Dynamic Health Wellness & Rehabilitation Center

Confidential Patient Information:

PATIENT INFORMATION		
Name: Last:	First:	M.I.
Address: Street:	City:	State, Zip:
Social Security #: - -	Date of Birth: - -	
Gender: Male Female		Marital status S _____ M _____ D _____ W_____
Contact Information: Home Phone:	Office:	Cell:
Email :		
Employer Name:	Title:	Phone:
Address:		
City:	State:	Zip:
Insured Information:		
Name: Last:	First:	M.I.:
Relationship to Patient:	S.S.N.:	D.O.B.:
Address:		
Name of Employer:		

Conditions:

Past / Present

- ☐ ☐ Neck Pain
- ☐ ☐ Shoulder Pain (R___ L___)
- ☐ ☐ Pain in Upper Arm or Elbow (R___ L___)
- ☐ ☐ Hand Pain (R___ L___)
- ☐ ☐ Pain in Wrist (R___ L___)
- ☐ ☐ Upper Back Pain (R___ L___)
- ☐ ☐ Lower Back Pain (R___ L___)

Past / Present

- ☐ ☐ Pain in Lower Leg (R___ L___)
- ☐ ☐ Pain in Upper Leg (R___ L___)
- ☐ ☐ Pain in Hip (R___ L___)
- ☐ ☐ Pain in Knee (R___ L___)
- ☐ ☐ Jaw Pain (R___ L___)
- ☐ ☐ Pain in Ankle or Foot (R___ L___)
- ☐ ☐ Headache

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Confidential Patient Information:

Past / Present	Past / Present	Past / Present
☐ ☐ AIDS/HIV	☐ ☐ Herniated Disc	☐ ☐ Tonsillitis
☐ ☐ Allergy Shots	☐ ☐ High Cholesterol	☐ ☐ Tumors/Growths
☐ ☐ Anemia	☐ ☐ Kidney Disease	☐ ☐ Ulcer
☐ ☐ Anorexia	☐ ☐ Measles	☐ ☐ Whooping Cough
☐ ☐ Appendicitis	☐ ☐ Migraine Headaches	☐ Other_____
☐ ☐ Arthritis	☐ ☐ Mononucleosis	☐ Other _____
☐ ☐ Asthma	☐ ☐ Multiple Sclerosis	**Social History:**
☐ ☐ Bronchitis	☐ ☐ Osteoporosis	**Social History:**
☐ ☐ Cancer	☐ ☐ Pacemaker	☐ ☐ Tobacco_____Packs per Day _____Years
☐ ☐ Chicken Pox	☐ ☐ Parkinson's Disease	☐ ☐ Alcohol _____Drinks/Week
☐ ☐ Depression	☐ ☐ Pinched Nerve	☐ ☐ Coffee/Tea/Caffeinated Drinks_____Per Day
☐ ☐ Diabetes	☐ ☐ Pneumonia	
☐ ☐ Emphysema	☐ ☐ Prostate Problems	**Women Only:**
☐ ☐ Fractures	☐ ☐ Psychiatric Care	☐ ☐ Birth Control Pills
☐ ☐ Gout	☐ ☐ Rheumatoid Arthritis	☐ ☐ Menstrual Flow
☐ ☐ Heart Disease	☐ ☐ Rheumatic Fever	☐ ☐ Breast Implants
☐ ☐ Hepatitis	☐ ☐ Stroke	
☐ ☐ Hernia	☐ ☐ Thyroid Problems	

If a family member has had any of the following please mark the appropriate box:

☐ Arthritis ☐ Epilepsy ☐ Diabetes ☐ Cancer ☐ Heart Disease ☐ Chronic Headaches ☐ Chronic Back Pain
☐ Kidney Disease ☐ Rheumatoid Arthritis ☐ Mental Illness ☐ Osteoporosis ☐ Lupus ☐ Lung Problems
☐ High Blood Pressure ☐ Other:_____

What is your reason for treatment?

☐ Optimizing/Maintaining My Health ☐ I have symptoms.

If so, when did you first notice the symptoms?_____

Where specifically are your symptoms located?

Is your condition getting better, worse, or staying the same? _____

Which activities are difficult to perform? ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying down ☐ Other

Are your symptoms:

☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting ☐ Burning ☐ Tingling
☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other _____

Rate the severity of your symptoms. (0= none to 10 = severe/unbearable) 0 1 2 3 4 5 6 7 8 9 10

Are your symptoms (% of the day)?
☐ Constant (90-100%) ☐ Frequent (50-75%) ☐ Intermittent (25-50%) ☐ Rare (<25%)

What makes your symptoms worse?
What makes your symptoms better?
What treatment(s) have you received for your condition: ☐ Medication ☐ Surgery ☐ Physical Therapy ☐ Other
How tall are you? _____' _____'' What is your present weight? _____ lbs.
Are you currently taking any prescription medication? If yes please list: **1._____** **2._____** **3._____** **4._____** **5._____** **6._____**
Name/Phone number of other doctor(s) you have seen for your condition; Dates of last exams; Surgeries:
Name: Phone: Date of last exam: Surgeries:
Name: Phone: Date of last exam: Surgeries:
How Did you hear about Dynamic Health Wellness & Rehabilitation Center?

Please read and sign the following:

Authorization to Communicate

I give permission to Dynamic Health Wellness & Rehabilitation Center to contact me by phone or email with appointment reminders, including leaving messages at home or work. I give permission to Dynamic Health to contact me with birthday cards, holiday related cards, and information about treatment alternatives or other health related information, including a practice newsletter. I give permission to receive thank you messages for referrals.

Client Signature: _____ Date: _____/_____/_____

No Show / Cancellation Policy

We charge a $25 fee for no call / no show appointments. Yes, we charge you for not showing up for your appointment or canceling with less than 24 hours notice just like a hotel or airline does. Why? We reserved the spot for you on your word that you would be here. If you don't show up or cancel too late, of course that hurts you because you don't get what you need, but it also hurts us. We won't have adequate time to fill the appointment for someone who is in need of treatment. So, please call us if you can't make your appointment at least 24 hours ahead of time. I have read and understand Dynamic Health's' No Show / Cancellation Policy.

Client Signature: _____ Date: _____/_____/_____

Consent To Release Information:

I give Dynamic Health Wellness & Rehabilitation Center permission to discuss my information related to my treatment in the office, insurance information, and anything related to my care.

Name:_____Relationship:_____Phone:_____

Name:_____Relationship:_____Phone:_____

Name:_____Relationship:_____Phone:_____

Name:_____Relationship:_____Phone:_____

Name:_____Relationship:_____Phone:_____

- I certify that the above information is true and correct to the best of my knowledge. I agree to notify the doctor and or staff immediately whenever I have a change of information or in my health condition.
- I consent to the release of my confidential and patient information in the possession of Dynamic Health Wellness & Rehabilitation Center to other health care professionals whom I am referred and to the insurance company or other entity responsible for payment.
- I authorize Dynamic Health Wellness & Rehabilitation Center and their staff to perform any services needed during diagnosis and treatment. I also authorize payment of insurance benefits to Dynamic Health Wellness & Rehabilitation Center for services rendered.
- Our policy requires payment for services rendered at time of visit unless other arrangements have been made with the office manager. I understand that I am ultimately liable for all charges for services rendered.
- All HIPPA guidelines and requirements are followed in this office.

Signed (patient or authorized person)_____ Date:_____