CULTIVATE
Wellness and Sports Rehab

WELCOME TO OUR PRACTICE! PLEASE HELP US SERVE YOU BETTER BY TAKING A FEW MINUTES TO PROVIDE THE FOLLOWING INFORMATION.

Full Name _____ Date of birth ____/____/____

Address _____ City/State _____ Zip Code_____

E-Mail _____ Phone Number _____

Allergies or Medical Precautions _____

Primary Physician _____ Diagnosis_____

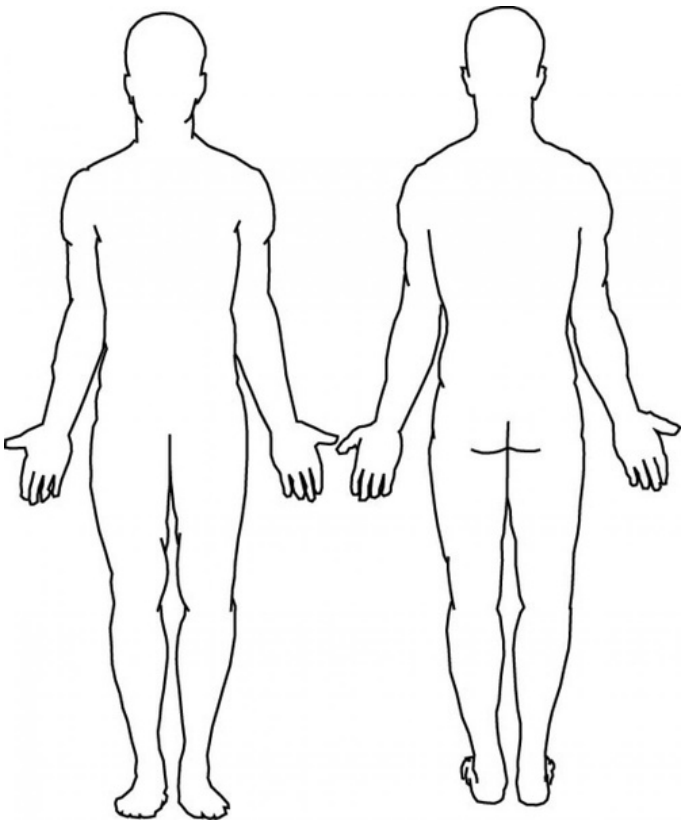
How did you hear about our practice? _____

EMERGENCY CONTACT DETAILS

Contact Name _____ Home Number _____

Relationship _____ Mobile Number _____

PLEASE SHADE IN THE AREAS WHERE YOU HAVE PAIN, DISCOMFORT OR TENSION.



What is the primary issue/problem?

When/how did this problem begin?

What makes pain/symptoms worse?

What makes pain/symptoms lessen?

CULTIVATE
Wellness and Sports Rehab

ARE YOUR SYMPTOMS WORSE IN THE:

Morning____ Afternoon____ Evening____ Inconsistent____

RATE YOUR PAIN ON A VISUAL SCALE (0-10)

0 1 2 3 4 5 6 7 8 9 10

WHAT OTHER TYPES OF TREATMENT HAVE YOU HAD FOR THIS PROBLEM?

Myofacial Release _____ Bodywork _____ Physical Therapy _____

Massage _____ Chiropractic _____ Surgery _____ None _____

other medical treatments (please describe): _____

_____

_____

_____

LIST PAST MEDICAL HISTORY & DATES OF OCCURENCE: SURGERIES, ACCIDENTS & OTHER TRAUMAS

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

CULTIVATE
Wellness and Sports Rehab

CHECK THE BOX IF YOU'VE HAD ANY OF THE FOLLOWING MEDICAL CONDITIONS:

- ☐ Diabetes
- ☐ Lung Disease
- ☐ Weight Change
- ☐ Heart Disease/Pacemaker
- ☐ Rheumatic Fever
- ☐ Osteoporosis
- ☐ Migraine Headaches
- ☐ Epilepsy/Seizures
- ☐ Heart Murmur
- ☐ Malignancy
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Circulatory Problems
- ☐ Liver disease
- ☐ Varicose Veins
- ☐ Neurological Problems
- ☐ Metal Implants
- ☐ Blackouts
- ☐ Arthritis
- ☐ Broken Bones (fractures)
- ☐ Stroke
- ☐ Others (explain below) _____

_____

_____

_____

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING, THE REASON FOR TAKING, DOSE, AND EFFECTIVENESS. (INCLUDE SUPPLEMENTS, HERBAL & HOMEOPATHIC REMEDIES)

Medication	Reason for taking	Dose/amount per day	Effectiveness

LIST ALL TASKS/ACTIVITIES THAT YOU HAVE DIFFICULTY PERFORMING & YOUR TOLERANCE (MINS/HOURS). IF YOU ARE NO LONGER ABLE TO PERFORM AN ACTIVITY, YOUR TOLERANCE WOULD BE "0"

Task / Activity	Tolerance (mins/hours)

CULTIVATE
Wellness and Sports Rehab

Informed Consent

I understand Cultivate Wellness & Sports Rehab will maintain my privacy to the highest standards and may use or disclose my personal health information for the purposes of conducting treatment, obtaining payment, evaluating the quality of services provided and/or any administrative operations related to treatment or payment.

Photographs/videos taken during initial evaluation, progress evaluation and discharge summary will be used for postural comparison purposes and as educational tools. By signing below, I consent to the use of these photographs/videos in a professional manner.

I, _____, do hereby agree and give my consent for Cultivate Wellness & Sports Rehab to furnish care and treatment that is necessary and proper in the diagnosing or treating of my physical condition.

I understand that I retain the right to revoke this consent by notifying the practice, in writing, at any time. I hereby certify that all the above information is true to the best of my knowledge.

Patient/Parent/Guardian Signature: _____

Date: _____