the wellness bank
INVEST IN YOUR HEALTH

fax: 310.882.6426
email: info@thewellnessbank.com
web: www.thewellnessbank.com

Client Information

Name _____ Date of Birth _____

Address _____

City _____ State _____ Zip _____

Phone _____ Email _____

Employer/School _____ Occupation/Sport _____

How did you hear about The Wellness Bank? _____

Referring Physician _____

Area(s) to be treated _____

Date of Injury/Onset of Pain _____ Date of Surgery _____

Emergency Contact

Name _____ Phone _____

Parent or Guardian (if under 18)

Name _____ Relationship _____

Address _____ Phone _____

Privacy Policy: I have read the Health Information Privacy Policy attached.

24 Hour Cancellation Policy: Please provide at least 24 hours' notice to reschedule or cancel. Your appointment time is reserved exclusively for you. Late cancellations be charged the full session amount of $125.

Billing: Any co-pay and/or deducible will be collected at the time of service. We will bill your insurance as a courtesy to you. The co-pay collected at the time of service is an estimation of your cost, based on the benefits quoted by your insurance company. You may be responsible for unpaid or disallowed amounts.

Signature _____ Date _____

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General Health Questionnaire

Do you currently experience any of these symptoms?

Fevers / chills / sweats	□ Yes	□ No
Unexplained weight loss / gain	□ Yes	□ No
Malaise (feeling generally unwell)	□ Yes	□ No
Unusual fatigue	□ Yes	□ No
Nausea / vomiting	□ Yes	□ No
Headaches	□ Yes	□ No
Dizziness / lightheadedness / loss of consciousness	□ Yes	□ No
Blurred vision	□ Yes	□ No
Numbness / tingling	□ Yes	□ No
Weakness	□ Yes	□ No
Muscle cramping	□ Yes	□ No
Chest pain / palpitations	□ Yes	□ No
Swelling in feet or hands	□ Yes	□ No
Difficulty breathing / shortness of breath	□ Yes	□ No
Difficulty breathing when lying down	□ Yes	□ No
Cough / change in cough/blood in phlegm	□ Yes	□ No
Wheezing	□ Yes	□ No
Difficulty swallowing	□ Yes	□ No
Heartburn / indigestion	□ Yes	□ No
Change in appetite	□ Yes	□ No
Specific food intolerance	□ Yes	□ No
Bowel pattern changes (color, texture, frequency	□ Yes	□ No
Difficulty urinating (starting, stopping)	□ Yes	□ No
Urine frequency changes	□ Yes	□ No
Possibility of pregnancy	□ Yes	□ No

Other Medical Conditions or prior surgeries: _____
_____

Current Medications: _____
_____

Family Medical History (birth parents & siblings): _____
_____
_____

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Consent to Treatment

Physical therapy and Chiropractic are patient care services provided in response to a wide range of medical care needs of patients of all ages regardless of gender, color, ethnicity, creed, national origin, or disability.

The purpose of physical therapy and chiropractic is to treat disease, injury and disability by examination, evaluation, diagnosis, prognosis and intervention by use of rehabilitative procedures, mobilization / manipulation, massage, exercises, and physical agents to aid the patient in achieving their maximum potential within their capabilities and to accelerate convalescence and reduce the length of the functional recovery. All procedures will be thoroughly explained to you before you are asked to perform them.

We would appreciate your full cooperation with the evaluation and treatment program. Because of the nature of services provided, you might be asked to disrobe. If this is necessary, your privacy, modesty and dignity will be considered at all times. Should you feel uncomfortable or embarrassed, you may refuse or stop the procedure.

There are certain inherent risks with treatments because you will be asked to exert effort and perform activities with increasing degree of difficulty that could cause an increase in your current level of pain or discomfort or an aggravation to your existing injury. You will be able to stop treatment if you feel any discomfort of pain. We will take every precaution necessary to ensure you are protected from any potentially hazardous situation. You will never be forced to perform any procedure you do not wish to perform.

Based on the above information, I agree to cooperate fully, to participate in all physical therapy and chiropractic procedures and to comply with the plan of care as it is established. I have read this consent form and authorize the release of medical information to appropriate third parties.

Signature _____ Date _____