PATIENT INFORMATION

Full Name: _____

Address: _____

City_____**State**_____**Zip Code**_____

Phone #: _____ **Date of Birth:** _____ **SS #** _____

Email Address: _____

Employer: _____ **Worker Comp Claim #:** _____

Employer Address: _____**Employer Phone #:** _____

PATIENT RESPONSBILITY

It is the patient's responsibility to provide Dynamic with a copy of their insurance card/information. We will contact your insurance carrier and provide you with your carrier's statement of benefits for therapy, co-pay and deductible information and will also acquire any pre-authorization required for therapy. This information is NOT a guarantee of payment. Any unpaid balance is the patient's responsibility.

CONSENT TO MEDICAL TREATMENT

I have been presented with a copy of Dynamic's privacy policy which details how may information may be used and disclosed as permitted under federal and state law. I understand the contents of the notice and I request the following restrictions regarding the use of my personal information:

_____

Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignments of benefits apply.

MISSED APPOINTMENT POLICY

Attendance at your schedule appointments is crucial to a successful outcome. With the exception of serious emergencies it is expected that you keep all of your appointments. Please provide 24 hour notice when needing to reschedule. In instances of repeated non-compliance with your scheduled visits, we reserve the right to discontinue care.

PLEASE SIGN THE BELOW STATEMENT

I hereby agree and give my consent to medical treatment of my physical condition. I authorize release of any medical information that is needed to process my claim. I understand that I am responsible for any charges that are not covered by my insurance carrier. Furthermore, I understand that I am responsible for informing the office of any changes that occur. I authorize release of payment from my insurance carrier.

PATIENT/PARENT/GUARDIAN: _____ **DATE:** _____

MEDICAL HISTORY QUESTIONNAIRE

The purpose of this questionnaire is to help us understand your health status. Please complete this form and your provider will answer any questions during your exam. This form is considered part of your medical record.

Name:_____ **Date:**_____ **Age:**_____ **Physician:**_____

Occupation:_____ **Last Day Worked:**_____ **Smoker:** Y/N **Height:** ____ **Weight:**_____

Current Injury/Complaint: _____

Have you had surgery for this injury? YES NO Type of Surgery/Date:_____

Is an attorney involved in this case? YES NO Attorney Name: _____

Pain: Please circle your current pain level intensity: 0 1 2 3 4 5 6 7 8 9 10

My pain can be described as: constant intermittent sharp dull aching stabbing numbness pins/needles

Current Medications:_____

_____

Medication Allergies: _____

Circle any other medical or rehabilitation care you have had for this injury/episode:

Chiropractor General Practitioner Occupational Therapy Physical Therapy Massage Neurologist Orthopedist

Podiatrist Emergency Room CT scan EMG/NCV MRI XRAY other:_____

Please circle any of the following that you have or have ever had:

Asthma, Bronchitis, or Emphysema Shortness of Breath Coronary Heart Disease Pacemaker Blood Clot Stroke

High Blood Pressure Heart Attack/Surgery Pins/Metal implants Joint Replacement Diabetes Infectious Disease

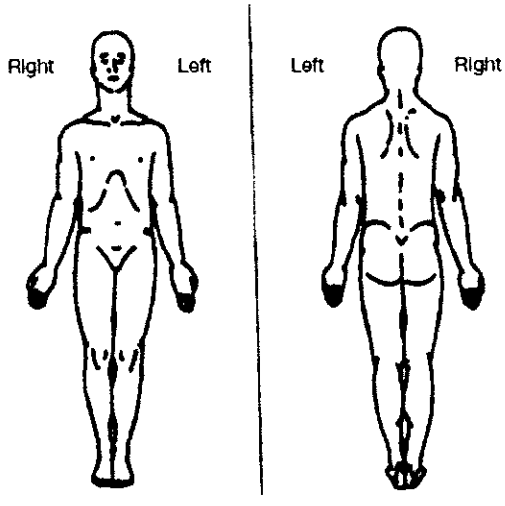
Cancer Arthritis Osteoporosis Severe/Frequent Headaches Vision or hearing problems Weakness Hernia

Weight Loss Epilepsy/Seizures Thyroid Trouble Incontinence Bowel or Bladder problems Multiple Sclerosis

Additional Surgeries in the past: _____

Other Medical Issues: _____

Please indicate on the drawing where your current problem is:



Relevant Additional Information: