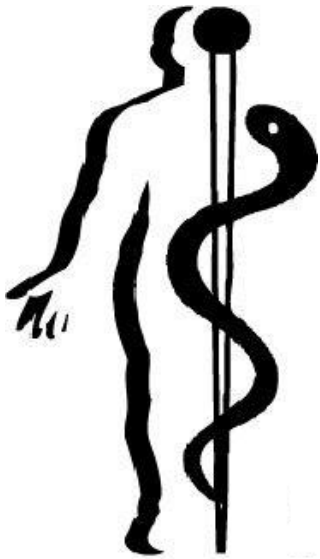


BODY STRUCTURE MEDICAL FITNESS FACILITY



Name _____ Date _____ Social Security # _____
 Address _____
 City _____ Zip _____ Age _____ Birth date _____
 Home Telephone _____ Cellular Phone _____
 Work Telephone _____ Emergency Contact _____
 Whom may we think for referring you? _____
 Email Address _____ Employer _____
 Occupation _____

HEALTH INFORMATION

Sex _____ Height _____ Weight _____ Right Handed _____ Left Handed _____

Main Complaint _____

Have you had previous chiropractic care? Yes No Date _____

Have you had previous physical therapy? Yes No Date _____

Other Complaints _____

How long have you had this condition? _____

Have you had similar conditions in the past? _____

Does this condition affect your work? Yes No

Does this condition affect your social life? Yes No

What aggravates this condition? _____

Other Doctors seen for this condition _____

Are you taking any medication? Yes No If yes, please list _____

What helps your symptoms? _____

Have you had: Surgery? Yes No Falls? Yes No Accidents? Yes No

When? _____ Please describe _____

Date of last physical examination _____

Who is your Primary Care Physician? _____

Are you pregnant? Yes No Do you smoke? Yes No

Have you ever been told you have high cholesterol? Yes No Level _____

Please check conditions or symptoms you currently have or have had in the past:

- Abdominal Pain
- Anemia
- Arm or Shoulder Pain
- Arthritis: rheumatoid, gout, osteoarthritis
- Back Pain
- Bladder Problems
- Cancer
- Chest Pain
- Circulatory Problems
- Constipation
- Depression
- Diabetes
- Digestive Disorder
- Dizziness
- Fatigue
- Fractures
- Headaches
- Heart Problems
- High or Low Blood Pressure
- Hip or Leg Pain
- Hot Flashes
- Immune System Problems
- Insomnia
- Kidney Problems
- Liver/Jaundice/Hepatitis
- Loose Stool
- Lung or Bronchial Disorder
- Memory Problems
- Menstrual Problems
- Metal Implants
- Neck Pain
- Nervousness
- Neurological: *strokes, seizures*
- Numbness
- Osteoporosis
- Palpitations
- Prostate Disorder
- Sinus Problems
- Swollen Joints
- Thyroid
- Visual Problems

Are you currently exercising at least 30 minutes most days of the week? Yes No

Has your physician ever advised you against exercise? Yes No

Do you have any orthopedic (including back) injuries, arthritis, or osteoporosis, which would interfere with your daily activity or ability to exercise? If yes, explain _____

Have you ever been hospitalized with any illness or injury? Yes No If yes, explain _____

Is there any pertinent information not already described? Yes No If yes, explain _____

Signature: _____ Date: _____

Consultant: _____ Date: _____

INSURANCE INFORMATION

Is this condition covered by:

Workers compensation? Yes No Automobile insurance? Yes No Health Insurance? Yes No

TYPES OF CARE

Please check the type of care desired so that we may be guided by your wishes whenever possible.

- Relief Care:** Relief Care is that care necessary to get rid of your symptoms or pain, but not the cause of it.
- Corrective Care:** Corrective care differs from relief care in that its goal is to get rid of the symptoms or pain while correcting the cause of the problem.
- Check here if you want the Doctor/Physical Therapist to select the type of care appropriate for your condition.

I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on this page and have completed the above answers. I certify that this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

Patient's Signature _____ Date _____

Guardian or Spouse's Signature _____ Date _____

Body Structure Clinic

Medical Fitness Facility
2600 Gribbin Drive
Lexington, KY 40517

Welcome to Body Structure Clinic, our goal is to provide you with the highest quality physical therapy care available. We want to strongly emphasize the importance of patient compliance and responsibility in abiding by the recommended treatment. You must notify us within 6 hours of your appointment if you need to reschedule. Not showing or canceling your appointment without a 6-hour notice will result in a \$30.00 fee. We can not help you if you do not show up for your appointment. **Initial:**_____

Consent for treatment:

I, hereby, give my permission for Body Structure Clinic to render treatment to me/my dependent. I realize that I will be given all available pertinent information, prior to the treatment being rendered. I will be given the opportunity to ask questions, and have them answered to my satisfaction. I understand that I may decline recommended treatment at any time, but if I choose to do so it is at my own medical risk.

Signature:_____ **Date:**_____

Consent to Release/Obtain Medical Information:

Permission, is hereby, granted to Body Structure Clinic to release information to my insurance company, employer, attorney, worker compensation carrier, physician/facility referred to for further treatment, and/or my referring/family physician. Permission, is hereby, granted to any facility where I have previously been treated to release medical records/x-rays to Body Structure.

Signature:_____ **Date:**_____

Authorization for Payment of Benefits:

I authorize insurance payment benefits to Body Structure Clinic for services rendered. Insurance checks and explanation of benefits sent to you for our services must be brought to us. The checks will be applied to your balance and the explanation of benefits will be copied and returned. I understand that any charges not paid by my insurance company are my responsibility, and are due and payable by me.

Signature:_____ **Date:**_____

Medicare Patients Only:

I authorize payment of Medicare benefits to Body Structure Clinic for services rendered, and I authorize the release of medical information to Health Care Finance Administration (HCFA), and /or its agents. I have received the Supplier Standards Information Sheet.

Signature:_____ **Date:**_____

Child Liability:

I understand that Body Structure Clinic will not be held responsible for the safety or welfare of any child left in the waiting room, or leaves the waiting room.

Signature:_____ **Date:**_____