



THERAHEALTH & WELLNESS

MOVING YOU TO BETTER HEALTH

Client Information

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Sex: _____ Social Security # _____

Home Phone #: _____ Work Phone #: _____ Cell #: _____

Email: _____ Marital Status: (circle one) Single Married Divorced Widowed

Emergency Contact: _____ Phone # _____ Relationship _____

Primary Care Physician / Family Doctor(s) _____

Have you had any Home Health in the past 12 months? ___ No ___ Yes, name of Co. _____

Have you had any physical, occupational, or speech therapy this year? Yes No

How did you hear about us? _____

If Client is a minor

Responsible party for bill if other than client: _____ Relationship: _____

Responsible party's address (if other than above): _____

Date of Birth: _____ Social Security # _____

Consent for Treatment: I hereby consent to receive care for therapy services by TheraHealth & Wellness. I consent to medical treatment as is deemed necessary or advisable by the physical, occupational or speech therapist.

Consent to Release Medical Information: I authorize TheraHealth & Wellness to release any information acquired in connection with my therapy services including, but not limited to, diagnosis, clinical records, to myself, my insurance(s), physician(s), and _____.

Consent to Obtain Medical Information: I authorize TheraHealth & Wellness to obtain and acquire any information that would be beneficial in connection with my therapy service, which may include X-rays, Cat scans, and MRI reports, along with Physician's Documentation.

Assignment of Insurance Benefits: I hereby authorize payment to be made directly to TheraHealth & Wellness.

Guarantee of Payment: I agree to pay any charges that my insurance does not pay. I am responsible to pay any uncovered portion on the date services are rendered. I am responsible for any incurred costs on overdue balances including, but not limited to, late fees, interest fees, legal fees, and collection agency fees.

I hereby certify that I understand these rights as set forth.

I acknowledge that I have been informed of TheraHealth & Wellness Privacy Practices as required by the Health Insurance Portability and Accountability Act (HIPAA) I have been presented with a brochure outlining these practices ___ Yes ___ No

I have received a copy of the Summary of the Florida Client's Bill of Rights and Responsibilities ___ Yes ___ No

Client/Responsible Party Signature _____ Date: _____

Legal Representation (if applicable): Attorney's Name _____

CLIENT HEALTH QUESTIONNAIRE

TheraHealth & Wellness Therapy & Balance Centers

Name _____ Age _____ Date ____/____/____

Please describe your Current Complaint or Limitation: _____

Please describe how your problem began: _____

Please tell us when your condition started: _____

List tests or other interventions for this condition that you have had: _____

Please indicate the daily activities that you cannot perform: _____

Please indicate your level of functioning prior to the onset of this condition: _____

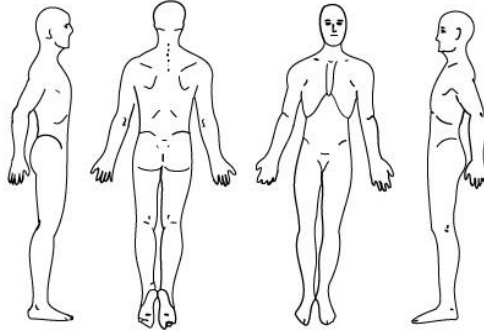
Please inform us of any environmental or living conditions that may have difficulties with: _____

Did you have surgery? No Yes Date ____/____/____ Procedure: _____

Please describe the nature of your pain:

- Sharp Pain
- Dull (Pain) Ache
- Throbbing
- Numbness
- Shooting
- Burning
- Tingling
- Constant (76 – 100%)
- Frequent (51 – 75%)
- Occasional (26 – 50%)
- Intermittent (25% - or less)

MARK ON PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS →→→→



Indicate the intensity of your pain at rest: (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable Pain)

Indicate the intensity of your pain with movement: (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable Pain)

Since this condition began your symptoms have: decreased not changed increased

Your symptoms are worse in: morning afternoon night increased during the day same all day

Activities or positions that increase symptoms: _____

Activities or positions that decrease symptoms: _____

Occupation _____ Has your work status changed because of this condition YES NO

If you have ever had a listed condition in the past, please check it in the PAST column. If you are presently troubled by a particular condition, check it in the PRESENT column. The information you provide concerning past and present conditions and diseases assists your therapist in more thoroughly understanding your state of health.

- | PAST | PRESENT | |
|--------------------------|--------------------------|--------------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure (401.9) |
| <input type="checkbox"/> | <input type="checkbox"/> | Angina (413.9) |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Attack (410.9) |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke (436) |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma (493.9) |
| <input type="checkbox"/> | <input type="checkbox"/> | HIV/AIDS (042) |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer (199.1) Location: _____ Date: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Tumor (229.9) |
| <input type="checkbox"/> | <input type="checkbox"/> | Systemic Lupus (710.0) |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis (5) |
| <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy (349.5) |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes (250.0) |
| <input type="checkbox"/> | <input type="checkbox"/> | Rheumatoid Arthritis (714.0) |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis (716.9) |
| <input type="checkbox"/> | <input type="checkbox"/> | Pregnancy |
| <input type="checkbox"/> | <input type="checkbox"/> | Other _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Tobacco (305.1) packs/day _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Drug or Alcohol Dependence (303.9) |

Hospitalization/Surgical Procedures (list if not described elsewhere):

Do you have a Pace Maker: ____yes ____no

Medications:

Present: Weight _____ Height ____ft ____in.