PERFORMANCE HEALTH & INTEGRATIVE TRAINING

Intake Form

Patient Name *(please print):*_____ **Date**: ____/____/____

How were you referred to us? TV/Radio/Friend/Doctor/Facebook/Website/Other_____

How would you like us to refer to you? _____

Primary Phone _____ Secondary Phone _____

Address_____ City_____ State____ Zip _____

Date of Birth: ___/___/_____ Age____ Gender: M or F Marital Status: Single Married Other

Email_____

Employment Status: Employed/Full-time student/Part-time student/Retired/Other

Occupation_____ Employer Name_____

Primary Care Physician _____

Medical Conditions _____

Signature/Guardian Signature _____ Date: ___/___/____

By signing above, I (we) agree to pay for services rendered to the above mentions patient as the charge is incurred. I (we) understand that that I am personally responsible for payment of any and all services, covered or non-covered. I also understand and agree to pay all fees for non-covered services prior to seeing a doctor. I (we) authorize the doctor and his/her staff to release information any information deemed appropriate concerning my physical condition to any insurance company, claims adjuster, case nurse, claims reviewer, employer, healthcare provider or attorney in order to process any claim for reimbursement or charges incurred by me as a result of professional services rendered and herby release him/her of any consequences thereof. I agree that a photo static copy of this arrangement shall serve as the original. I (we) hereby authorize and direct payment of any medical/chiropractic expense benefits allowable to the doctor as payment toward the total charges for professional services rendered.

Name: _____ Date: ___/___/____

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train@jphitness.com

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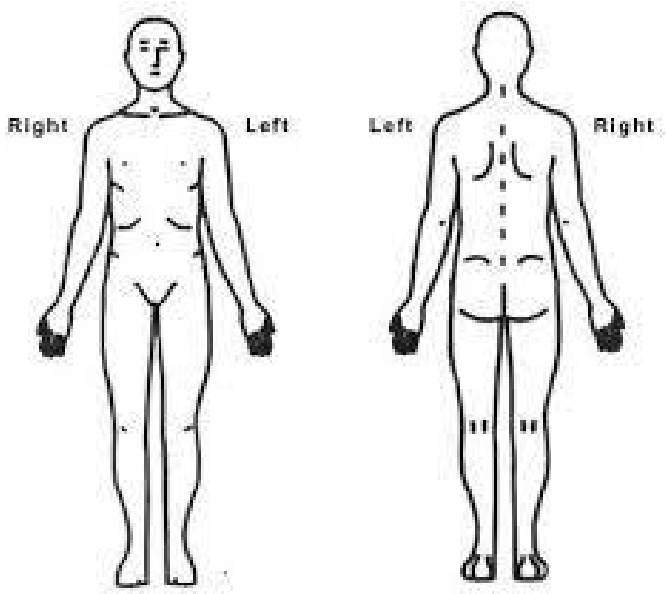


Please indicate on the body diagram where you are experiencing pain by marking an "X" in all body regions

Describe your symptoms: _____

When did your symptoms start? _____

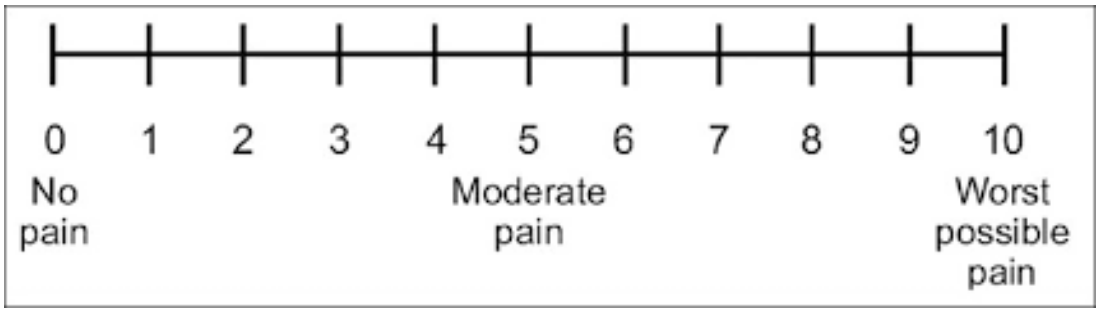
How did your symptoms begin? _____

_____

Did your symptoms begin due to an auto accident? YES or NO

If so, when was the date of your auto accident? ___/___/____

Please rate your pain level on the pain scale below:



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Past Medical History

Name (*please print*):_____ **Date:** ____/____/____

Please "check" the answers that apply to you

Medical Conditions:

- o Arthritis
- o Hypertension
- o Cancer
- o Psychiatric Illness
- o Diabetes
- o Skin Disorder
- o Heart Disease
- o Stroke

Allergies:

- o Eggs
- o Soy
- o Fish & Shellfish
- o Sulfites
- o Milk or Lactose
- o Wheat/Gluten
- o Peanuts
- o Other_____

Social History:

- o Caffeine used
- o Chew tobacco
- o Drink alcohol
- o Smoke
- o Exercise
- o Wear seat belts

Family History: *(please write which family member and type in space provided)*

- o Arthritis _____
- o Cholesterol _____
- o Heart Conditions_____
- o Psychiatric _____
- o Thyroid _____
- o Hypertension _____
- o Stroke _____
- o Diabetes _____

Previous Surgeries:

- o Spinal/disc surgery {Neck or Lumbar}
- o Cardiovascular procedure
- o Appendectomy
- o Joint replacement
- o Hysterectomy
- o Hernia repair
- o Other _____

Diagnosed Conditions: _____

_____

Review of Systems

(*please check all that apply*)

General-

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□ Weight loss or gain
□ Fatigue
□ Fever or chills
□ Weakness
□ Trouble sleeping

Skin-

□ Rashes
□ Lumps
□ Itching
□ Dryness
□ Color changes
□ Hair and nail changes

Head-

□ Headache
□ Head injury
□ Neck Pain

Ears-

□ Decreased hearing
□ Ringing in ears
□ Earache
□ Drainage

Eyes-

□ Vision Loss/Changes
□ Glasses or contacts
□ Redness
□ Blurry or double vision
□ Flashing lights
□ Specks
□ Glaucoma
□ Cataracts

Nose-

□ Stuffiness
□ Discharge
□ Itching
□ Hay fever
□ Nosebleeds
□ Sinus pain

Throat-

□ Dentures
□ Sore tongue
□ Dry mouth
□ Sore throat
□ Hoarseness
□ Thrush
□ Non-healing sores

Neck-

□ Lumps
□ Swollen glands
□ Pain
□ Stiffness

Breasts-

□ Lumps
□ Pain
□ Discharge
□ Breast-feeding

Respiratory-

□ Cough
□ Coughing up blood
□ Shortness of breath
□ Wheezing
□ Painful breathing

Cardiovascular-

□ Chest pain or discomfort
□ Tightness
□ Palpitations
□ Shortness of breath with activity
□ Difficulty breathing lying down
□ Swelling
□ Sudden awakening from sleep with shortness of breath

Gastrointestinal-

□ Swallowing difficulties
□ Heartburn
□ Change in appetite
□ Nausea
□ Rectal bleeding
□ Constipation
□ Diarrhea
□Yellow eyes or skin

Urinary-

□ Frequency
□ Urgency
□ Burning or pain
□ Blood in urine
□ Incontinence

Vascular-

□ Calf pain with walking
□ Leg cramping

Musculoskeletal-

□ Muscle or joint pain
□ Stiffness
□ Back pain
□ Redness of joints
□ Swelling of joints
□ Trauma

Neurologic-

□ Dizziness
□ Fainting
□ Seizures
□ Weakness
□ Numbness
□ Tingling
□ Tremor

Hematologic-

□ Ease of bruising
□ Ease of bleeding

Endocrine-

□ Head or cold intolerance
□ Sweating
□ Frequent urination
□ Thirst
□ Change in appetite

Psychiatric-

□ Nervousness
□ Stress
□ Depression
□ Memory loss

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Additional Questions

(Please circle YES or NO)

- Do you have any problems with recurring headaches? **Y N**
- Have you lost weight without trying? **Y N**
- Does your pain wake you up at night? **Y N**
- Have you had a change in bowel or bladder habits? **Y N**
- Do you have any numbness in your groin region? **Y N**
- Have you had an unresolved sore throat? **Y N**
- Have you recently had any unusual bleeding or discharge? **Y N**
- Do you have any thickening/lump in breast or other tissue? **Y N**
- Do you have indigestion or difficulty swallowing? **Y N**
- Have you had an obvious change in a mole? **Y N**
- Do you have a nagging cough or hoarseness? **Y N**

If you answered yes to any of the previous questions, please provide an explanation below:

_____

Any additional comments or questions: _____

_____

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It is our goal that you receive care from our office which will meet your expectations. Our doctors will take a history and perform an examination relevant to your condition. In some cases, we will recommend imaging such as x-rays or MRIs. We also may need to refer you to a medical physician or another form of care. We will attempt to offer you an explanation of your condition. We encourage you to ask questions during your visit or to call our office.

While chiropractic care is generally accepted to be safe and effective, certain questions regarding risks have been raised. It is our intent to be able to provide information and answers to any questions you may have. By signing below, you agree to the Informed consent and the Notice of Privacy Practices.

Informed Consent: I understand and am informed that, as in all healthcare, in the practice of chiropractic there are some rare risks to treatment, including but not limited to muscle strains and sprains, fractures, dislocations, disc injuries and stroke.

HIPAA: I acknowledge that I was provided a copy of the Notice of Privacy Practices on the Performance Health and Integrative Training, LLC., website and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that these privacy practices will be followed by Performance Health and Integrative Training, LLC, to ensure the privacy of my personal health information. I understand that this form will be placed in my patient chart and maintained for six years.

Patient Signature: _____ **Date:** ___/___/_____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

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Name: _____ Social Security (last 4 digits) _____
Address: _____
Date of Birth: ___/___/____ Phone #: _____

I hereby authorize the release of medical records indicated below to: _____
Phone #: _____
Address: _____

I hereby authorize the release of medical records indicated below by: _____
Phone #: _____
Address: _____

Date/s of service for medical records to be released: _____
Medical records to be released (check and initial each):
_____Complete images (films to be returned) with reports
_____ Imaging reports only
_____Blood work
_____Complete records
_____Other _____

The purpose for the release of information at the request of the individual is:
__Continued Treatment __Insurance __Blood Work __Other _____

This authorization will expire on the following date, event, or condition: _____
I understand that this authorization extends to all or any part of records as designated above unless initiated below or otherwise required by law.
__HIV/AIDS __Mental Health __Drug and /or Alcohol Abuse

_____ Date: ___/___/_____
Patient/Legal Representative or Parent/Legal guardian Signature

__ I wish to revoke this authorization
_____
Date: ___/___/_____
~~Sign/legal Representative or Parent/Legal guardian Signature~~

Consent to Treat / Assignment of Insurance Benefits

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Consent Authorization

1. I hereby request and authorize Performance Health and Integrative Training, LLC, and any such Chiropractic physicians, associates or assistants as may be employed or contracted by Performance Health and Integrative Training, LLC., to perform any and all chiropractic exams and services, including but not limited to, chiropractic adjustments, physical rehabilitation, and any other services deemed medically necessary to diagnose or treat me condition or conditions which has brought about my visit to Performance Health and Integrative Training LLC, and which appear indicated. If in the preparation for, during or following the procedure contemplated above, other conditions are discovered which, in the best judgment of the doctor, make a change or an extension of the originally intended procedures necessary or advisable, I authorize the request that the physician(s), or associates and assistants perform such extended or revised procedure or procedures.
2. I understand and have been advised of the nature and purpose of the treatment and procedures stated in the above paragraph, possible alternative methods of treatment, the risks involved, and possibility of complications.
3. I have also been informed that in the performance of any procedure there are risks. I am aware that the practice of chiropractic medicine is not an exact science and acknowledges that no guarantees have been made to me concerning the results of the treatment or procedure. I recognize that it is my responsibility to disclose any physical or emotional condition and medication recently taken which may be detrimental in any way to the success of the treatment or to my ultimate recover.

Release of Information

I, the undersigned patient/insured, herby authorize this Health Care Provider to: furnish an insurer, an insurer's intermediary, my other medical providers and my attorney(s) via mail, facsimile or e-mail with any and all information that may be contained within my medical records to : obtain insurance coverage information (i.e. declarations page and policy of insurance) in writing and telephonically from the insurer, request from any insurer all Explanation of Benefits/Review forms (EOBs) for all of my medical providers, obtain a non-redacted PIP payout sheet, obtain written and verbal statements that I or anyone else provided to the insurer, obtain copies of the entire claim file and all medical records, including, but not limited to: documents, reports, scans, notes, bills, opinions, X-Rays, IMEs, peer reviews and MRIs from any of my medical providers or any insurer. The Health Care Provider is permitted to produce my medical records to its attorney in connection with pursuing a legal action. The

insurer is directed to keep my, the undersigned patient's/insured's medical records confidential. The insurer is not authorized to provide my, the undersigned patient's/insured's medical records confidential. The insurer is not authorized to provide my, the undersigned patient's/insured's,

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medical records to anyone without my, the undersigned patient's/insured's and the Health Care Provider's express written permission.

MEDICARE PATIENT CERTIFICATION-PATIENTS CERTIFICATION AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST: I certify that the information given by me in applying for payment under the Title XVIII and or Title XI of the Social Security Act is correct. I authorize any holder of medical or other information about me, to release to the Social Security Administration or its Intermediary carriers, any information needed for this or related Medicare claims. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable to Performance Health and Integrative Training LLC, for physician (s) services. I understand that I am responsible for my health insurance deductibles and coinsurance.

Missed Appointment Policy: In an effort to accommodate other patients seeking an appointment, we ask that you notify us within 24 hours if you need to change or cancel your appointment. **Performance Health and Integrative Training LLC reserves the right to charge up to a $25 fee for missed appointments without proper notification.**

WOMEN: Verification of pregnancy: BY my signature, I do hereby state that, to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time. If I am pregnant, by my signature, I confirm that I have made the physician(s) aware of my pregnancy.

Acknowledgment of receipt of Privacy Practices: By my signature, I have received and understand the Notice of Privacy Practices of Performance Health and Integrative Training LLC, which describes the practice's policies and procedures regarding the use and disclosure of any of my protected health information created, received or maintained by the practice.

Consent and Liability Waiver - Release of all claims (must be signed to participate)

As lawful consideration for being permitted to participate in personal training. I agree that I will not make a claim against, sue, attach the property of or prosecute Performance Health and Integrative Training (P.H.I.T) and their agents, sponsors and employees for damages for death, personal injury or property damage which I may sustain as a result of my participation in these sporting activities. This release is intended to discharge in advance P.H.I.T and their agents, sponsors and employees from and against any and all liability, including for negligent actions, arising out of or connected in any way with my participation in the performance training, except

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for liability that may arise out of the willful or wanton misconduct of P.H.I.T and their agents, sponsors and employees.

I FURTHER UNDERSTAND THAT WEIGHT TRAINING INVOLVES THE POSSIBLITY OF SERIOUS ACCIDENTS THAT CAN OCCASIONALLY OCCUR DURING SUCH SPORTING ACTIVITIES, AND THAT PARTICIPANTS IN SUCH SPORTING ACTIVITIES OCCASIONALLY SUSTAIN SERIOUS PERSONAL INJURIES (INCLUDING DEATH) AND/OR PROPERTY DAMAGE, AS A CONSEQUENCE THEREOF, KNOWING THE RISKS OF PARTICIPATION, NEVERTHELESS, I HEREBY AGREE TO ASSUME THOSE RISKS AND TO RELEASE AND HOLD HARMLESS PERFORMANCE HEALTH AND INTEGRATIVE TRAINING AND THEIR AGENTS, SPONSORS AND EMPLOYEES WHO (THROUGH NEGLIENCE OR CARELESSNESS) MIGHT OTHERWISE BE LIABLE TO ME (OR MY HEIRS OR ASSIGNS) FOR DAMAGES.

I attest that I am eighteen (18) years old or older, am physically fit and have no known medical conditions which prohibit participation in this sport. I agree to follow all laws, rules and guidelines regulating the conduct of the sports league.

I HAVE CAREFULLY READ THIS AGREEMENT AND FULLY UNDERSTAND ITS CONTENTS. I AM AWARE THAT THIS IS A RELEASE OF LIABILITY AND A CONTRACT BETWEEN MYSELF AND FFG AND THEIR AGENTS, SPONSORS AND EMPLOYEES, AND I HAVE SIGNED IT OF MY OWN FREE WILL.
I also agree that PHIT and its agents, sponsors and employees may use my photograph in future promotions.

Signature: _____ Print_____

Under 18: Guardian/Parent: _____ Date:_____

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