Today's Date ____________________ **EMAIL**________________________________ **File No**:________________________

CONFIDENTIAL PATIENT INFORMATION FORM

The information on this form is for Point by Point Myotherapy use only. Information will not be released to any other source unless permitted by the patient/guardian or authorized signature who signs below. Any unauthorized use of this information will be subject to legal prosecution.

Last Name____ **First** name____________________________________ MI____________

Address____ City___________________________ State__________ Zip____________

Phone________________Cell:________________ Date of Birth__________________Marital Status: S M W D #of Children:________

Occupation ____________________________________ Employer______________________________Work Phone #____________________

Referred by:____________________________Are you currently being seen by a Chiropractor? If so, who?__________________________

What are you being seen for today?____

PLEASE CIRCLE ANY OF THE FOLLOWING CONDITIONS YOU HAVE EXPERIENCED OR CURRENTLY HAVE: (Therapist may write additional comments in **green ink** to clarify responses)

Headaches / Migraines	Heart / Coronary Disease	Asthma / Respiratory Disorder	Cancer: Type__________
Whiplash / Neck Pain	High Blood Pressure	Allergies / Sinus	Pregnancy: Due:__________
Mid / Low Back / Hip / Leg	Diabetes: DX_________	Arthritis: Where__________	Epilepsy / Stroke
Arm / Shoulder / Knee / Foot	Osteoporosis / Menopausal	T.M.J. Dysfunction	Fractures______________
Sports Injuries: __________	Fibromyalgia / M.S / Scoliosis	Sleep Difficulties / Apnea / CPAP	Other:_______________

Surgical Procedures:____

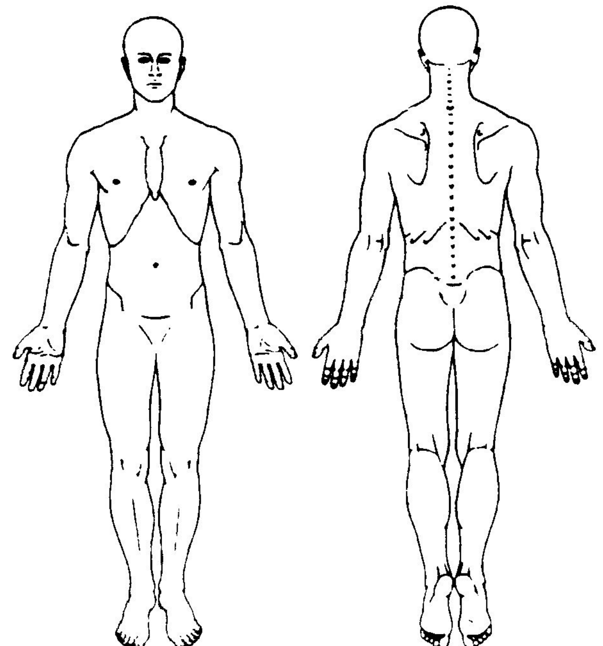
Medications:____ **ALL** Accidents (auto, falls, etc)_____________________________

Therapist Notes:____

____

On a scale of 1 – 5 (5 = most severe), indicate your level of pain._________

PLEASE INDICATE WITH AN X YOUR AREAS OF DISCOMFORT.



Please take a moment to carefully read the following information and policies and sign where indicated. Thank you for your cooperation.

Let it be known that myotherapy is not a substitute for medical care. Some medical conditions are contraindicated by myotherapy and should not be performed. A referral from your primary care physician may be required prior to services being rendered. I (the patient) therefore affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep Lisa Shelter, L.M.T. of Point by Point Myotherapy updated as to any changes in my medical profile and understand there shall be no liability to Lisa A. Shelter, L.M.T., should I neglect to inform her of any changes or omissions.

Any sexually illicit remarks or advances made will result in immediate termination of the session and the patient will be liable for payment of the scheduled appointment.

Point by Point Myotherapy reserves the right to refuse treatment to anyone who has knowingly given inaccurate information and who does not cooperate with treatment.

Appointments not cancelled within 6 hours will be charged to the patient, unless an emergency occurs which is determined by the Point by Point Myotherapy therapist.

The patient or guardian is ultimately financially responsible for all services rendered. Payment for services rendered shall be **CASH OR CHECK ONLY, NO CREDIT CARDS**. The returned check fee is $25.00.

I understand the above information and agree to follow Point by Point Myotherapy policies.

Patient/ Authorized Signature:____________________________Date ________/**11**