Synergy Myofascial Release & Rehab, Inc.

Patient Intake and Consent Form

Today's Date _____

First Name_____ MI _____ Last Name _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Date of Birth _____ Age _____

Cell Phone _____ SS# _____

Work Phone _____ Sex: Circle: **Male** **or** **Female**

Email _____ Marital Status: Circle: **S M D W**

Area to be treated _____

Accident Related? Circle: **Yes** **or** **No**

If accident: Circle: **Auto** **Work** **Home**

Nature of Accident _____

Responsible Party: Circle: **Same as Above**

(if different)

Name _____

Address _____

City/State/Zip _____

Phone Number _____

Relationship to Responsible Party _____

Employer_____

Address _____

City/State/Zip _____

Occupation _____

Contact Person at Employer _____

Referring Physician _____ Phone Number _____

Primary Insurance _____ Insured Name _____

Group # _____ ID# _____ Address _____City _____

Insured Employer _____ _State_____ Zip _____ Phone _____

Relationship to Insured _____ Insured Date of Birth _____ Sex: **M or F**

Secondary Insurance _____ Insured Name_____

Group# _____ ID# _____ Address _____ City_____

Insured Employer _____ State_____ Zip_____ Phone_____

Relationship to Insured _____ Insured Date of Birth _____ Sex: **M or F**

Emergency Contact _____ **Daytime Phone Number** _____

Are you receiving any other physical therapy services or home health? **YES** **or** **NO**

Synergy Myofascial Release & Rehab, Inc. / Patient Intake and Consent Form (cont.)

Consent for Treatment

Myofascial Release is performed in a private treatment room on a massage table. Hands on treatment requires access to patient's skin to release fascial restrictions. Patients are asked to undress to comfort level and patient gowns are provided along with appropriate draping so patient remains covered at all times. Modesty and personal privacy are essential part of the treatment process.

Patient Initials _____I have read and understand the nature of treatment as described above and request a third party sitting in the room during treatment.

Patient Initials _____I have read and understand the nature of treatment as described above and **DO NOT** require a third party sitting in the room during treatment.

Treatment of Minors

I as a parent/guardian of a minor receiving treatment hereunder, do herby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so. **Patient Guardian Initials** _____

Liability

I know and agree that Synergy Myofascial Release & Rehab, Inc. is not responsible for loss or damage to personal valuables. **Patient Initials** _____

Waiver and Release

I hereby release, discharge and acquit Synergy Myofascial Release & Rehab, Inc., it's agents, representatives, affiliates, employees, or assigns, of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency and or medical services, including but not limited to ambulance service, Emergency Medical Technician, physician or urgent care services. **Patient Initials** _____

Authorization of Payment

I hereby assign all benefits directly to and also authorize release of any medical records to facilitate my treatment to process medical claims and as otherwise permitted or required in the Notice of Privacy Practices. I understand fully that in the event my insurance company or financially responsible party does not pay for the service I receive, I will be financially responsible for payment. **Patient Initials** _____

Notice of Privacy

I acknowledge receipt of Notice of Privacy Practices under the Health Insurance Portability and Accountability Act (HIPPA). **Patient Initials** _____

I certify that all of the information provided herein is true and correct.

Patient/Guardian Signature _____ **Witness Signature** _____

Synergy Myofascial Release & Rehab, Inc.

New Patient Evaluation Subjective Report and Medical History

Name: _____

Date: _____

*Please fill out these forms as specifically as possible to provide us with a clear picture of your present symptoms, abilities and goals.

What is the primary complaint that brings you here?

Please describe your symptoms as specifically as possible.

When did your symptoms begin?

Did your symptoms begin as a result of an accident or trauma, or did they begin without a known reason?

Have you ever received other treatments for this condition? If yes, please indicate the type of treatment, length of treatment, and effectiveness.

Physical Therapy: _____

Other Treatment Services
(Chiropractor/Massages/Acupuncture): _____

What activities or positions increase your pain?

What activities or positions decrease your pain?

What are your goals for this treatment program? For example, what activities would you like to be able to perform better or longer?

Do you have any of the following medical conditions?

____	Circulatory problems	____	Blackouts
____	High blood pressure	____	Visual disturbances
____	Heart trouble	____	Recent or rapid weight changes
____	Pacemaker	____	Headaches/Migraines
____	Epilepsy	____	TMJ/jaw pain
____	Diabetes	____	Tinnitus/ringing in the ears
____	Pregnancy	____	Vertigo
____	Stroke	____	Bowel/bladder problems
____	Cancer	____	Arthritis
____	Fibromyalgia	____	Lymphedema
____	Disc disease/herniation	____	Radiating pain/radiculopathy
____	Osteoporosis	____	Trouble Bruising

Past Medical History: Please list any surgeries, traumas, accidents or other conditions and date of occurrence.

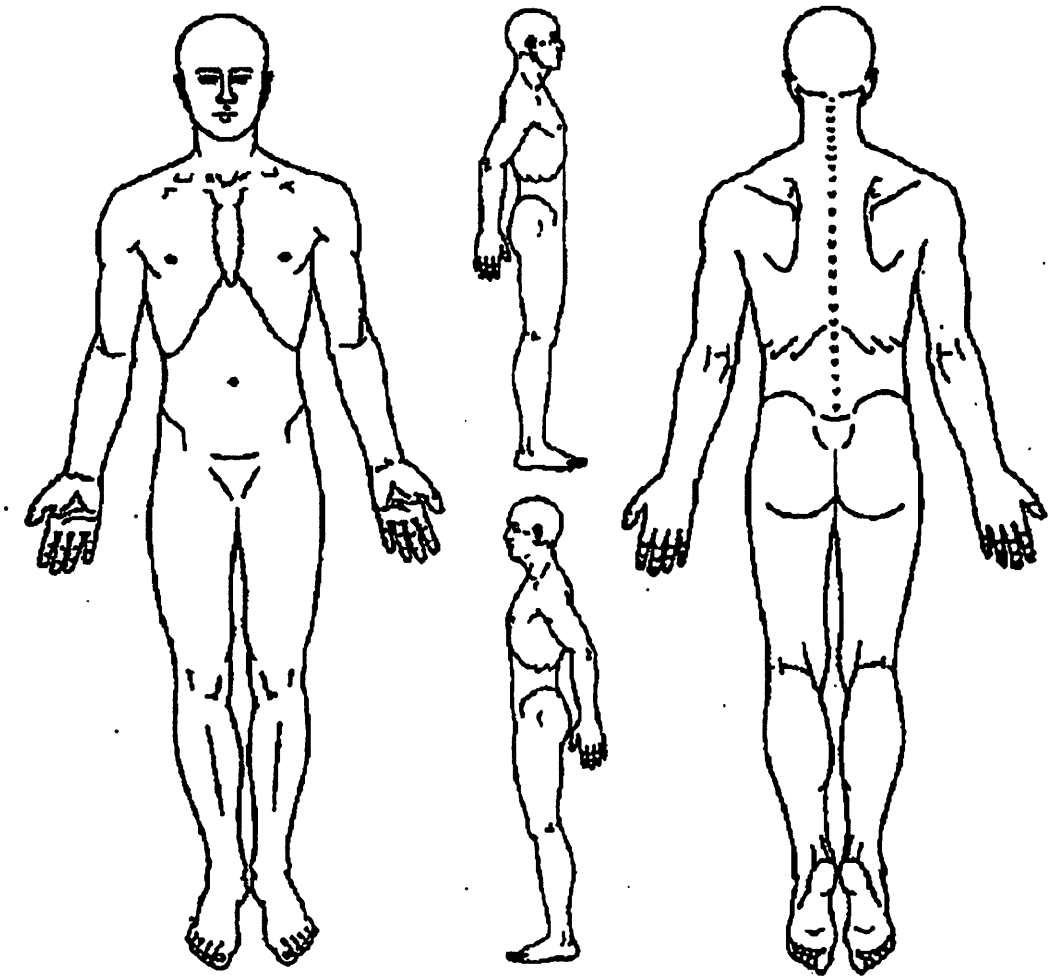
Please list any additional symptoms that you experience monthly or more frequently:

Medications:
Please list below medications that you are currently taking, the problem for which you are using them, the dosage and their effectiveness.

Pain Diagram

Please mark the area of injury or discomfort on the chart below, using the appropriate symbols:

Numbness	Pins & Needles	Burning	Aching	Stabbing
- - - - - -	O O O O O	^ ^ ^ ^	X X X X	⊗ ⊗ ⊗ ⊗
- - - - - -	O O O O O	^ ^ ^ ^	X X X X	⊗ ⊗ ⊗ ⊗
- - - - - -	O O O O O	^ ^ ^ ^	X X X X	⊗ ⊗ ⊗ ⊗



NAME _____ DATE _____

No Pain |——————————————————————————| Worst Possible Pain

Please make a slash through this line as to the level of your pain.

_____

Patient Signature