LIFECARE
THERAPEUTIC MASSAGE & HEALTH CLINIC
ACUPUNCTURE NATUROPATHIC REFLEXOLOGY

Patient Information Form (*please print legibly*)

Last Name: _____ First Name: _____ MI: _____

Other names/Maiden Name: _____ Date of Birth: _____ Sex:_____

Address: _____ Apt: _____

City: _____ State: _____ Zip: _____ SS#: _____

Employer/School: _____

Home Phone: _____ Work: _____ Cell: _____

Best contact Email _____

Insurance Company: _____

Mother's Name (minors only): _____

Father's Name (minors only): _____

Emergency Contact: _____ Contact's Phone #: _____

Emergency Contact is my: (specify relationship) _____

Are you visually impaired? **Yes** **No** Are you hearing impaired? **Yes** **No**

How did you hear about us? (Circle One) Search Engine (Bing, Google, Other)

City Search Mailer/Flyer Website Workshop/Event Medical Referral

Friend/Family Insurance Co. Social Media Other:

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General

□ Chills
□ Fever
□ Spontaneous sweating
□ Night sweats
□ Bleed or bruise easily
□ Strong thirst
□ Fatigue
□ Sudden energy drop
- Time of day? _____
□ Edema - Where? _____
□ Insomnia
□ Tremors
□ Poor balance
□ Cravings
□ Change in appetite
□ Poor appetite
□ Weight gain
□ Weight loss

Skin & Hair

□ Rashes
□ Itchy skin
□ Eczema
□ Oozing lesions
□ Hives
□ Loss of hair
□ Change in moles

Respiratory

□ Cough
□ Asthma/wheezing
□ Pain with deep breath
□ Difficult breathing when lying down
□ Production of phlegm
- Color? _____
□ Coughing blood
□ Pneumonia
□ Bronchitis
- Other lung problems: _____

Gastrointestinal

□ Bad taste in mouth
□ Nausea
□ Vomiting
□ Heartburn
□ Belching
□ Indigestion
□ Diarrhea
□ Constipation
□ Blood in stool
□ Black stool
□ Gas
□ Rectal pain
□ Hemorrhoids
- Other stomach or intestinal problems: _____

Genitourinary

□ Painful urination
□ Urgency to urinate
□ Frequent urination
□ Blood in urine
□ Decrease in flow
□ Unable to hold urine
□ Dribbling
□ Kidney stones
□ Impotency
□ Sores on genitals
- Do you wake up to urinate?
  □ Yes □ No
- How often? _____
- Any particular color to your urine? _____
- Any other genital or urinary problems? _____

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Cardiovascular

□ High blood pressure
□ Low blood pressure
□ Chest pain/discomfort
□ Heart palpitations
□ Cold hands or feet
□ Swelling of hands
□ Swelling of feet
□ Blood clots
□ Fainting
□ Difficulty breathing
- Other heart or blood vessel problems: _____

Head, Eyes, Ears, Nose & Throat

□ Dizziness
□ Migraines
□ Headaches
□ Facial Pain
□ Poor vision
□ Night blindness
□ Blurred vision
□ Spots "floaters" in front of eyes
□ Eye pain
□ Cataracts
□ Eye dryness
□ Excessive tearing
□ Eye discharge
□ Poor hearing
□ Ringing in ears
□ Earaches
□ Ear infections
□ Nose bleeds
□ Sinus congestion
□ Nasal drainage
□ Teeth grinding
□ Jaw clicks
□ Recurrent sore throat
□ Lip or tongue sores

Gynecology and Pregnancy

- # of pregnancies: _____
- # of births: _____
- # of premature births: _____
- # of miscarriages: _____
- # of abortions: _____
- Age at first menses: _____
- # of days between menses: ___
- Duration of menses: _____
- First date of last menses: ___/___/___

□ Heavy periods
□ Light periods
□ Painful periods
□ Irregular periods
□ PMS symptoms□ Clots
□ Menopause: _____
- Age: _____
- Menopause symptoms: _____
- If so, any treatment? _____

□ Vaginal discharge
□ Postcoital bleeding
□ Vagina sores
- Date of last PAP _____/_____/_____

□ Breast lumps/cysts
- Do you practice birth control? □ Yes □ No
- What type and for how long? _____

Musculoskeletal

□ Neck pain
□ Shoulder pain
□ Back pain
□ Elbow pain
□ Hand/wrist pain
□ Hip pain
□ Knee pain
□ Foot/ankle pain
□ Muscle pain
□ Muscle weakness

Neuropsychological

□ Seizures
□ Numbness
□ Sleep disorders
□ Concussion
□ Bad temper
□ Vertigo
□ Lack of coordination
□ Depression
□ Easily stressed
□ Loss of balance
□ Poor memory
□ Anxiety

- Have you ever sought treatment for emotional problems? ☐Yes ☐No
- Other neurological or psychological problems _____

-Please list any **medications** you take regularly:

_____
_____

Comments:

_____
_____
_____

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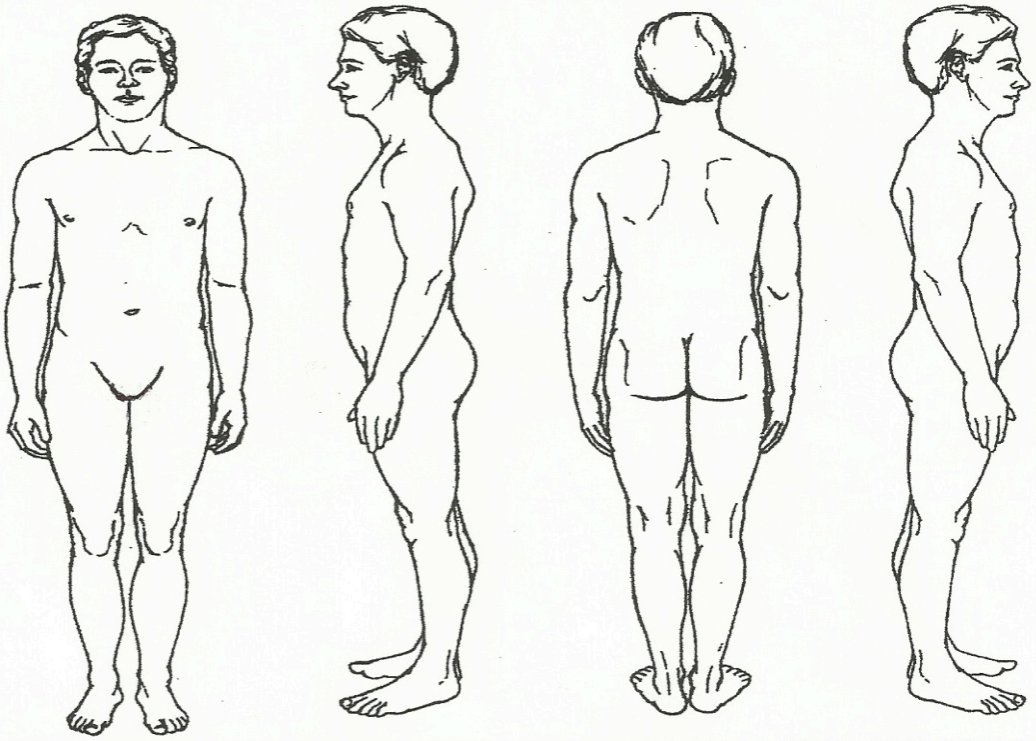
Patient Name _____ Date _____

Date of Injury _____ Insurance ID# _____

A. Draw today's symptoms on the figures.

1. Identify CURRENT symptomatic areas in your body by marking letters on the figures below. Use the letters provided in the key to identify the symptoms you are feeling today.
2. Circle the area around each letter, representing the size and shape of each symptom location.

Key
P = pain or tenderness
S = joint or muscle stiffness
N = numbness or tingling



B. Identify the intensity of your symptoms.

1. Pain Scale: Mark a line on the scale to show the amount of pain you are experiencing today.

No Pain |————————————————————| Unbearable Pain

2. Activities Scale: Mark a line on the scale to show the limitations you are experiencing today in your daily activities.

Can Do Anything I Want |————————————————————| Cannot Do Anything

C. Comments

_____

_____

_____

_____

Signature _____ Date _____

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CONSENT FOR TREATMENT

***General Information*:** LifeCare Therapeutic Massage and Health Clinic is a multidisciplinary health clinic and integrates a number of medical treatment modalities. LifeCare uses a 'Team Care' approach where clinicians work as a team to address your health concerns. Your medical history, treatment plan and progress is discussed (without identifying information) among other clinicians for cross-discipline purposes at the clinic for appropriateness and effectiveness. Due to the diversity of modalities offered at LifeCare, your treatment may include any or all of the following general modalities: Acupuncture and Oriental Medicine, Naturopathic Medicine, Massage Therapy, Homeopathy, Psychological Counseling, and Nutritional Counseling. Some modalities may be used exclusively on some specialty shifts, but many LifeCare clinic teams use multiple treatment modalities.

Methods, Procedures and Therapeutic Approaches: Clinicians may perform any of the following procedures as necessary to give proper assessments, determine treatment approaches, treat or otherwise address your health concerns.

General Diagnostic Procedures (including but not limited to venipuncture, pap smears, radiography, and blood and urine labwork, general physical exams, neurological and musculoskeletal assessments)

Psychological Counseling; Lifestyle Counseling; Exercise Prescriptions
Acupuncture: (insertion of special sterilized needles at specific points on the body)
Topical Treatments and Prepping (includes cupping --a technique using glass cups on the surface of the skin with usually a heat-created vacuum; and Gua Sha--rubbing on an area of the body with a blunt, round instrument)
Herbs/Natural Medicines (prescribing of various therapeutic substance including plants, minerals and animal materials. Substances may be given in the form of teas, pills, powders, tinctures—may contain alcohol; topical cremes, pastes, plasters washes; suppositories or other forms. Homeopathic remedies, often highly dilute quantities of naturally occurring substance, may also be used.)
Dietary Advice and Therapeutic Nutrition (use of foods, diet plans or nutritional supplements for treatment—may include intramuscular vitamin injections.)
Soft Tissue and Osseous Manipulation (use of massage, neuro-muscular techniques, muscle energy stretching or visceral manipulation, as well as manipulations of the extremities and spine including traction and craniosacral therapy)
Electromagnetic and Thermal Therapies (includes the use of ultrasound, low and high volt electrical muscle stimulation, transcutaneous electrical stimulation, microcurrent stimulation, diathermy, and infrared and ultraviolet therapies or moxa—warming or indirect burning of an acupuncture point and hydrotherapies.)

Potential Risks: Pain, discomfort, blistering, discolorations, infection, burns, loss of consciousness or deep tissue injury from needle insertions, topical procedures, heat or frictional therapies, electromagnetic- and hydrotherapies; allergic reactions to prescribed herbs or supplements; soft tissue or bone injury from physical manipulations; and aggravation of pre-existing symptoms.

Potential benefits: Restoration of health and the body's maximal functional capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.

Notice to Pregnant Women: All female patients must alert the doctor if they know or suspect that they are pregnant , since some of the therapies used could present a risk to the pregnancy. We do not

use labor-stimulating acupuncture points or any labor-inducing substances unless the treatment is specifically for the induction of labor. A treatment intended to induce labor requires a letter from a primary care provider authorizing or recommending such a treatment.

I understand that I may ask questions regarding my treatment before signing this form and that I am free to withdraw my consent and to discontinue participation in these procedures at any time. With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by the LifeCare Therapeutic Massage and Health Clinic or any of its personnel regarding cure or improvement of my condition. I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by my representative or me or otherwise permitted or required by law.

_____ _____
Guardian/Personal Representative's Name (PRINT) Patient's Name (PRINT)

_____ _____
Guardian/Personal Representative's Signature Patient's Signature

_____ _____
Relationship/Representative's Authority Date

_____
Date

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PATIENT RESPONSIBILITY FORM

1. INDIVIDUAL'S FINANCIAL RESPONSIBILITY

- I understand that I am financially responsible for my health insurance deductible, coinsurance or non-covered service.
- Co-payments are due at time of service.
- If my plan requires a referral, I must obtain it prior to my visit.
- In the event that my health plan determines a service to be "not payable", I will be responsible for the complete charge and agree to pay the costs of all services provided.
- If I am uninsured, I agree to pay for the medical services rendered to me at time of service.

2. INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

I hereby authorize and direct payment of my medical benefits to LifeCare Therapeutic Massage and Health Clinic on my behalf for any services furnished to me by the providers.

3. AUTHORIZATION TO RELEASE RECORDS

I hereby authorize LifeCare Therapeutic Massage and Health Clinic to release to my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information, including diagnosis and the records of any treatment or examination rendered to me needed to substantiate payment for such medical services as well as information required for precertification, authorization or referral to other medical provider.

4. MEDICARE REQUEST FOR PAYMENT

I request payment of authorized Medicare benefits to me or on my behalf for any services furnished me by or in LifeCare Therapeutic Massage and Health Clinic. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

_____ _____

Signature of Patient, Authorized Representative or Responsible Party — Date

_____ _____

Print Name of Patient, Authorized Representative or Responsible Party — Relationship to Patient