145 Vista Ave. Suite 103, Pasadena, CA 91107 . Phone: (626) 365-1380

Patient Information Sheet

Date: __________ Gender: M / F Date of Birth: __________Age:_____

Full Name:__________________________ Preferred Name: ___________

Marital Status: Single Married Separated Divorced

Address : ______________________________________

____

Daytime Phone #: ( ) - Cell Phone #: ( ) -

Email: ____

Your email will be used to send appointment confirmations and for internal purposes only.

Emergency Contact:

Name: ____________________ Relationship: __________________

Phone #: ( ) -

Primary Care Physician: ______________________ Specialty: __________

Other Doctors You See: ______________________ Specialty: __________

How did you hear about us?______________________________________

List your major complaint(s), in order of importance to you:

Severe Moderate Slight

1. ☐ ☐ ☐ ______________________________
2. ☐ ☐ ☐ ______________________________
3. ☐ ☐ ☐ ______________________________

Level of Pain of Complaint: 0 1 2 3 4 5 6 7 8 9 10

Pains are: ☐ Sharp ☐ Dull/ Ache ☐ Constant ☐ Intermittent

Does this pain shoot, radiate, or travel in your body? YES or NO If Yes, Where? ________________________

Are you experiencing numbness or tingling ? YES or NO If Yes, Where? ________________________

Since it began, is it: ☐ Same ☐ Better ☐ Worse

What activities aggravate your condition/pain?____

What activities lessen your condition/pain?____

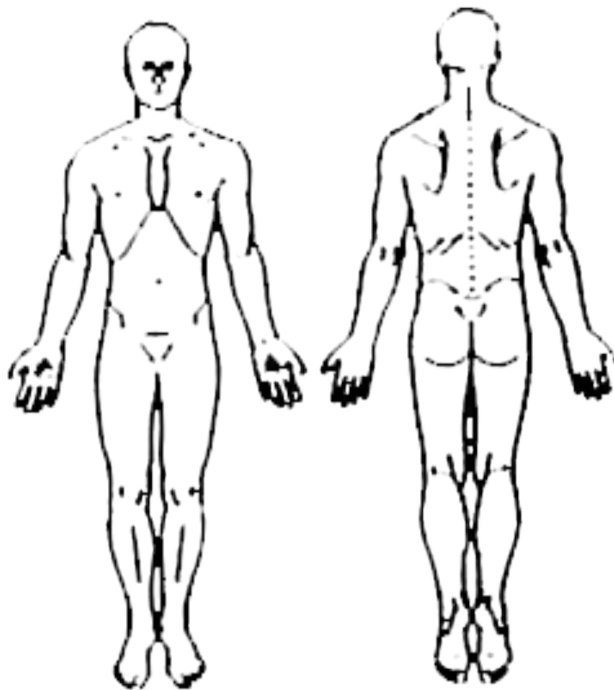
Is this condition worse during certain times of the day? ____

Is this condition interfering with ☐ Work ☐ Sleep ☐ Routine ☐ Other: __________________________________

Is this condition progressively getting worse? YES or NO

Other Doctors seen for this condition: ____

***Using the symbols below, mark on the pictures where you feel pain.



Numbness = = = Dull Ache OOO Burning XXX Sharp/Stabbing / / / Tingling+ + +

MEDICAL HISTORY

Please list any conditions that you have or have had. (ie. Cancer, diabetes, stroke, heart attack, etc.)
Please include Date of diagnosis.

Condition:	Date Diagnosed:	Date Subsided:

HEALTH HABITS

Please check all that apply, indicate the amount consumed.

- ☐ **Alcohol**
- ☐ **Tobacco**
- ☐ **Caffeine**
- ☐ **Sugar**
- ☐ **Art. Sweeteners**
- ☐ **Drugs**

OCCUPATIONAL CONCERNS

Please check all that apply, comment if necessary.

- ☐ **Stress**
- ☐ **Excessive Computer Use / Typing**
- ☐ **Heavy Lifting**
- ☐ **Repetitive Motion**
- ☐ **Hazardous Substances**
- ☐ **Other**

MEDICATIONS & SUPPLEMENTS

Please list all the prescription meds and supplements that you are currently taking as well as the duration and dosage.
Please bring your medications and supplements with you to the first office visit.

Name	**Purpose**	**Duration Dosage**
1.)		
2.)		
3.)		
4.)		
5.)		
6.)		

FEMALES ONLY

Date of your last pap smear: _____/_____/_____ Current form of birth control: ___________________________
Date of Last Period: ______/______/______ How heavy is the bleeding? ☐ Light ☐ Normal ☐ Heavy
What color is the blood? ☐ Light red ☐ Red ☐ Dark Red ☐ Purple ☐ Brown ☐ Black Is there clotting? ☐ Yes ☐ No
Do you have premenstrual symptoms? ☐ Yes ☐ No Do you have breast tenderness before periods? ☐ Yes ☐ No
Pregnant? ☐ Yes ☐ No # of Pregnancies______________
# of Vaginal deliveries ________ # of Miscarriages ________ # of Abortions _________
How many days in your cycle: ________ Age at which menses began: ______________

EXERCISE / STRESS RELIEF

How often do you exercise? ___________ Which exercises do you do? _____________________________
How do you usually relieve stress? (yoga, meditation, smoking, exercise,etc.) ___________________________

Please mark any of the following conditions or symptoms that you are currently experiencing:

☐ Headaches	☐ TMJ	☐ Diabetes	☐ Blood Clots
☐ Neck Pain	☐ Ringing in the ears	☐ High Blood Pressure	☐ Joint Disorder
☐ Neck Stiffness	☐ Tension	☐ Heart Attack	☐ Muscle Injury
☐ Numbness in Hands / Arms	☐ Dizziness	☐ Stroke	☐ Asthma
☐ Numbness in Legs or Feet	☐ Irritability	☐ Cancer	☐ Allergies
☐ Pain in Hands or Arms	☐ Loss of Memory	☐ Weight Loss	☐ Arthritis
☐ Pain in Legs or Feet	☐ Fatigue	☐ Menopause	☐ Seizures
☐ Shoulder Pain	☐ Lights Bother Eyes	☐ Stomach Problems	☐ Sinus Problems
☐ Chest Pains	☐ Nervousness	☐ Constipation/Diarrhea	☐ Skin Problems
☐ Low Back Pain	☐ Depression	☐ Painful Urination	☐ Dental Problems
☐ Abdominal Pain	☐ Sleeping Problems	☐ Circulatory Disorder	☐ Other:
☐ Carpal Tunnel	☐ Respiratory Disorder	☐ Contagious Disease	

Informed Consent

Consent for Care:

I, ______________________________________, hereby give my consent to treatment at HealthFit, Pasadena; and any employee working under the direction of the physicians to provide care and/or render services that are necessary for my care. Treatment and service may include but are not limited to preventative diagnostics, therapeutic, rehabilitation, maintenance, palliative, counseling, assessment, and the sales or dispensing of medical devices, therapeutic equipment, and nutritional supplements required and in accordance with my treatment plan or prescription.

I also understand that there may be risk involved in any diagnostic/treatment/physical activity and that there are other treatment options available. I hereby consent to care and release HealthFit, and it's agents from any liability now and in the future for possible injury.

To administer any relevant treatment, therapy, training for my care.

Consent for release of information and assignment of Benefits:

I also authorize this practice to furnish information to the identified insurance carrier(s) for any and all payment activities. I consent to assign all payments for services directly to this practice.

Direct Physical Therapy Treatment Services Disclosure

You (the patient) are receiving direct physical therapy treatment services from an individual who is a physical therapist (PT) licensed by the Physical Therapy Board of California. Under California law, you may continue to receive direct physical therapy treatment services for a period of up to 45 calendar days or 12 visits, whichever occurs first, after which time a physical therapist may continue providing you with physical therapy treatment services only after receiving, from a person holding a physician and surgeon's certificate issued by the Medical Board of California or by the Osteopathic Medical Board of California, or from a person holding a certificate to practice podiatric medicine from the California Board of Podiatric Medicine and acting within his/her scope of practice, a dated signature on the physical therapist's plan of care indicating approval of the physical therapist's plan of care and that an in-person patient and evaluation was conducted by the physician and surgeon or podiatrist.

With your written authorization, your physical therapist shall notify your physician and surgeon, if any, that he/she is treating you.

I have read, understand, and agree to the above consent and service disclosure policies and statements and accept full responsibility as stated above.

Signature of Patient or Guardian: x____

Print Name:____ Date:_____________________

Patient Financial Responsibility/ Appointment Cancellation and Rescheduling Policy

Thank you for choosing HealthFit for your health care needs. We are honored by your choice and committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial responsibility and appointment cancellation/rescheduling policies, which are as follows:

- The patient is ultimately fully responsible for the payment of all charges or fees for services provided, regardless of any contract of insurance, any action at court, any settlement, structured settlement, verdict or arbitration award which may be received or be due, or the course or outcome of any dispute regarding the same.
- The patient may be charged a 1.5% monthly interest charge for any balances unpaid after 30 days of the date that appears on the patient's statement.
- The patient's financial responsibility in regards to services performed will not exceed current listed service prices. (i.e. service costs $65-insurance pays HealthFit $45=Patient responsible for $20)
- The patient is aware that failure to pay for his/her treatment and care will result in collection actions being taken to collect the debt (i.e. being sent to a collection agency)
- The patient is responsible for any costs associated with the collection of patient balances.
- The office charges a $30 fee for returned checks.
- **In order to control outstanding balances, it is our policy to collect co-pays, co-insurance, and deductibles at time of service.**

Please remember that insurance is considered a method of reimbursing the patient for fees put to the doctor and is NOT A SUBSTITUTE FOR PAYMENT. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance.

In the event your insurance provider sends payment directly to you for out-of-network chiropractic services, please note that you are responsible for submitting these payments to HealthFit as reimbursement for services rendered.

Our appointments are confirmed 24 hours in advance via text and/or email alerts. Since the services are reserved for you personally, a cancellation and/or rescheduling fee may apply. See following:

- Less than 24 hour notice will result in a charge equal to 50% of the scheduled service amount.
- "NO SHOWS" will be charged 100% of the scheduled service amount.
- Appointments made within the 24 hour period that need to cancel/reschedule, must be done so within 4 hours of scheduled appointment time or will result in a charge of 50% of the scheduled service amount.

HealthFit reserves the right to settle cancellation/rescheduling fees, co-pays, deductibles, and any outstanding balances due with the patient's payment information on file.

I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim.

I have read, understand, and agree to the provisions of this Patient Financial Responsibility Form and Appointment Cancellation/ Rescheduling Policy:

Signature of Patient or Guardian: x______________________________

Print Name: ______________________________ Date:________________