

Name: \_\_\_\_\_



**ADULT PATIENT INFORMATION SHEET**

<b>FIRST NAME</b>		<b>LAST NAME</b>		<b>MIDDLE INITIAL</b>		<b>SSN</b>		
<b>MALE</b>	<b>DATE OF BIRTH</b> (MM/DD/YYYY)	<b>MARTIAL STATUS</b>		<b>EMPLOYMENT</b>		<b>EMAIL ADDRESS</b>		
<b>FEMALE</b>		SINGLE MARRIED SEPARATED DIVORCED WIDOWED		EMPLOYED UNEMPLOYED RETIRED STUDENT				
<b>HOME PHONE (PRIMARY YES/NO)</b> _____			<b>CELLPHONE (PRIMARY YES/NO)</b> _____			<b>APPOINTMENT REMINDER PREFERENCE</b> ____ TEXT MESSAGE ____ EMAIL ____ PHONE CALL		
<b>MAILING ADDRESS</b>		<b>APT #</b>	<b>CITY</b>	<b>STATE</b>	<b>ZIP CODE</b>			
<b>WHY ARE YOU BEING SEEN TODAY? LEFT RIGHT BOTH</b> _____			<b>IS THIS A WORKER'S COMPENSATION CASE?</b>		<b>DO YOU HAVE A LAWYER REPRESENTING YOU FOR THIS INJURY?</b>		<b>ARE YOU RECEIVING HOME HEALTHCARE OF ANY KIND?</b>	
<b>WHEN DID YOUR SYMPTOMS BEGIN?</b> _____			YES NO		YES NO <b>IF SO, DO YOU HAVE HEALTH INSURANCE?</b>		YES NO  YES NO	
<b>IS THIS INJURY A RESULT OF A MOTOR VEHICLE ACCIDENT?</b> YES NO				<b>PRIMARY CARE PROVIDER:</b> _____  <b>REFERRING PHYSICIAN:</b> _____				
IF YES... <b>WHAT STATE DID THE ACCIDENT OCCUR?</b> _____								
<b>WHAT WAS THE DATE OF ACCIDENT?</b> _____								
<b>WERE YOU HOSPITALIZED DUE TO THE ACCIDENT?</b> YES NO <b>IF SO, WHAT DATES?</b> _____								
<b>WERE YOU UNABLE TO WORK DUE TO THE ACCIDENT?</b> YES NO <b>IF SO, WHAT DATES?</b> _____								
<b>HOW DID YOU HEAR ABOUT TBTW?</b>		<b>EMPLOYER:</b> _____						
WORKSHOP REFERRAL FRIEND/FAMILY FACEBOOK WALK-IN PHYSICIAN REFERRAL FORMER PATIENT INTERNET SEARCH LAWYER NEWSLETTER OTHER: _____		<b>EMPLOYER ADDRESS:</b> _____ _____						
		<b>EMPLOYER PHONE:</b> _____						

EMERGENCY CONTACT					
<b>RELATIONSHIP TO PATIENT</b>	<b>FIRST NAME</b>	<b>LAST NAME</b>	<b>PHONE NUMBER</b>	<b>EMAIL ADDRESS</b>	<b>THIS PERSON HAS PERMISSION TO DISCUSS MEDICAL RECORDS FOR THE PATIENT?</b>
					YES NO
<b>ADDRESS (IF DIFFERENT FROM PATIENT)</b>		<b>APT #</b>	<b>CITY</b>	<b>STATE</b>	<b>ZIP CODE</b>

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/ PRE- 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):**

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**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):**

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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 IMPLANTED 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.**

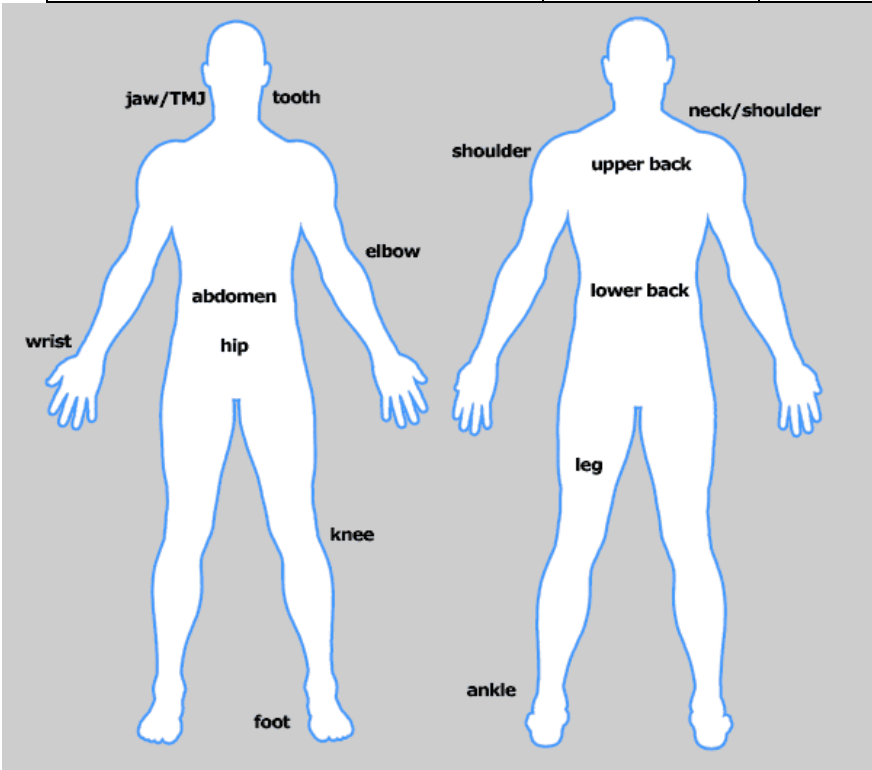
**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

Name: \_\_\_\_\_

**Patient Medication**

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

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



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: \_\_\_\_\_

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 APPOINTMENTS. 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 EXCHANGES 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 COMPANY 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 SERVICES RENDERED. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS/PROCEEDS UNDER ANY APPLICABLE POLICIES/AGREEMENTS. I FURTHER INTEND FOR THIS ASSIGNMENT TO CREATE 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: \_\_\_\_\_

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?			

**PELVIC FLOOR QUESTIONNEER**

1. Do you usually experience heaviness, dullness or deep ache in the lower Abdomen, vagina or tailbone area?
2. Do you usually have a fullness sensation, bulge or something falling out that you can see or feel in the vaginal or rectal area?
3. Do you feel you have not completely emptied your bowels or bladder at the end of a bowel movement / urination?
4. Do you experience a strong sense of urgency and have to rush to the bathroom to urinate or to have a bowel movement?
5. Do you usually have constipation, lose gas or stool from the rectum beyond your control?
6. Do you usually experience urine leakage associated with a feeling of urgency; that is, a strong sensation of needing to go to the bathroom?
7. Do you usually experience urine leakage related to laughing, coughing, or sneezing?
8. Do you have pain with intercourse or using a tampon?
9. Have you had childbirth that required forceps, stitches (episiotomy) or other specialized tools?
10. Do you feel "broken" or "weak" after carrying and birthing a child/children? Have you carried more than 2 children?
11. Do you have to push up on the vaginal/rectal area to have a complete bowel movement?

NONE	SOME	MODERATE	OFTEN
0	1	2	3
0	1	2	3
0	1	2	3
0	1	2	3
0	1	2	3
0	1	2	3
0	1	2	3
0	1	2	3
0	1	2	3
0	1	2	3
0	1	2	3
0	1	2	3
0	1	2	3
0	1	2	3

**\*\*Score 2 or more talk to PT\*\***

**TOTAL= \_\_\_\_\_**