

Patient Information

Name: _____ **Date of Birth:** _____
Last First Middle Initial

Sex: Male Female

SSN: _____

Address: _____ **Email Address:** _____
Street Apt, Ste, #

Home Phone: _____

Cell Phone: _____

Other: _____

City State Zip

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 hereby 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

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	Difficulty swallowing
Numbness or Tingling	Headaches
Changes in appetite	Increased pain at night
Depression	
Shortness of breath	
Dizziness	
Changes in bowel or bladder function	
Nausea/Vomiting	

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: _____

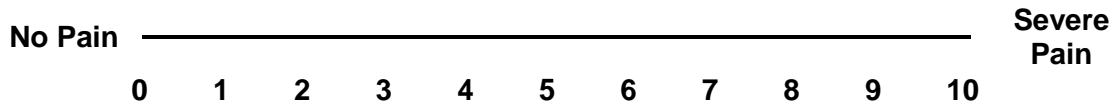
For Administrative Use: Height: _____ Weight: _____ BP: _____ % Fat: _____ Age: _____ Sex: _____ HR: _____
 % Muscle: _____ BMI _____ Body Age: _____

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.



Mark the location of the pain on the diagram below.



FRONT



BACK