PHYSICAL THERAPY
CHIROPRACTIC
ACUPUNCTURE
MASSAGE THERAPY

New Patient Paperwork

Name ____________________________________

Date ____________________________________

Patient Information

First Name:_________________________ Middle Name:______________________ Last Name:___________________________

Sex: Male Female Marital Status: Married Single Divorced DOB:_________________________________

Address: ____

City:______________________________ State:______________________________ Zip Code:___________________________

Home #:__________________________ Work #:___________________________ Cell #:_______________________________

Email:____ Cell Provider:_______________________

Emergency Contact:_________________ Relation:___________________________ Phone:______________________________

Spouse's Name:____________________ Parent's Name (If patient is a minor):____

Employed: Full Part Unemployed Student:__________________________ School:______________________________

Employer Name:____________________ Employer Address:____

Occupation:________________________ How did you hear about our office? Name: ______________________________

Insurance Information

Primary Ins:________________________ Phone #:________________________ ID#:__________________________________

Claim Address: ____ Group#______________________________

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City: ______________________________ State: __________________________ Zip Code: ___________________________

Subscriber Name____________________ Subscriber DOB:__________________ Secondary ID#:______________________

Secondary Ins_______________________ Secondary Phone #:_______________ Secondary GRP#:_____________________

Secondary Address: ____

City: ______________________________ State: __________________________ Zip Code:___________________________

Subscriber Name____________________ Subscriber DOB:__________________

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Name ____________________________________

Date _____________________________________

Complaint Information

How did injury occur? Auto Accident Work School Sports Other

Date of injury____

Describe discomfort____

Frequency of pain: Always Hourly Daily Occasionally

Does pain interfere with activities___________________________ Pain interfere with sleep? _____________________

Are you able to work? Yes No Explain ____

Have you received treatment? Yes No Explain ____

Xrays? Yes No Date ____

MRI? Yes No Date ____

History Information

Last physical exam _______________ Primary Care Physician_________________________ Phone#_____________

Height __________________________ Weight______________________________________

Previous Chiropractic: Yes No Explain: ____

Previous PT: Yes No Explain: ____

Previous Acupuncture: Yes No Explain: ____

Previous Massage: Yes No Explain: ____

Pregnant: Yes No Planning: Yes No

Medications: ____

Supplements: ____

Broken Bones: Yes No Explain: ____

Sprains: Yes No Explain: ____

Hospitalized: Yes No Explain: ____

Surgery: Yes No Explain: ____

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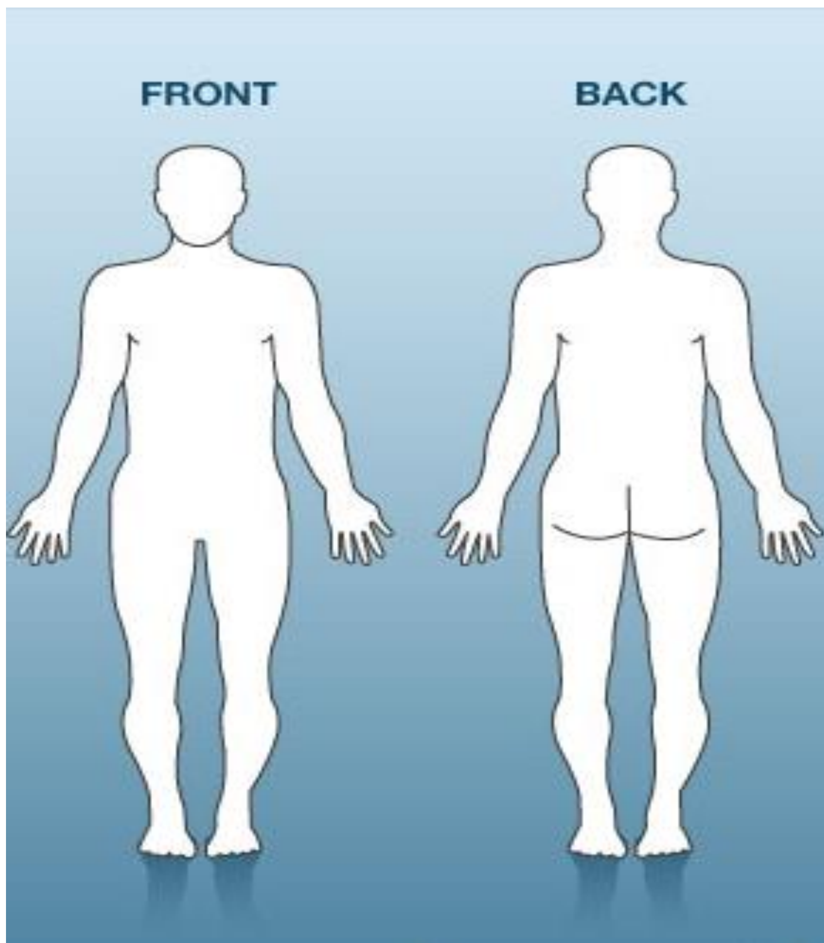
New Patient Paperwork

Name ____

Date ____

Please Mark Your Symptoms



Notes:

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Doctor's Notes:

PHYSICAL THERAPY
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Name ______________________________________

Date ______________________________________

Health Checklist (Please check all that apply)

Allergies	Alcoholism	Anemia
Arteriosclerosis	Arthritis/Rheumatoid	Asthma
Back Pain	Breast Lump	Bronchitis
Bruise Easily	Cancer	Chest Pain
Cold Extremities	Constipation	Cramps
Depression	Diabetes	Digestion Problems
Dizziness	Excessive Menstruation	Eye Pain/Difficulties
Fatigue	Frequent Urination	Headache
Hemorrhoids	High Blood Pressure	Hot Flashes
Irregular Heartbeat	Irregular Menstrual Cycle	Kidney Infection
Kidney Stones	Loss of Memory	Loss of Balance
Loss of Smell	Loss of Taste	Nosebleeds
Pacemaker/Defibrillator	Polio	Poor Posture
Prostate	Sciatica	Shortness of Breath
High Blood Pressure	Sinus Infection	Insomnia
Spinal Curvatures	Stroke	Swelling of Ankles
Swollen Joints	Thyroid Condition	Tuberculosis
Ulcers	Varicose Veins	Heart Disease
Seizures	STDs	HIV
Hepatitis	Osteoporosis/Osteopenia	Multiple Sclerosis
Blood Clots	Latex Sensitivity	Parkinson’s Disease
Pelvic Organ Prolapse	Urinary Incontinence	Pelvic Pain

Social Information

Alcohol:	Daily	Weekly	Occasionally	Never
Caffeine:	Daily	Weekly	Occasionally	Never
Drugs:	Daily	Weekly	Occasionally	Never
Tobacco:	Daily	Weekly	Occasionally	Never
Exercise:	Daily	Weekly	Occasionally	Never
Water:	Daily	Weekly	Occasionally	Never

HIPAA Privacy Policy

I understand that I have certain rights to privacy under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize TOTAL HEALTH ASSOCIATES to use and disclose my protected health information to carry out treatment, including direct or indirect treatment by other healthcare providers involved in my treatment, obtaining payment from third party payers and day to day healthcare operations of TOTAL HEALTH ASSOCIATES. I have also been informed of and given the right to review and secure a copy of the Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that THA reserves the right to change the terms of this notice and that I may contact THA at any time to obtain an up-to-date copy of this notice. I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, however, THA is under no obligation to comply with these requested restrictions. In the case that restrictions are mutually agreed upon THA is bound to comply with these new restrictions. I understand that I may revoke this consent at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Name of Patient or Legal Guardian ____

Signature of Patient or Legal Guardian ____

Date ____

Name ______________________________________

Date ______________________________________

Informed Consent for Acupuncture Treatment

Your traditional Chinese Medicine treatment sessions may include the following:

Acupuncture: Thin sterile needles inserted into the skin and muscle with or without electric stimulation. Acupuncture needles are sterilized and discarded after each use. Needles are never reused
Acupresssure/Tuina/Massage/Myofascial Release: Hand and finger pressure to areas of the body.
Moxibustion: Mugwort herb that is lit and used directly or indirectly on the patient's body.
Cupping: Small suction cups placed on body regions for muscular tension and a variety of ailments.
Gua-Sha: Gentle gliding on the skin with a special tool.
Warming/ Cooling Therapy: Using a hot or cold pack or heat lamp to move circulation.
Herbal Medicine and Dietary Recommendations: Individual powders, pills, herbs and food recommendations based on individual needs

The FDA regulates acupuncture needles as medical devices and rates them in the category of "safe and effective". Acupuncture side effects may include mild bruising, swelling and redness. Severe side effects are rare when a trained and licensed practitioner performs Acupuncture. Dizziness and fainting are unlikely and are usually brought on by hunger and excessive fear. Cupping and Gua-Sha may intentionally leave red marks that will usually disappear within a week. The energy heat lamp may leave redness and can potentially burn. Always let us know if it becomes too hot. As with the introduction of any new substance, herbs and dietary changes can affect your digestive system.

I certify that I am the patient or legal guardian listed above. I have read and understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to TOTAL HEALTH ASSOCIATES. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctors and licensed providers to release all information necessary to any insurance company, attorney or adjustor for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me and I am responsible for timely payment of such services. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and an individual. I understand that fees for professional services are due at the time of service.

Name of Patient or Legal Guardian ____

Signature of Patient ____

Date ____

Name ______________________________________

Date _______________________________________

Informed Consent For Chiropractic Treatment and Payment

Due to the nature of Chiropractic treatment, the Doctor will use his hands or a mechanical device in order to move your joints. You may feel a “click” or a “pop”, such as the noise when a knuckle is “cracked” and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or traction may also be used. As with any healthcare procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of the bone, muscular strain, ligament sprain, dislocation of joints or injury to intervertebral discs, nerves or the spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A small percentage of patients may notice stiffness or soreness after the first few days of treatment. Ancillary procedures may cause skin irritation, burns or other minor complications, however, these complications are rare.

I certify that I am the patient or legal guardian listed above. I have read and understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to TOTAL HEALTH ASSOCIATES. I authorize this office and its staff to examine and treat my condition. I hereby authorize the doctors and licensed providers of THA to release all information necessary to any insurance company, attorney or adjustor for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me and I am responsible for timely payment of such services. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and an individual. I understand that fees for professional services are due at the time of service.

Name of Patient or Legal Guardian ____

Signature of Patient or Legal Guardian ____

Date ____

Name ______________________________________

Date _______________________________________

Informed Consent For Physical Therapy

As is the nature of Physical Therapy, the Physical Therapist will use different manual approaches to stretch and facilitate movement to joints or soft tissue. In addition, some activities and exercises that may cause transient muscle soreness. You may feel mild discomfort during a stretch, but not intolerable pain. Various ancillary procedures, such as hot or cold packs, electric stimulation and therapeutic ultrasound may also be utilized. There are no significant risks with Physical Therapy. The ancillary procedures can produce skin irritation or minor superficial burns to those patients who have hyper sensitive skin. The probability of adverse reaction is considered rare. However, if undesirable discomfort is felt during the time of treatment, please let your Physical Therapist know immediately. It is important that you advise and communicate with your Physical Therapist about medical procedures such as minor surgeries, recent hospitalizations, doctor's visits, changes in medication, falls or any significant occurrence as they may present a contraindication and risk to continuing Physical Therapy. Physical Therapy is a system of health care delivery. As with many health care delivery systems we cannot promise a cure for any symptom, disease, or condition as a result of treatment in this office. If results are not acceptable, we will refer you to another health care provider for additional assistance.

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Name of Patient or Legal Guardian ____

Signature of Patient or Legal Guardian ____

Date ____

Name ______________________________________

Date _______________________________________

Informed Consent For Massage Therapy

I agree that it is my responsibility to inform the massage therapist of any pre-existing conditions, limitations or specific sensitivities. I understand that massage therapy used is for the purpose of stress reduction, relief of muscular tension or spasm and/or for increasing circulation and energy flow. I understand that the massage therapist does not diagnose illness, disease or any other physical or mental disorder. I understand that the massage therapist does not administer medical treatment or prescribe pharmaceuticals nor do they perform spinal manipulations. It has been made clear to me that the massage therapy is not a substitute for medical examinations and/or diagnosis and that it is recommended I see a physician for any physical ailment. I have stated all known medical conditions and take it upon myself to keep the massage therapist updated on my physical health.

I certify that I am the patient or legal guardian listed above. I have read and understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to TOTAL HEALTH ASSOCIATES. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctors and licensed providers to release all information necessary to any insurance company, attorney or adjustor for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me and I am responsible for timely payment of such services. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and an individual. I understand that fees for professional services are due at the time of service.

Name of Patient or Legal Guardian ____

Signature of Patient or Legal Guardian ____

Date ____