



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? \_\_\_\_\_

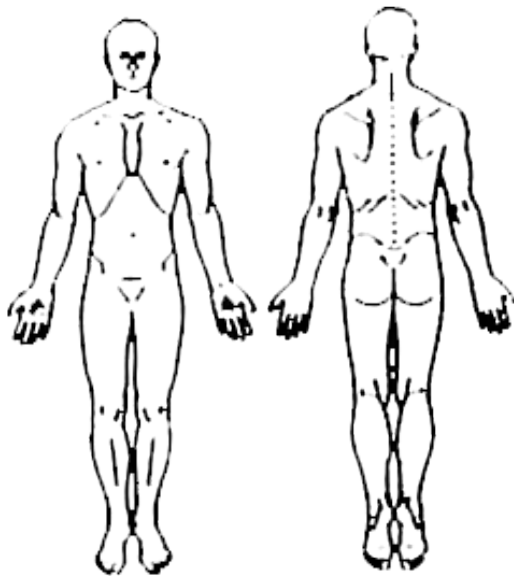
Is this condition interfering with  Work  Sleep  Routine  Other: \_\_\_\_\_

Is this condition progressively getting worse? YES or No \_\_\_\_\_

Other Doctors seen for this condition: \_\_\_\_\_

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\*\*\*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. Comment if necessary.

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

**OCCUPATIONAL CONCERNS**

- 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.) _____	_____	_____

**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:

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



## Informed Consent

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 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.
- **It is our policy to payment in full for Physical Therapy & Chiropractic service on the date rendered.**

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.

- **Physical Therapy Services:** The patient (Under the age of 65 with PPO Insurance) will be provided a superbill for self-submittal upon request.
- **Chiropractic Services:** If you have PPO insurance, we will submit a claim on your behalf to our independent biller. Any reimbursement received up to the amount paid for each individual session will be allocated back to the patient.

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 the difference to HealthFit if it exceeds your out-of-pocket payment.

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 of cancellation 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: \_\_\_\_\_