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RESILIENT
HEALTH & PERFORMANCE

RESILIENT HEALTH AND PERFORMANCE - PATIENT REGISTRATION

Full-Name:_____ Today's Date:____/____/ _____

Male:_____ Female: _____

Age:_____ DOB:_____/_____/_____ Height: _____ft._____in. Weight:_____lbs

Email Address:_____ Best Phone #:_____-_____- _____

Address:_____

City:_____ State: _____ Zip:_____

Occupation:_____ Employer:_____

Emergency Contact:_____ Emergency Contact Phone # _____

Primary Care Physician:_____ Practice Location: _____

How did you hear about Resilient: _____

Do you have health insurance? If so, what carrier?_____

Policy No: _____ Group No:_____

Policy Holder's Name:_____

Please have your health insurance card ready so that they can be copied for the clinic's records. *

RESILIENT'S MISSION STATEMENT

To provide superior quality and personalized care while empowering patients and clients with tools to eliminate pain, prevent injury, and improve everyday performance.

RESILIENT HEALTH & PERFORMANCE

REASON FOR YOUR VISIT

Circle One:

Pain Complaint Training and Performance

What is the reason for your visit today? _____

_____

When did your symptoms begin? _____

_____

How would you describe the pain? Sharp/Stabbing Dull Numbness/Tingling Burning Other

Rate you pain on a scale from 1-10, 10 being the worst: _____

Since the problem started, it is: Getting better Getting worse About the same

Is the condition interfering with you: Work Sleep Training/Sport Daily

Routine

How frequent is the condition? Constant Intermittent Night Only Morning Only

What makes the problem worse? _____

Is there anything you can do for temporary relief? _____

Has another doctor treated you for this problem? _____

Were X-rays or other imaging procedures performed? _____

How often do you exercise? 5-7 days/week 3-4 days/week 1-2 days/week None

What types of exercises, if any, do you enjoy most? _____

_____

RESILIENT HEALTH & PERFORMANCE

REVIEW OF SYSTEMS

	QUESTIONS:	YES	NO
	Do you have skin, hair, or nail problems?		
	Do you have mouth and/or throat problems?		
	Do you have nose and/or sinus problems?		
	Do you have ear problems		
	Do you have eye problems?		
	Do you have chest or lung (breathing) problems?		
	Do you smoke?		
	Do you have heart and/or blood vessel problems?		
	Do you have blood or lymph node problems?		
	Do you have digestive problems?		
	Do you have urinary, bladder, or kidney problems?		
	Do you have any nervous system diseases?		
	Do you have any mental health disease?		
	Do you have any gland and/or hormone problems?		
	Do you have allergy or immunity problems?		
	Do you have any muscle, tendon, or ligament problems?		
	Do you have any bone or joint diseases?		
	Do you have any familial diseases or conditions?		
FEMALES	Have you had menstrual problems?		
	Are you taking birth control pills?		
	How many children have you given birth to?		
	Is there any chance that you are currently pregnant?		
	Do you have pain with gyno exams or pain with intercourse?		
	Do you experience leakage with exercise, coughing, laughing, or sneezing?		
PAST HISTORY	Have you recently been diagnoses with any diseases or conditions?		
	Have you suffered any physical injuries: head injury, fracture, whiplash, lacerations, sprains, strains, dislocations?		
	If yes, describe the accident including the date.		
	Please list any scars and surgeries that you have had including dates:		
	Have you been hospitalized for any reason other than surgery?		
	Please list all medications that you are taking.		
	Have you ever seen a chiropractor before?		
	Have you ever seen a physical therapist before?		

RESILIENT
HEALTH & PERFORMANCE

INFORMED CONSENT FOR PATIENT CARE

By signing below, I authorize Resilient Associates, LLC DBA Resilient Health and Performance to release medical records required by my insurance company(s). I authorize my insurance company(s) to pay benefits directly to Resilient Associates, LLC, and I agree that a reproduced copy of this authorization will be as valid as the original. I understand that I am responsible for any amount not covered by my insurance, or amount for a patient for which I am the guarantor. I agree that I will be responsible for any collection agency or attorney fees incurred. I understand that by signing below, I am giving written consent for the use and disclosure of protected health information for treatment, payment, and health care operations.

You have a right to be informed about your condition, the recommended chiropractic and/or physical therapy treatment and the potential risks involved with the recommended treatment. This information will assist you in making an informed decision whether or not to have the treatment. This information is not meant to scare or alarm you;it is simply an effort to make you better informed so you may give or refuse to give your consent to treatment.

I request and consent to the performance of all treatments and procedures, including manipulations / adjustments, soft tissue therapy, functional dry needling, taping applications, physical therapy modalities, and exercise instruction by the doctors and Resilient Associates, LLC DBA Resilient Health & Performance. Treatment may be performed by the doctors working at this office.

I have had the opportunity to discuss with the providing doctor my diagnosis, the nature and purpose of my treatment, the risks and benefits of my treatment, alternatives to my treatment, the risks and benefits of alternative treatment, including no treatment at all.

I understand that results are not guaranteed. I further understand and am informed that, as in all health care, there may be some risks to treatment. I do not expect the providing doctors to be able to anticipate and explain all risks and complications. I wish to rely on the doctor providing treatment to exercise judgment during the course of the procedure which he/she feels at the time, is in my best interest.

I understand that there are some risks to chiropractic treatment including, but not limited to: stroke, dizziness, nausea, broken bones, dislocations, sprains/strains, worsening and/or aggravation of spinal conditions, increased symptoms and pain, and/or no improvements of symptoms.

In rare cases there have been reported complications of vertebral artery dissection (stroke) when a patient received a cervical adjustment. The complications reported can include temporary minor dizziness, nausea, paralysis, vision loss, locked in syndrome (compete paralysis of voluntary muscles in all parts of the body except for those that control eye movement), and death.

I understand it is my responsibility to inform this office of any changes in medical status.
I have read, or have had read to me, the above consent has had an opportunity to ask questions about its content. I intend for this consent form to cover the entire course of treatment for my present condition and / or any future conditions for which I may seek treatment from a providing doctor at Resilient Associates, LLC DBA Resilient Health & Performance. The above information is true to the best of my knowledge.

_____ _____

Patient (or Parent / Guardian) Signature Date

_____

Doctor or Staff Signature

RESILIENT
HEALTH & PERFORMANCE

APPPOINTMENT CANCELLATION POLICY

If, for any reason, you are unable to keep an appointment we require that you telephone immediately to reschedule your visit. Charges may be made for missed appointments and those cancelled without 24 hours notice.

We charge $65 for the first missed appointment without adequate notice of cancellation. Subsequent appointment times that are missed are subject to a $135 charge. Charges are at the discretion of the manager.

This policy was implemented out of respect for both our doctors and our patients. Late cancellations are difficult to fill. When you cancel the day of your appointment, you prevent someone else from being able to schedule and be served.

We sincerely attempt to honor all appointments at the scheduled time. If you are late, your time may need to be cut short. The best health services are based on a friendly, mutual understanding between provider and patient. We invite you to discuss with us any questions regarding our policies and services.

_____ _____

Signature Date

_____

Patient Name

Please bring a copy of the completed form with you to the office OR scan the completed form and email it to Renee' at resilientfrontdesk@gmail.com