



Today's Date: _____

Child's Last Name: _____ First Name: _____

Age: _____ Sex: M F Date of birth: _____

SS#: _____ Students-Grade level: _____

Name of parents: _____

Address: _____

City: _____ St: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Responsible parties name: _____

Employer: _____

Work #: _____

Emergency Contact: _____ Phone # _____

*Female Patients: Is there a possibility you might be pregnant? No Yes

Date of Last Menstrual Period _____ Due Date _____ OB/GYN: _____

Where will you be delivering: St. Vincent's Women's Other:

How did you hear about our office: Drive-by, Phone book, Newspaper, Other Ad, Patient or Other Person- (please list so we may thank them) _____

HEALTH INFORMATION:

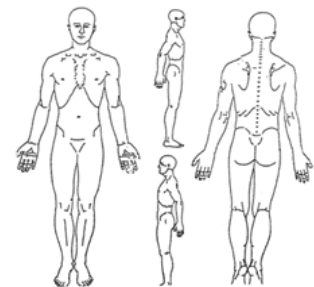
Why are you bringing your child to the office?

- 1 _____
- 2 _____
- 3 _____
- 4 _____

Please mark the areas of pain/problem on the figures below...

Is your pain: (mark all that apply)

- dull sharp stabbing numb
- tingling throbbing tight achy



Who is your primary care doctor: _____

Printed Name: _____

◆ Signature of Parent/Guardian: _____ Date: _____

*****Mark all that apply in the last 12 months*****

Review of systems: check any past or current symptoms

<input type="checkbox"/> recent fever/sweats	<input type="checkbox"/> nighttime urination
<input type="checkbox"/> unexplained weight loss/gain	<input type="checkbox"/> menstrual problems
<input type="checkbox"/> unexplained fatigue/weakness	<input type="checkbox"/> muscle/joint pain
<input type="checkbox"/> Change in vision	<input type="checkbox"/> back pain
<input type="checkbox"/> difficulty hearing/ringing in ears	<input type="checkbox"/> rash
<input type="checkbox"/> hay fever/ allergies/ congestion	<input type="checkbox"/> change in skin
<input type="checkbox"/> trouble swallowing	<input type="checkbox"/> Headache
<input type="checkbox"/> chest pain/discomfort	<input type="checkbox"/> memory loss
<input type="checkbox"/> palpitations	<input type="checkbox"/> fainting
<input type="checkbox"/> shortness of breath on exertion	<input type="checkbox"/> dizziness
<input type="checkbox"/> cough/wheezing	<input type="checkbox"/> anxiety/stress
<input type="checkbox"/> coughing up blood	<input type="checkbox"/> sleep problems
<input type="checkbox"/> heartburn/reflux	<input type="checkbox"/> unexplained lumps
<input type="checkbox"/> changes in bowel movements	<input type="checkbox"/> easy bruising/ bleeding
<input type="checkbox"/> nausea/vomiting/ diarrhea	<input type="checkbox"/> cold/heat intolerance
<input type="checkbox"/> pain in abdomen	<input type="checkbox"/> increased appetite
<input type="checkbox"/> painful/bloody urination	<input type="checkbox"/> increased thirst

Family History:
 indicate family member with any of the following:

alcoholism _____

cancer _____

heart disease _____

depression/ suicide _____

genetic disorders _____

diabetes _____

high cholesterol _____

high blood pressure _____

stroke _____

bleeding/clotting disorders _____

asthma/ COPD _____

other: _____

Personal Medical history

<input type="checkbox"/> osteoporosis	<input type="checkbox"/> thyroid problem
<input type="checkbox"/> asthma/ lung disease	<input type="checkbox"/> kidney disease
<input type="checkbox"/> high blood pressure	<input type="checkbox"/> Seizures
<input type="checkbox"/> diabetes: taking insulin Y N	<input type="checkbox"/> depression
<input type="checkbox"/> high cholesterol	<input type="checkbox"/> Cancer (specify) _____
<input type="checkbox"/> Heart disease (specify) _____	

other: _____

Surgical History: list all surgeries and dates

Medications & Vitamins: list all prescription and non-prescription

Social History

* **tobacco use**
 cigarettes: Never Quit Date: _____
 current smoker
 packs/day _____ # of years _____

* **Alcohol use:** Yes No
 # drinks/week _____

* **Drug use**
 recreational drugs Yes No
 Needle use to inject drugs Yes No

* **Caffeine Intake**
 None Coffee/tea/soda _____ cups/day

* **Are you satisfied with your weight** _____

* **Rate your diet:** good fair poor

* **Exercise Regularly?** Yes No
 what type: _____
 how long: _____
 how often: _____

* **Current Occupation** _____

* **Past Occupations** _____

* **Favorite Hobbies/Activities** _____

Current Primary Care Physician: _____

Printed Name: _____

◆ **Signature of Parent/Guardian:** _____ **Date:** _____

Consent to Share Confidential Medical Information

TO BE VALID, ALL LINES WITH AN ASTERIK (*) ON THIS FORM, MUST BE FILLED OUT COMPLETELY, including what information you are giving us permission to share. Place N/A on lines not applicable to your care.

*Patient's Legal Name: _____ *DOB _____

***I HEREBY AUTHORIZE VSC WELLNESS CENTER TO SHARE:**

- 1. Any of my medical information, including information about my medical diagnoses and imaging results
- 2. My appointment times, dates, and reasons for the visits and/ or billing issues
- 3. The following information (specify): _____

***WITH THE FOLLOWING PEOPLE:**

Full Name: _____ Relationship: _____

Authorized to share: 1 2 3 This authorization expires: Date: _____

Full Name: _____ Relationship: _____

Authorized to share: 1 2 3 This authorization expires: Date: _____

*I understand that my treatment, enrollment, or eligibility for benefits will not be conditioned on my signature -----Initial _____

*I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law ----- Initial _____

*I understand that I may cancel this consent at any time (by writing to VSC Wellness Center), but that canceling it will not affect any information that has already been released. I understand that I do not have to sign this form, and that I should only sign it if I want my provider or my clinic to share my information with someone. If no expiration date or event is specified, this authorization will expire one (1) year after the date it is signed.

*Signature: _____ Date: _____

*Relationship to minor patient (if parent or legal guardian): _____
If you are not the minor patient's parent, you must give us proof of guardianship (for example, a court order or power of attorney)

Witness: _____ Date: _____

Acknowledgement of Policies and Procedures / Please Read and Sign

*Co-Pays are due at the time of service. Account balances must be below \$150.00. -----Initial _____

*It is required that you arrive 10 minutes before your scheduled muscle therapy appointment. If you are not here at that time your appointment may be given to another patient. -----Initial _____

***We require a 24-hour notice to change or cancel appointment. A \$25 fee for a 30 min appointment or a \$30 fee for a 60 min appointment will be charged if you cancel or miss a muscle therapy appointment with less than 24-hour notice. No-Show/less than 24-hour notice more than 3 times will require prepayment at the time of scheduling for any future muscle therapy appointments.** -----Initial _____

*I have been given the opportunity to review the Financial Terms and Conditions -----Initial _____

HIP & MEDICAID PATIENTS:

*If you miss three (3) scheduled muscle therapy appointments, you will not be able to schedule any muscle therapy appointments for a year. Any previously scheduled appointments will be cancelled after the third missed appointment-----Initial _____

Acknowledgement of Privacy Policy

*Certain treatments may be performed in a common therapy area and/or you may find yourself within public areas within the clinic, but please note private rooms are always available, upon request, for discussing your private health information----- Initial _____

*This is to acknowledge that I have been given the opportunity to review VSC Wellness Center's Notice of Privacy Practices. I acknowledge that I have read and understand the policies and procedures of VSC Wellness. I understand that I have the right to request a personal copy of this office's Notice of Privacy Practice.

*Sign _____ *Date _____