



Today's Date: \_\_\_\_\_

**Patient Information**

Name (First, Middle, Last): \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Sex: M  F  Marital Status:  Single  Married  Widowed  Divorced

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Preferred Name: \_\_\_\_\_ Email: \_\_\_\_\_

Employment Status:  Employed  Full-time  Part-time Student  Full-time Student  Other

Weight \_\_\_\_\_ Height: \_\_\_\_\_

**Employment Information**

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

**Responsible Party (if different from above)**

Name (First, Middle, Last): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Social Security#: \_\_\_\_\_ Responsible Party's Phone #: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Employer Phone: \_\_\_\_\_

**Insurance Information**

Name of Insured: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Insured's Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_ Phone: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Group #: \_\_\_\_\_ ID #: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Employer Ph #: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

**Spouse Information**

Name (First, Middle, Last): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Social Security#: \_\_\_\_\_ Employer: \_\_\_\_\_ Employer Phone: \_\_\_\_\_

**Relative to Contact in Case of an Emergency**

Name (First, Middle, Last): \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

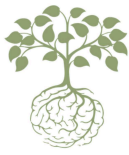
Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

**Is Your Illness or Injury Related**

Employment  Emergency  Accident (Other)  Auto Accident (State of Auto Accident) \_\_\_\_\_

If Employment related, has employer been notified?  Yes  No Employer Contact Name: \_\_\_\_\_

Employer Contact Phone and Extension: \_\_\_\_\_



**How Were You Referred to Our Office?**

By An Attorney  By a Doctor  Print Ad  Online Directory  Search Engine  Marketing Event

Please Specify Source Here: \_\_\_\_\_

Are you involved in any kind of litigation due to your condition?  Yes  No

**Medical/Family History**

**S=Self, M=Mother, F=Father**

S	M	F		S	M	F		S	M	F	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nervousness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Earache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Night Sweats
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Numbness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Poor Circulation
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Reproductive Trouble
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bladder Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Serious Injury
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bone Fracture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Trouble
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bowel Control Loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HIV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Spinal Curvature
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Indigestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Concussion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problem
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual Cramps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Weakness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Weight Gain/Loss
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dislocated Joints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other _____

Have you been treated by a physician for any health condition in the last year?  No  Yes

Describe Condition: \_\_\_\_\_ Date of Last Physical Exam: \_\_\_\_\_

Primary Doctor's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**SURGICAL HISTORY:**

1. \_\_\_\_\_ **Date:** \_\_\_\_\_

2. \_\_\_\_\_ **Date:** \_\_\_\_\_

3. \_\_\_\_\_ **Date:** \_\_\_\_\_

**ACCIDENT HISTORY:**  Job  Auto  Other 1. \_\_\_\_\_ **Date:** \_\_\_\_\_

Job  Auto  Other 2. \_\_\_\_\_ **Date:** \_\_\_\_\_

Job  Auto  Other 3. \_\_\_\_\_ **Date:** \_\_\_\_\_

**PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS:**

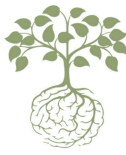
Please Rate Your Symptoms (1-10, with 1 being very minimal and 10 being the worst you can imagine)

1. \_\_\_\_\_ **Pain Scale #** \_\_\_\_\_

2. \_\_\_\_\_ **Pain Scale #** \_\_\_\_\_

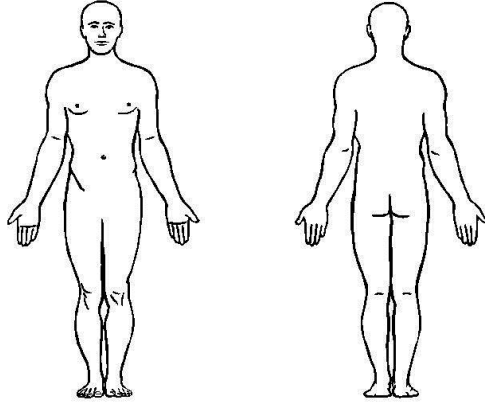
3. \_\_\_\_\_ **Pain Scale #** \_\_\_\_\_

4. \_\_\_\_\_ **Pain Scale #** \_\_\_\_\_



Please circle and mark the areas of concern on the diagram below.

N=Numbness    T=Tingling    P=Pain    W=Weakness    B=Burning    A=Ache



Symptoms are worse in the:  Morning     Afternoon     Night

When and how did it occur? \_\_\_\_\_

Symptoms developed from:  Job Related Injury     Auto Accident     Other Accident     Illness

Symptoms have persisted for # \_\_\_\_\_ Hour(s) \_\_\_\_\_ Day(s) \_\_\_\_\_ Week(s) \_\_\_\_\_ Month(s) \_\_\_\_\_ Year(s) \_\_\_\_\_

Have you ever had this before:  No     Yes    If Yes, when? \_\_\_\_\_

If you were to guess, what do you think is causing your complaint(s)?  
\_\_\_\_\_

Name and location of doctors previously seen for present condition(s):  
\_\_\_\_\_

Are you pregnant?  No     Yes    Date of last menstrual period (onset): \_\_\_\_\_

Have you ever used tobacco?  Never     Previously     Daily     Weekly     Monthly     Yearly

**Please check the following activities that aggravate your condition:**

- Bending     Lifting     Lying down     Reaching     Sitting     Standing     Straining with bowel movement  
 Turning head     Walking     Other \_\_\_\_\_

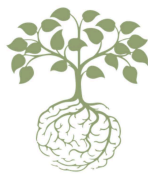
**Please check the following activities that relieve your condition:**

- Bending     Lifting     Lying Down     Reaching     Sitting     Standing     Turning Head     Walking  
 Other \_\_\_\_\_

Please check any additional symptoms you may be experiencing:

- |   |  |   |  |
|---|--|---|--|
| <input type="checkbox"/> Constipation                 | <input type="checkbox"/> Insomnia                | <input type="checkbox"/> Cold hands               | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Ankle swelling               | <input type="checkbox"/> Low back pain           | <input type="checkbox"/> Depression               | <input type="checkbox"/> Wheezing            |
| <input type="checkbox"/> Chills                       | <input type="checkbox"/> Pain between shoulders  | <input type="checkbox"/> Fever                    | <input type="checkbox"/> Loss of smell       |
| <input type="checkbox"/> Difficulty breathing         | <input type="checkbox"/> Sore throat             | <input type="checkbox"/> Loss of balance          | <input type="checkbox"/> Numbness (fingers)  |
| <input type="checkbox"/> Gall bladder problems        | <input type="checkbox"/> Buzzing in Ears         | <input type="checkbox"/> Nausea                   | <input type="checkbox"/> Stomach pain        |
| <input type="checkbox"/> Loss of taste                | <input type="checkbox"/> Fainting                | <input type="checkbox"/> Pins and needles in legs | <input type="checkbox"/> Fainting            |
| <input type="checkbox"/> Numbness in toes             | <input type="checkbox"/> Light bothers eyes      | <input type="checkbox"/> Tremors                  | <input type="checkbox"/> Face flushed        |
| <input type="checkbox"/> Stiff neck                   | <input type="checkbox"/> Muscles jerking         | <input type="checkbox"/> Cold feet                | <input type="checkbox"/> Buzzing in Ears     |
| <input type="checkbox"/> Blurred Vision               | <input type="checkbox"/> Pins and needles (arms) | <input type="checkbox"/> Diarrhea                 |  |
| <input type="checkbox"/> Concentration loss/confusion |  | <input type="checkbox"/> Frequent colds           |  |





## **HIPPA NOTICE, INFORMED CONSENT, PHOTO RELEASE**

### **HIPAA Notice:**

I understand and agree to allow Myofascial & CranioSacral Therapies of Oklahoma to use my Patient Health Information for the purpose of treatment, payment, healthcare operation, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like a more detailed account of our policy and procedures concerning the privacy of your Patient Health Information, please let the desk staff know you would like the full HIPAA Notice before signing this consent. If there is anyone you do not want to receive your medical records please inform our office.

**Patient's Signature:** (parent if minor) \_\_\_\_\_ **Date:** \_\_\_\_\_

### **Informed Consent for Myofascial, Massage, or Physical Therapy Treatment: I**

hereby request and consent to the performance of myofascial release, massage, advanced bodywork, manual therapy, or physical therapy by Myofascial & CranioSacral Therapies of Oklahoma and/or its employees. I understand and am informed that, with the practice of myofascial release, massage, advanced bodywork, manual therapy, or physical therapy there are some risks to treatment, including but not limited to soreness, and stiffness of muscles and related tissue. I understand that I must inform the practitioner of any possibility of pregnancy at any point during the treatment process.

**Patient's Signature:** (parent if minor) \_\_\_\_\_ **Date:** \_\_\_\_\_

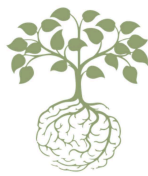
### **Consent To Be Photographed for Postural Assessment**

I \_\_\_\_\_ consent to be photographed, for the purpose of postural assessment by Myofascial & CranioSacral Therapies of Oklahoma. I understand that only the healthcare professionals employed by Myofascial & CranioSacral Therapies of Oklahoma will view the photos taken for postural assessment. The photos will not be used for any other purpose by Myofascial & CranioSacral Therapies of Oklahoma or for public display. If you consent to the photos being taken for this assessment please sign below.

I \_\_\_\_\_ have read and understand the information provided.

I \_\_\_\_\_ give my permission to be a part of the recording and for the use of that recording as assessment based upon the conditions outlined above.

**Patient signature:** \_\_\_\_\_ **Date** \_\_\_\_\_



## **PATIENT FINANCIAL RESPONSIBILITY and INSURANCE RELEASE**

Please indicate how you would like to satisfy your financial responsibility for treatment.  
Read carefully and initial your selection below.

- \_\_\_\_\_ **1. PURCHASE DISCOUNTED PACKAGE(S)**
- Includes 5-pack, 10-pack, Silvercare, or other value package offered
  - **Available Documentation:** Proof of payment receipt only
- \_\_\_\_\_ **2. SELF-FILE WITH MY INSURANCE**
- I will pay full per session price for my treatment each visit
  - **Available Documentation:** Invoice with insurance codes
  - I understand that to receive reimbursement from any insurance company or federal/health savings accounts, I must file for these benefits myself

**Patient's Signature:** (parent if minor) \_\_\_\_\_ **Date:** \_\_\_\_\_

### **ALL PATIENTS**

- I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees.
- I authorize Myofascial & CranioSacral Therapies of Oklahoma to release any information including my diagnosis and records of any treatment or examination rendered to my child or me, to third party payers and/or health practitioners.
- A photocopy of this authorization is to be considered as valid as the original.
- I certify that I have read and understand all of the above information.

**Patient's Signature:** (parent if minor) \_\_\_\_\_ **Date:** \_\_\_\_\_



## **Cancellation and Missed Appointment Policy**

### **Cancellation of an Appointment**

Kindly give 24 hours notice if you need to cancel or change your appointment. This courtesy allows us to schedule waiting clients. Except in cases of emergency, the cost of the session will be charged without 24 hour advanced notice.

### **How to Cancel Your Appointment**

To cancel appointments, please call 405-541-1078. If you do not reach the receptionist you may leave a detailed message on the voice mail. If you would like to reschedule your appointment, please leave your phone number. We will return your call and give you the next available appointment time.

**I understand the above Cancellation and Missed Appointment policy.**

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Signature

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Date