BAUDRY therapy center

For office use only

Account # _____

Date of 1st Visit: _____

Patient Information

Name: _____ (*Last*) _____ (*First*) _____ (*Middle Initial*)

Date of Birth: _____

Sex: ☐ Male ☐ Female

SSN: _____

Address: _____ (*Street*) _____ (*Apt, Ste, #*)

Email Address: _____

Home Phone: _____

Cell Phone: _____

_____ (*City*) _____ (*State*) _____ (*Zip*)

Other: _____

Employer: _____

Work Phone: _____

Emergency Contact: _____ **Phone:** _____ **Relation:** _____

Name of Referring Physician: _____

How did you hear about us? ☐ Facebook ☐ Website ☐ BTC Staff(Name)_____ ☐ Doctor Name_____

☐ Friend (Name) _____ ☐ Other _____

Consent for Treatment & Release of Information

I do hereby consent to treatment which may be performed during the course of my outpatient therapy at Baudry Therapy Center. I do herby consent to authorize the release of any medical information concerning billing, my diagnosis evaluation and treatment to my physician, insurance company, case manager and myself ("Patient"). (If under the age of 18, parental *consent is required.) Any other release of information will require patient to complete a "Release of Medical Information"* form.

_____ Signature of Patient or Legal Representative

_____ Date

If signed by legal representative, relationship to patient: _____

_____ Signature of Witness

_____ Date

Authorization for Payment

I hereby authorize Baudry Therapy Center to file claims on my behalf and have payment sent directly to Baudry Therapy Center for all individual/group benefits, including major medical for the account of the named patient herein below but not to *exceed the balance due of the health care provider's regular charges for the above period of service. I understand that I am* financially responsible for charges not covered by my insurance plan.

I hereby authorize the Baudry Therapy Center to release any information (medical or other) to any person or corporation which is or may be a family member or employer of the patient for all or part of the charge including, but not limited to, *hospital or medical companies, workers compensation carriers, welfare funds, or the patient's employer.*

I further appoint the Baudry Therapy Center as my agent and attorney-in-fact and authorize it to assert, in my name and on my behalf, any and all claims, by lawsuit or otherwise, which I may have relative to payment of those insurance benefits due for health care services rendered by the Baudry Therapy Center. I understand in the event my account becomes delinquent, I agree to pay all cost of collections. Should an attorney be retained for any personal injury actions, I further agree to pay reasonable attorney fees and all court costs.

_____ Signature of Patient or Legal Representative

_____ Date

BAUDRY therapy center

Health History

In order to design a safe and effective program it is important that you complete the following Health History form. It is crucial that you answer all of the questions honestly and to the best of your ability. Please be advised that all information is kept strictly confidential.

A. Past Surgical History (list all & date):

_____

_____

B. Please List All Current Medications:

_____

_____

Have you had an X-ray, MRI, or other imaging study? _____

C. Medical History: Please circle each condition that you have been told you have (or had).

Cancer	*Diabetes*	*Kidney Disease*	*Liver Disease*	*Stroke*
High Blood Pressure	*Heart Disease*	*Angina/Chest Pain*	*Ulcers*	*Fibromyalgia*
Osteoporosis	*Osteoarthritis*	*Rheumatoid Arthritis*	*Sexually Transmitted Disease*	
Allergies/Asthma	*Lung Disease*			

*Have you had a recent illness (explain if yes)*_____

Do you take blood thinners? YES NO *Are you allergic to latex? YES NO*

During the past month, have you often been bothered by feeling down, depressed, or hopeless? YES NO

During the past month, have you often been bothered by little interest or pleasure in doing things? YES NO

D. Currently I am experiencing (circle all the apply):

Fever/chills/sweats	*Poor balance (falls)*		
Unexplained weight loss	*Numbness or Tingling*	*Changes in appetite*	*Difficulty swallowing*
Depression	*Shortness of breath*	*Dizziness*	*Headaches*
Changes in bowel or bladder function		*Nausea/Vomiting*	*Increased pain at night*

How are you able to sleep at night? ☐ *Fine* ☐ *Moderate Difficulty* ☐ *Only with medication*

E. Are you currently undergoing treatment from any of the following:

Physical Therapist *Chiropractor* *Massage Therapist*

If yes, why? _____

F. Do you exercise regularly? If yes, what kind of exercise/activity? How often? Are there any other reasons (health or personal) that may prevent or limit you from exercising?

_____

Print Name: _____ *Date:*_____

Signature: _____

For Administrative Use: Height: _____ Weight: _____ BP: _____ % Fat:_____ Age: _____ Sex: ____ HR: _____
% Muscle: _____ BMI _____ Body Age: _____

BAUDRY
therapy center

Visual Pain Scale

Name: _____ *Date:* _____

Describe the character of the pain: (i.e. numbness, tingling, burning, sharp, dull ache, other)

_____

_____

Please indicate the **RANGE** *of pain (least to most) that you have had over the past 24 hours by marking a vertical line through the horizontal pain scale below.*

No Pain ——————————————— **Severe Pain**

0 1 2 3 4 5 6 7 8 9 10

Mark the location of the pain on the diagram below.

FRONT **BACK**