRIBES ME EXACTLY	SOMEWHAT DESCRIBES ME	NO, DOESN'T DESCRIBE ME AT ALL
1. I GIVE UP TOO EASILY			
2. I HAVE DIFFICULT CONCENTRATING			
3. I AM COMFORTABLE BEING AROUND PEOPLE			

DURING THE PAST WEEK, HOW MUCH TROUBLE HAVE YOU HAD WITH:

QUESTION	NONE	SOME	A LOT
4. SLEEPING			
5. GETTING TIRED EASILY			
6. FEELING DEPRESSED OR SAD			
7. NERVOUSNESS			

ELDERLY ABUSE SCREEN (FOR PATIENTS 65 AND OLDER ONLY)

QUESTIONS 1-5 ANSWERED BY PATIENT AND QUESTION 6 IS ANSWERED BY DOCTOR.

WITHIN THE LAST 12 MONTHS (PLEASE CHECK ONE):

QUESTION	YES	NO	DID NOT ANSWER
1. HAVE YOU RELIED ON PEOPLE FOR ANY OF THE FOLLOWING: BATHING, DRESSING, SHOPPING, BANKING, OR MEALS?			
2. HAS ANYONE PREVENTED YOU FROM GETTING FOOD, CLOTHES, MEDICATION, GLASSES, HEARING AIDES, OR MEDICAL CARE, OR FROM BEING WITH PEOPLE YOU WANTED TO BE WITH?			
3. HAVE YOU BEEN UPSET BECAUSE SOMEONE TALKED TO YOU IN A WAY THAT MADE YOU FEEL SHAMED OR THREATENED?			
4. HAS ANYONE TRIED TO FORCE YOU TO SIGN PAPERS OR TO USE YOUR MONEY AGAINST YOUR WILL?			
5. HAS ANYONE MADE YOU AFRAID, TOUCHED YOU IN WAYS THAT YOU DID NOT WANT, OR HURT YOU PHYSICALLY?			
6. DOCTOR: ELDER ABUSE MAY BE ASSOCIATED WITH FINDINGS SUCH AS: POOR EYE CONTACT, WITHDRAWN NATURE, MALNOURISHMENT, HYGIENE ISSUES, CUTS, BRUISES, INAPPROPRIATE CLOTHING, OR MEDICATION COMPLIANCE ISSUES. DID YOU NOTICE ANY OF THESE TODAY OR IN THE LAST 12 MONTHS?			