THERAPY SPECIALISTS INC. DEMOGRAPHICS FORM

Patient's Name	**Date of Birth**	**Marital Status** S M D W
Address	**Social Security #**	**Sex** M F
City, State, Zip	**E-mail**	**Fax #**

Home #	**Cell #**	**Work #**
If minor, name of parent/guardian	**Emergency contact name**	**Emergency contact phone#**

Patient's Current Employer and Occupation
Address
City, State, Zip
Phone #

Area of Injury	**Date of Injury/Surgery**
Have you seen any doctors for this issue? Please name all	
Which, if any, tests were done? (please circle) **X-ray MRI CAT Scan**	
Did you ever experience similar symptoms prior to your injury?	**Has your condition** **Improved / worsened / stayed the same** **since it began? (circle one)**
Please share any other relevant information that may be important to your diagnosis and treatment:	

Insurance Information:

Carrier	**Claim #**	**Contact**	**Phone #**

Patient Signature_____ Date _____

THERAPY SPECIALISTS INC. CURRENT HEALTH CONDITIONS

What is your primary complaint?	**When did the symptoms start?**

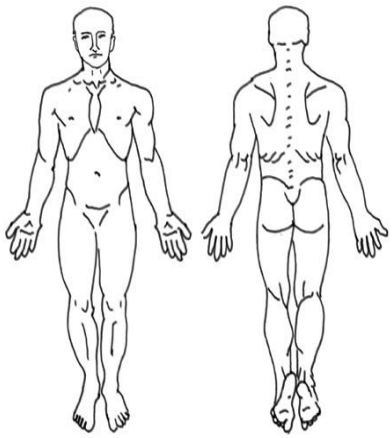
Who is your primary care physician?	**Who referred you to therapy?**	**Date of next follow-up:**

Have you had chiropractic, physical or occupational therapy in the past 12 months? **Y N**	**If yes:** **Date/type of injury:** **How many times?** **Did it help? Y N**

Please shade in the area(s) in which you are experiencing symptoms:

Pain Scale: in past 48 hours
Worst: 0 1 2 3 4 6 7 8 9 10
Best: 0 1 2 3 4 6 7 8 9 10
none worst

Description: please circle
Achy Burning
Sharp Dull
Throbbing Numb
Tingling Other:_____



Are there others in your family with the same condition?	**Y N**
Do you have trouble sleeping due to your condition?	**Y N**
Have you missed work because of your condition? How many days?	**Y N**
Is your condition due to: work? motor vehicle accident? Date of Injury:	**Y N** **Y N**
Have you had any major accidents or falls?	**Y N**

Please provide a list of any **prescription medications** (including injections and skin patches) and **over the counter medications** (including supplements), including dosage, that you are currently taking:

1.	2.	3.
4.	5.	6.
7.	8.	9.
10.	11.	12.

Please list all **allergies** that we should know about, including latex or medications:

Patient's Initials _____ Therapist's Initials_____

THERAPY SPECIALISTS INC. CURRENT HEALTH CONDITIONS

Have you ever been diagnose with any of the following conditions: (please circle if YES)

Cancer	Thyroid problems	Depression
Heart problems	Diabetes	Tuberculosis
High blood pressure	Hepatitis	Stroke
Circulatory problems	Epilepsy	Kidney disease
Asthma	Multiple Sclerosis	Anemia
COPD	Parkinson's	Other:_____
Chemical dependency	Rheumatoid Arthritis	
	Other arthritic issues	

Please explain:_____

During the past month, have you had little interest or pleasure in doing things?	Y N
Do you feel unsafe at home or has anyone tried to injure you in any way?	Y N
FOR WOMEN: Are you currently or think you may be pregnant?	Y N
Have you recently noticed any of the following? (please circle) Unexpected weight gain/loss weakness Nausea/vomiting fever/chills/sweats Fatigue numbness/tingling	
How many, if any, packs of cigarettes do you smoke per day?	
How many, if any, drinks do you have per week?	

Please list any significant **injuries**, **hospitalizations**, or **surgeries** for which you have been treated and the approximate dates of them:

Injury/Date	Injury/Date
Injury/Date	Injury/Date
Injury/Date	Injury/Date
Injury/Date	Injury/Date

Would you like to receive e-mail information about current health, sports, nutrition and medical trends? Y N

How did you hear about Therapy Specialists Inc.? _____

THERAPY SPECIALISTS INC. OFFICE POLICIES

The following are Therapy Specialist Inc.'s policies with regards to appointment scheduling, payment, and information release. Read this document carefully before signing, and be sure to ask any questions you have before signing the document.

Appointment Scheduling- We at Therapy Specialist Inc. are glad to accept insurance assignment on your behalf in handling your personal injury or worker's compensation claim. We request a 24 hour cancellation notice for all appointments. If you miss three (3) appointments in a three (3) week period without calling to cancel or notifying Therapy Specialist Inc., you may be dismissed from care and your file may be closed.

Consent for Treatment- I, the undersigned, give Therapy Specialist Inc. my permission to evaluate and treat my injury. I further understand that in the course of recommended treatment, sometimes it may feel worse before it gets better.

Acknowledgment and Understanding- It is further understood that I, the undersigned, agree to pay the full amount of the charges should my condition be such that it is not covered by my policy, or if, for any reason, the insurance company and/or my attorney refused to pay my balance at this office.

Authorization to Release Information- I authorize TSI to release any information regarding my case to any insurance companies or attorney to facilitate reimbursement for this office.

Private Health Insurance- I understand that I am responsible for whatever fees my insurance company does not pay on my claim. (Typically, this includes deductibles and/or co-payments).

I certify that I have read and understand all appointment and office policies listed above.

Patient Signature_____ Date _____