New Patient Information

Name: _____ Date of Birth: _____ Today's Date: _____

Address: _____ City: _____ State: ____ Zip: _____

Phone: _____Email: _____ Primary MD: _____

Health Insurance Carrier: _____ Who may we thank for referring you? _____

In case of emergency, who should be notified? _____ Phone: _____

Sex: M□ F□ Other□ Circle One: Married Single Divorced Widowed Separated Other

Occupation: _____ Full-time□ Part-time□ Disability□ Sick Leave□

Do you smoke? Yes□ No□ If yes, how many packs per day? _____

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

□ Cancer (type)_____
□ Rheumatoid arthritis
□ Diabetes
□ Heart disease
□ Stroke
□ Multiple sclerosis
□ High blood pressure
□ Depression
□ Kidney/liver problems
□ Asthma
□ Anemia
□ Stomach ulcers
□ Pacemaker inserted
□ Lung problems
□ Epilepsy
□ Osteoporosis
□ Thyroid problems
□ Parkinson's disease
□ Chemical dependency (i.e., alcoholism)
□ Heart Attack
□ HIV/AIDS
□ Other_____ □ Other_____

Please list all current medications:_____
Are you currently taking a blood thinner or anticoagulant medication? **YES NO**
ALLERGIES: _____ Are you latex sensitive? Yes No
Please list any surgeries or other conditions for which you have been hospitalized, including dates:
1. _____ 2._____ 3._____

During the past month have you been feeling down, depressed or hopeless? **YES NO**
During the past month have you lost interest or pleasure in doing things? **YES NO**
FOR WOMEN: Are you currently pregnant or think you might be pregnant? **YES NO**

In the spaces below, please describe your primary reason for seeking Yoga Therapy at this time.

Please describe your current complaint or limitation:

_____

Please describe how your problem began:_____

When did your condition begin?_____Specific Date if possible:___/___/___

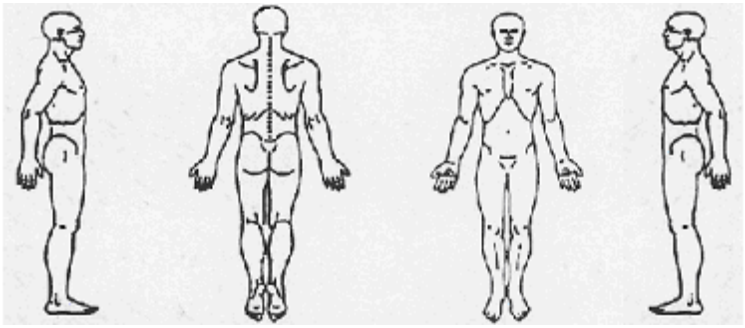
Did you have surgery for this condition? □No □Yes Date____/____/____

Have you had any diagnostic tests for this condition? □ X-Ray □MRI □CT Scan □Other: _____

Please describe the nature of your pain/discomfort (check all that apply):

□ Sharp Pain
□ Dull Ache
□ Throbbing
□ Numbness
□ Shooting
□ Burning
□ Tingling
□ Constant (76%-100% of the time)
□ Frequent (51%-75% of the time)
□ Occasional (26%-50% of the time)
□ Intermittent (25% or less of the time)

MARK ON THE PICTURES BELOW WHERE YOU HAVE PAIN OR OTHER SYMPTOMS



Indicate the intensity of your ***pain at rest*** : (NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable Pain)

Indicate the intensity of your ***pain with movement*** : (NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable Pain)

Since this condition began, your symptoms have: □ Decreased □ Not changed □ Increased

Your symptoms are worse in: □ Morning □ Afternoon □ Night □ During the day □ Same all day

Have you been treated in the past for the same problem? □ Yes □ No If yes, who did you see?

□MD □Physical Therapist □Occupational Therapist □Chiropractor □ Massage Therapist □Other

Briefly describe your dietary habits:_____

Briefly describe your previous Yoga experience:_____

Current level of psychological/emotional stress (circle one): **Low** **Medium** **High**

Current level of satisfaction with personal relationships (circle one): **Low** **Medium** **High**

Please list your current favorite past times or hobbies: _____

- **PAYMENT OF FEES**

Full payment by check or cash is expected at the time of treatment. I do not accept insurance or file with insurance companies.

_____I understand that Asheville Holistic Physical Therapy, Inc. requires fees to be paid at the time of service (initial). _____I understand that Asheville Holistic Physical Therapy, Inc. does not participate with any insurance provider, and therefore will not bill my insurance carrier for services rendered (initial).

- **CANCELLATION AND NO-SHOW POLICY**

If you need to change your appointment, we require at least **24 hours notice by phone (828) 553-4844,** or there will be a **$30.00 fee**. Repeated late cancelations and no-shows will result in discharge from the practice.

I understand and agree to the terms stated above.

_____ _____

Patient/Guardian Signature **Witness Signature**

_____ _____

Print Name **Print Name**

- **CONSENT FOR TREATMENT:**

By signing below, I authorize and request Asheville Holistic Physical Therapy, Inc. to administer all necessary treatments and care required for my (or my dependent's) rehabilitation. This consent is effective from the date it is executed until the date the client terminates it in writing.

_____ _____

Patient/Guardian Signature **Witness Signature**

_____ _____

Print Name **Print Name**

- **HIPAA DISCLOSURE STATEMENT:**

_____ I acknowledge that I have been informed of the Provider Notice of Patient Information Practices which is located in the Asheville Holistic Physical Therapy, Inc. office area (initial).

- **PHONE CALL AUTHORIZATION:**

I authorize Asheville Holistic Physical Therapy, Inc. to leave messages on my answering machine regarding relevant information. _____(Initial) _____(Decline) I authorize Asheville Holistic Physical Therapy, Inc. to text message my cell phone for appointment reminders. _____(Initial) _____(Decline)

I understand and agree to the all of the terms stated above.

_____ _____

Patient/Guardian Signature **Witness Signature**

_____ _____

Print Name **Print**