



PHYSICAL MEDICINE INTAKE

*** Please arrive 15 min. prior to scheduled appointment to take your photo, copy insurance card, and input paperwork into computer. Remember to bring Completed Paperwork. (If paperwork not completed, arrive 45 min prior to appt.)**

First Name: _____ MI: _____ Last Name: _____ SS# _____

Street Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Email: _____

Sex: M F DOB: ___/___/___ Age: ___ Marital Status: Single Married Divorced Widowed Separated

Employer: _____ Work Address: _____ Zip: _____

Occupation: _____ Work Phone: _____

Emergency Contact Name: _____ Phone: _____ Relationship: _____

Do you give permission for Dr. Davies to update your general medical practitioner with the progress of your condition? Yes No

Name of Medical Doctor: _____ Who may we thank for referring you to us? _____

RESPONSIBLE PARTY INFORMATION

If you are the responsible party mark "self" and move down to "Payment Information".

Person responsible for patient's charges: Self Spouse Parent Other: _____

First Name: _____ MI: _____ Last Name: _____ SS#: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Sex: M F DOB: ___/___/___ Age: ___ Cell: _____ Work Phone: _____

Employer: _____ Occupation: _____

PAYMENT INFORMATION

Please check the following payment methods that apply: Health Insurance Cash

This injury is related to a Work Injury. Date of Injury: ___/___/___.

This injury is related to an auto accident. Date of Accident: ___/___/___.

ASSIGNMENT AND RELEASE

Scheduling an appointment reserves this time especially for you and no one else. Therefore, our office requires **24 hours notice to cancel an appointment. If 24 hours is not given, a charge of \$20** will be billed to your account.

I _____ clearly **understand and agree that all services provided will be charged directly to me and that I am personally responsible for payment.** I agree to allow Dr. Mark Davies, DC, CCN, CCSP, RN to bill my insurance company as a courtesy and permit the release of medical records necessary to process my claims. I authorize payments to be made directly to Dr. Mark Davies, DC, CCN, CCSP, RN for treatment rendered. **I understand that co-payments and cash fees are due at the time of service and that I may receive an additional bill for services not covered by my insurance.**

Patient's Signature: _____ **Date:** _____

Parent or Guardian's Signature if under 18

For office use only: Photo Copy Ins Card Ins Entered in CT

WELCOME TO OUR OFFICE

To the New Patient:

Outline of Procedure for New Patients

STEP 1: All new patients are requested to fill out a variety of different forms (depending on case type). Please fill out the forms as complete as possible. If you have questions please ask the front desk.

STEP 2: The Doctor will review your completed forms and provide you with a consultation and physical examination to determine what care is appropriate for your condition.

STEP 3: The doctor will advise you as to the need of additional procedures such as laboratory tests, x-rays, MRI's and other tests if necessary

STEP 4: The doctor will provide you with a diagnosis, review relevant contributing and complicating factors as well as risk factors specific to your condition.

STEP 5: The doctor will discuss your goal with treatment. He will then provide you with treatment recommendations to reach your goals.

STEP 6: If you decide to receive care, a treatment plan will be designed for you and a date for reevaluation will be scheduled and expectations discussed.

GOALS FOR CARE?

People seek help from professional health-care providers for many reasons. Please check beside which goal you are interested in:

- RELIEF CARE:** Focus on symptomatic relief of pain and discomfort
- CORRECTIVE / REHABILITATIVE CARE:** For those interested providing good healing the injured symptomatic area and promote function of the area to work towards creating an environment where injury is less likely to recur
- MAINTENANCE / PREVENTATIVE CARE:** Geared towards those who wish to reduce the risk of future injury and degeneration while maximizing function and performance of their bodies come in for periodic "check-ups"
- WOULD LIKE THE DOCTOR TO SELECT THE TYPE OF CARE APPROPRIATE FOR YOUR CONDITION.**

DESIRED APPROACH TO CARE?

A "Natural Medicine" approach to care can be separated into two main categories. Please check beside which approach you are interested in:

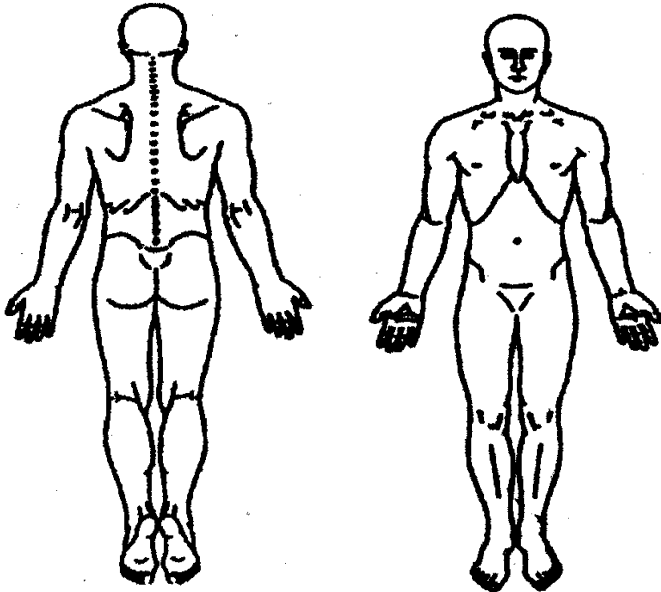
- PHYSICAL MEDICINE:** Focus on more on orthopedic approach to care. Goals of care usually involve those described above and focus on range of motion, flexibility, strength, core stability, posture, ergonomics etc. Treatment usually involves both manual passive care (joint manipulation, myofascial release performed by doctor) and physically active care (home exercises done by patient).
- FUNCTIONAL MEDICINE:** Focus more on the physiologic functioning of the body as a whole. Special laboratory evaluation is often considered to help diagnosis and guide treatment. Treatment approach focuses on diet modification, nutritional recommendations and prescribed supplementation.
- UNSURE or BOTH** (would like doctors opinion and/or to discuss further)

CHIEF COMPLAINT FORM

1. What is your **major** complaint? _____

Using the following abbreviations to indicate on the figure below where you are experiencing symptoms

P = Pain **S** = Stiffness **A** = Aching **B** = Burning **NT** = Numbness / Tingling



2. When did your symptoms **begin**? _____

3. Did the symptoms begin **gradually** or **suddenly**? _____

4. Was there any **trauma** involved? **YES NO**
If yes, describe: _____

5. Any **changes** in the following? **YES NO**
If yes, check & describe:

- Medication
- Work duties
- Hobbies
- Exercise (new or changed)
- Body weight
- Eating habits
- Ergonomics
- Stress
- Sleep patterns

6. Are the symptoms **constant** or tend to **come and go**? _____

7. How **often** do the symptoms bother you? _____

8. How **long** do the symptoms last for? _____

9. Do you have **pain at night**? **YES NO** Is the condition getting **progressively worse**? **YES NO**

10. Has this condition **bothered you before**? _____

11. Would you **describe** it as (circle): SHARP, SHOOTING, ELECTRICAL, DEEP, DULL, ACHING, STIFF, THROBING, NUMBNESS, TINGLING, CRAMPY, OTHER: _____

12. How **severe** are your symptoms? **Mild Moderate Severe Unbearable**

13. Does this condition **prevent** you from any **daily** or **recreational activities**? **YES NO**
If yes, please describe: _____

14. What **aggravates** the condition? _____

15. What **relieves** it? _____

16. Are there any **other symptoms** that you can associate with this condition? **YES NO**
If yes, please describe: _____

17. If not mentioned above, do you ever experience **foot** or **knee pain**? **YES NO**

EVALUATION & TREATMENT HISTORY FORM

Have you received any evaluation and/or treatment for your current injuries? Yes No

If yes, please fill out the boxes below for EACH in chronological order (from 1st seen until today)

1st

Date:	Doctor or therapist name:
Testing done?: <input type="checkbox"/> No <input type="checkbox"/> Yes ▶	
Diagnosis:	
Treatment / recommendations:	
Effects of treatment?	

2nd

Date:	Doctor or therapist name:
Testing done?: <input type="checkbox"/> No <input type="checkbox"/> Yes ▶	
Diagnosis:	
Treatment / recommendations:	
Effects of treatment?	

3rd

Date:	Doctor or therapist name:
Testing done?: <input type="checkbox"/> No <input type="checkbox"/> Yes ▶	
Diagnosis:	
Treatment / recommendations:	
Effects of treatment?	

4th

Date:	Doctor or therapist name:
Testing done?: <input type="checkbox"/> No <input type="checkbox"/> Yes ▶	
Diagnosis:	
Treatment / recommendations:	
Effects of treatment?	

5th

Date:	Doctor or therapist name:
Testing done?: <input type="checkbox"/> No <input type="checkbox"/> Yes ▶	
Diagnosis:	
Treatment / recommendations:	
Effects of treatment?	

HEALTH HISTORY

PAST HEALTH

1. Have you ever had any **SERIOUS ILLNES?** YES NO

If yes, describe: _____

2. Have you ever been **HOSPITALIZED** or had **SURGERY?** YES NO

If yes, describe:

Year	Reason	Surgery	Outcome

3. Have you ever had any **MODERATE TRAUMA** or **ACCIDENT?** YES NO
 (ie. Falls, Car accidents, Work related injuries, Sports injuries, Fractures)

If yes, describe:

Year	Trauma	Treatment	Outcome

4. Do you take any **MEDICATION** or **VITAMINS / HERBS?** YES NO

If yes, describe:

Med/supp	Dose	x/day	How long	Reason

6. Have you ever had any **SPECIAL TESTS** done? (x-rays, MRI, CT etc) YES NO

If yes, describe:

Test	When	Reason	Results

7. When was your **LAST PHYSICAL** by your general practitioner? Date: / /

Were they any problems / concerns? YES NO
 If yes, describe

WOMEN ONLY

8. Date of last menstrual period? _____
 Date of last pap smear? _____
 Date of last mammogram? _____

Are you **pregnant?** _____ Due date? _____
 How many children do you have? _____
 Have you ever had a "C-section"? _____

FAMILY HISTORY

1. Have **you** or **anyone** in your immediate **family** suffered from:
- | | | |
|-------------------|------------------------|------------------|
| 1. Cancer | 6. Heart disease | 11. Neck pain |
| 2. Arthritis | 7. High blood pressure | 12. Back pain |
| 3. Aneurysm | 8. Osteoporosis | 13. Knee pain |
| 4. Stroke | 9. Diabetes | 14. Foot pain |
| 5. Skin condition | 10. Depression | 15. Other: _____ |

PERSONAL HISTORY

1. Describe your **WORK CONDITIONS**
- | | None | 25% | 50% | >75% |
|---------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Sitting | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Standing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Light labor | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Heavy labor | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Prolonged postures | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Repetitive stresses | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Physical discomfort | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Mental stress | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
2. Do you have **STRESS** in your life? YES NO
 If yes, describe:
 a) What stresses do you have? _____
 b) How do you manage your stress? _____
3. Please note the following **HABITS**
- | | Light | Moderate | Heavy | None |
|--------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Coffee | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Alcohol | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Tobacco | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Recreational drugs | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
4. Do you **EXERCISE**? YES NO
 If No, would you like to? YES NO
 If Yes, answer the following
 a) What **type**?
 b) # **days** per week? 1 2 3 4 5 6 7
 c) How many **minutes** is each session? 15-30 30-60 60-90 90-120 >120
 d) How many **years**?
 e) **Intensity** level? LOW MED HIGH
 f) Are you a **competitive athlete**? YES NO
 g) Do you do **balance/stability training**? YES NO
5. Do you **SLEEP WELL** at night? YES NO
 If No, answer the following
 Do you have trouble falling asleep? YES NO
 Do you wake-up frequently during the night? YES NO
 Do you grind your teeth at night? YES NO
 Do you feel rested in the morning? YES NO

CERTIFICATE OF AUTHENTICITY

I hereby certify that the above information is true and correct within the best of my knowledge.

Signature of Patient: _____ Date: _____

Parent or Guardian: _____ Date: _____
 (If patient is under 18)

REVIEW OF SYSTEMS

- 1. CONSTITUTIONAL** Please rate your overall level of health (compared to others in your age group)
- | | | |
|--------------|---------|-----------------|
| 1. Excellent | 3. Good | 5. Poor |
| 2. Very Good | 4. Fair | 6. other: _____ |

Please **circle YES or NO** to the following system review. If **YES please continue and circle the symptom** you are experiencing or have experienced in the PAST 6 MONTHS

- 2. GENERAL PROBLEMS?** YES NO
- | | | |
|-------------------------|------------------------|-----------------|
| 1. Fever/sweats | 5. Multiple joint pain | 9. Weight loss |
| 2. Chills | 6. Swollen joints | 10. other _____ |
| 3. Recent infections | 7. <i>Fatigue*</i> | |
| 4. Recurrent infections | 8. Fainting | |

- 3. SKIN PROBLEMS?** YES NO
- | | | |
|------------------------|---------------|----------------|
| 1. Dry skin | 4. Warts | 7. Psoriasis |
| 2. Skin lesions / Rash | 5. Dermatitis | 8. Skin Cancer |
| 3. Pimples | 6. Infections | 9. other _____ |

- 4. HEAD / JAW PROBLEMS?** YES NO
- | | | |
|--------------|--------------------------|-------------------------|
| 1. Headaches | 3. Unexplained hair loss | 5. Grind teeth at night |
| 2. Migraines | 4. Jaw pain | 6. other _____ |

- 5. NEUROLOGICAL PROBLEMS?** YES NO
- | | | |
|---------------------------------|---------------------------|--------------------------------|
| 1. Nausea / vomiting | 6. <i>Memory*</i> changes | 11. Seizures |
| 2. <i>Dizziness*</i> | 7. Sleep changes | 12. Stroke |
| 3. <i>Concentration*</i> change | 8. Numbness/tingling | 13. ADD / ADHD / Impulsiveness |
| 4. Personality changes | 9. Weakness | 14. Learning difficulties |
| 5. <i>Mood*</i> changes | 10. Bowel/bladder changes | 15. other _____ |

- 6. EYE PROBLEMS?** YES NO
- | | | |
|-------------------------------|---------------------|--------------------------|
| 1. Loss/change in vision* | 5. Glasses/contacts | 9. Flashing lights/halos |
| 2. Pain/sensitivity to light* | 6. Cataracts | 10. other _____ |
| 3. Excessive watering | 7. Glaucoma | |
| 4. Double vision | 8. Floaters | |

- 7. EAR – HEARING PROBLEMS?** YES NO
- | | | |
|------------------------------------|-------------------|-----------------------------|
| 1. Loss/change in hearing | 4. Ear infections | 7. <i>Balance problems*</i> |
| 2. Ear pain | 5. Tubes | 8. other _____ |
| 3. <i>Ringing/buzzing*</i> in ears | 6. Ear discharge | |

- 8. NOSE-THROAT PROBLEMS?** YES NO
- | | | |
|---------------------|-------------------------------|---------------------------|
| 1. Changes in smell | 5. Colds | 9. Voice changes |
| 2. Nose pain | 6. Post nasal drip | 10. Sore throat/infection |
| 3. Nose bleeds | 7. <i>Trouble swallowing*</i> | 11. other _____ |
| 4. Sinus infection | 8. Changes in taste | |

- 9. CARDIOVASCULAR PROBLEMS?** YES NO
- | | | |
|-------------------------|--------------------------|------------------------------|
| 1. Chest pain / angina | 5. Heart disease | 9. Rheumatic fever |
| 2. Irregular heart beat | 6. Cold fingers / toes | 10. Leg cramps at night |
| 3. Fast heart rate | 7. Leg or ankle swelling | 11. Leg cramps while walking |
| 4. Low blood pressure | 8. Heart murmur | 12. other _____ |

- 10. RESPIRATORY PROBLEMS?** YES NO
- | | | |
|------------------------|--------------------------------|----------------|
| 1. Shortness of breath | 4. Allergies / Asthma /Anxiety | 7. Bronchitis |
| 2. Pain with breathing | 5. Wheezing | 8. TB |
| 3. Cough / sputum | 6. Emphysema | 9. other _____ |

11.	GASTROINTESTINAL PROBLEMS?	YES	NO
1.	Constipation	7.	Appetite / diet changes
2.	Diarrhea	8.	Nausea / vomiting
3.	Burping or gas	9.	Bowel habit changes
4.	Rectal bleeding	10.	Hemorrhoids
5.	Stomach/abdominal pain	11.	Gall bladder trouble
6.	Heart burn / reflux	12.	Pancreatitis
		13.	Colitis
		14.	Hepatitis
		15.	Jaundice (yellowing)
		16.	Liver disease / Cirrhosis
		17.	Ulcers
		18.	other _____
12.	URINARY PROBLEMS?	YES	NO
1.	Pain with urination	6.	Night time urination
2.	Blood in urine	7.	Trouble starting/stopping
3.	Pus in urine	8.	Leakage
4.	Smelly urine	9.	Sores on genitals
5.	Frequent urination	10.	Infections
		11.	Urinary discharge
		12.	Herpes
		13.	HIV / AIDS
		14.	Venereal disease (VD)
		15.	other _____
13.	EMOTIONAL PROBLEMS?	YES	NO
1.	Nervous breakdown	7.	Abusive
2.	Feel blue	8.	Short attention span
3.	Frequent crying	9.	Scattered thoughts
4.	<i>Anxious*</i>	10.	Short tempered
5.	Irritable / impatient	11.	Prone to stress
6.	Impulsive	12.	Exhausted
		13.	Prone to depression
		14.	<i>Difficulty sleeping*</i>
		15.	Poor dream recall
		16.	Abuse drugs
		17.	Abuse alcohol
		18.	other _____
14.	ENDOCRINE PROBLEMS?	YES	NO
1.	Heat / cold intolerance	5.	Headaches
2.	Weight gain / loss	6.	Fatigue
3.	Difficulty losing weight	7.	Menstrual problem
4.	Dry skin, hair, nails	8.	Diabetes
		9.	High / low blood sugar
		10.	Thyroid problems
		11.	Growth disorders
		12.	other _____
15.	BLEEDING DISORDER / PROBLEMS?	YES	NO
1.	Anemia	3.	Blood transfusion
2.	Bleeding problem	4.	Leukemia
		5.	Bruise easy
		6.	other _____
18.	ORTHOPEDIC PROBLEMS?	YES	NO
1.	Arthritis	9.	Soft bones
2.	Bursitis	10.	Rheumatic arthritis
3.	Gout	11.	Rheumatic fever
4.	Bone cyst / tumor	12.	Recurrent sprains
5.	Bone / joint infection	13.	Tendonitis
6.	Inherited bone disorder	14.	Torn Cartilage
7.	Lymes disease	15.	Torn Ligaments
8.	Osteoporosis	16.	Torn muscle
		17.	Torn tendon
		18.	Popping / locking of joints
		19.	Giving way of joints
		20.	Joint swelling
		21.	Injured / Pinch nerve
		22.	other _____

WOMEN ONLY

16.	Do you <u>have now or have had</u> any of these symptoms in the last 3 months?	YES	NO
1.	Menstrual cramps	4.	Irregular flow
2.	Sore breasts	5.	Discharge / odor
3.	Irregular cycle	6.	Yeast infections / itchiness
		7.	Pain with intercourse
		8.	Abdominal / pelvic pain
		9.	other _____

MEN ONLY

17.	Do you <u>have now or have had</u> any of these symptoms in the last 3 months?	YES	NO
1.	Errection difficulties	3.	Penis discharge
2.	Lumps in testicles	4.	Sores on penis
		5.	Breast lumps
		6.	other _____

CERTIFICATE OF AUTHENTICITY

I hereby certify that the above information is true and correct within the best of my ability.

Signature of Patient: _____ Date: _____

Parent or Guardian: _____ Date: _____

(If patient is under 18)

CONSENT OF DISCLOSURE

PLEASE REVIEW THE FOLLOWING CAREFULLY AS IT PERTAINS TO THE USAGE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

I hereby give consent to Falling Waters Natural Health and Fitness, LLC, and all health care providers furnishing care within Falling Waters Natural Health and Fitness, LLC, to use and disclose my protected health information for the purposes of treatment, payment, and health care operations.

You may cancel this consent at any time; your cancellation must be in writing, signed by you or on your behalf, and delivered to the address at the bottom of this form. This may be delivered in person or by mail, but it will only be effective when we actually receive it. Your cancellation will not be effective to the extent that we or others have acted in reliance upon this consent.

You have the right to request restriction on the usage and disclosure of your protected health information for the purposes of treatment, payment, or health care operations. We are not required to grant your request, however, if we do, the restriction will be obligatory to us.

Our Posted Privacy Health Information provides more detailed information about the usage and disclosure of your (PHI). You have the right to review and/or request a copy of this Policy before you sign this consent.

We reserve the right to amend the terms of our Posted Privacy Policy.

Signature of Patient: _____ Date: _____

Parent or Guardian: _____ Date: _____

(If patient is under 18)

FAR-INFRARED SAUNA

Liability Waiver/Informed Consent

As with all professional equipment, you may put yourself at risk if you do not fully understand how to use the sauna. Far infrared saunas do not cure or treat any disease.

DO NOT attempt to self treat any disease with a far infrared sauna without direct supervision of a certified physician. If any of the items listed below apply to you, be certain to consult with your physician before using a far infrared sauna.

In all situations, hydration is a requirement for sauna use. Drinking advanced electrolyte replacement water is also recommended before and after sauna use.

Medications: Individuals who are using prescription drugs should seek the advice of their personal physician or a pharmacist for possible changes in the drugs effect when the body is exposed to Far infrared waves or elevated body temperature. Diuretics, barbiturates and beta-blockers may impair the body's natural heat loss mechanisms. Some over the counter drugs such as antihistamines may also cause the body to be more prone to heat stroke.

Children: The core body temperature of children rises much faster than adults. This occurs due to a higher metabolic rate per body mass, limited circulatory adaptation to increased cardiac demands and the inability to regulate body temperature by sweating. Consult with the child's Pediatrician before using the sauna.

The Elderly: The ability to maintain core body temperature decreases with age. This is primarily due to circulatory conditions and decreased sweat gland function. The body must be able to activate its natural cooling processes in order to maintain core body temperature.

Cardiovascular Conditions: Individuals with cardiovascular conditions or problems (hypertension / hypo tension), congestive heart failure, impaired coronary circulation or those who are taking medications, which might affect blood pressure, should exercise extreme caution when exposed to prolonged heat. Heat stress increases cardiac output, blood flow, in an effort to transfer internal body heat to the outside environment via the skin (perspiration) and respiratory system. This takes place primarily due to major changes in the heart rate, which has the potential to increase by thirty (30) beats per minute for each degree increase in core body temperature.

Alcohol / Alcohol Abuse: Contrary to popular belief, it is not advisable to attempt to "Sweat Out" a hangover. Alcohol intoxication decreases a person's judgment; therefore they may not realize it when the body has a negative reaction to high heat. Alcohol also increases the heart rate, which may be further increased by heat stress.

Chronic Conditions / Diseases Associated With A Reduced Ability To Sweat Or Perspire: Parkinson's, Multiple Sclerosis, Central Nervous System Tumors and Diabetes with Neuropathy are conditions that are associated with impaired sweating.

Hemophiliacs / Individuals Prone to Bleeding: The use of Infrared should be avoided by anyone who is predisposed to bleeding.

Fever: An individual that has a fever should not use the Solo® or any other type of sauna.

Insensitivity to Heat: An individual that has insensitivity to heat should not use the Solo® or any other type of sauna.

Pregnancy: Pregnant women should consult a physician before using the Solo® or any other type of sauna because fetal damage can occur with a certain elevated body temperature.

Menstruation: Heating of the low back area of women during the menstrual period may temporarily increase their menstrual flow. Some women endure this process to gain the pain relief commonly associated with their cycle whereas others simply choose to avoid sauna use during that time of the month.

Joint Injury: If you have a recent (acute) joint injury, it should not be heated for the first 48 hours after an injury or until the hot and swollen symptoms subside. If you have a joint or joints that are chronically hot and swollen, these joints may respond poorly to vigorous heating of any kind. Vigorous heating is strictly contraindicated in cases of enclosed infections be they dental, in joints or in any other tissues.

Implants: Metal pins, rods, artificial joints or any other surgical implants generally reflect Far infrared waves and thus are not heated by this system, nevertheless you should consult your surgeon prior to using an Infrared Sauna. Certainly, the usage of an Infrared Sauna must be discontinued if you experience pain near any such implants. Silicone does absorb Far infrared energy. Implanted silicone or silicone prostheses for nose or ear replacement may be warmed by the Far infrared waves. Since silicone melts at over 200°C (392°F), it should not be adversely affected by the usage of an Infrared Sauna. It is still advised that you check with your surgeon and possibly a representative from the implant manufacturer to be certain.

Pacemaker / Defibrillator: The magnets used to assemble our units can interrupt the pacing and inhibit the output of pacemakers. Please discuss with your doctor the possible risks this may cause.

In the rare event, you experience pain and/or discomfort, immediately discontinue sauna use.

I hereby affix my signature to this paper to attest that I have read and understand the information on this page about far-infrared sauna therapy and will not hold Falling Waters Natural Health & Fitness, LLC or any of its physicians or affiliates liable for any ill effects, injury, or death that may be related, in any way, to the use of their far-infrared sauna.

PRINTED NAME

SIGNATURE

DATE

MUTUAL UNDERSTANDING & CONSENT TO TREATMENT

Name: _____

Date: _____

The following information is provided to enable our sharing of common understanding of our rights and roles in this professional therapeutic relationship. Please read this agreement and sign at the end indicating that you have understood and agree to the following. Please ask any questions if you would like clarification or additional information.

- Information revealed during counseling and discussion sessions is confidential. Exceptions to this confidentiality include disclosure by you regarding intention to harm yourself or others. Your record and the information contained within it will not be disclosed to others unless you direct us to do so or unless the law authorizes or compels us to do so.
- All procedures and/or treatment carries with it both risk and benefits, risks including but not limited to injury, fracture, burns, worsening of condition, and stroke. Not receiving or accepting treatment recommendations, medication, surgery all carry inherent risks and possible worsening of condition. There may be additional or alternative treatments available. You are encouraged to ask questions if you would like additional information. Although your plan will be thoroughly researched and will be customized to your unique health status and your personal goals no guarantees can be assured regarding the outcomes of treatment(s) or procedure(s).
- **Fees are charged for professional services, and full payment with cash, check, or credit card is due at the time these services are rendered.** Treatments, consultations (whether by phone, e-mail, or in the office), detailed correspondence on your behalf are examples of professional services.
- **You are responsible for payment for office fees, treatments, and lab tests regardless of insurance coverage.** As a courtesy, we provide insurance billing service; however, each insurance plan offers different levels of reimbursement and/or coverage for services. Many “preventative approaches” to healthcare are not covered by insurance plans. **Any expense not covered by your insurance plan is your responsibility to pay in full.** At your request, you will receive a detailed receipt to request reimbursement from your insurance carrier. Our office does not bill or affiliate with Medicare/Medicaid, and Medicare/Medicaid does not reimburse for lab tests, nutritional consultation, prevention medicine regardless of your need for these services.
- If you have a serious health problem that requires immediate attention, you should call 911, or have someone take you to the nearest hospital emergency room. If you notice an adverse effect from one of the components of your health plan, you should discontinue it then call our office and inform the Dr. of your concerns.
- Treatments with other physicians or healthcare providers are not necessarily to be discontinued. Please let the Dr. know if you are being treated by other healthcare providers (physicians, counselors, therapists, etc.). Consult your prescribing doctor before discontinuing medications. It is your responsibility to disclose changes in your condition, symptoms, contact information, or treatments by other providers between visits.
- You are welcome to bring a friend or relative to your visits if such companionship is comfortable to you.
- You are encouraged to ask questions on any health-related topic and to take an active role in your health care. Ours is a team approach, and natural treatments may involve encouraging you to make changes in your diet and lifestyle that can help you attain your highest level of health.

My signature below assures that the contact information, health history, and other information that I provide on my intake forms are complete and accurate. I understand and agree to the information on this page. My questions, if any, were answered to my satisfaction.

Signature of Patient: _____ Date: _____

Parent or Guardian: _____ Date: _____

(If patient is under 18)

PERSONAL INJURY PAYMENT INFORMATION

Name: _____

Date of Accident or Injury: _____
mm / dd / yyyy

Do <u>you</u> or <u>someone else</u> have insurance coverage for the vehicle you were in?	<input type="checkbox"/> I have, <input type="checkbox"/> Someone else has coverage. ~ Indicate name of person policy is under:
How is this person related to you	<input type="checkbox"/> Self, <input type="checkbox"/> Parent, <input type="checkbox"/> Friend, <input type="checkbox"/> Other
Name of your Automobile Insurance Carrier :	
Address of your Automobile Insurance Carrier:	
Claim Adjusters Name :	
Claim Adjuster's Telephone Number :	
Claim Number :	
Do you have an Insurance Deductible ?	<input type="checkbox"/> Yes, <input type="checkbox"/> No Deductible is: \$
Do you know your Policy Limits for medical bills?	<input type="checkbox"/> Yes, <input type="checkbox"/> No Limit is: \$
Have you reported this injury to your insurance carrier?	<input type="checkbox"/> Yes, <input type="checkbox"/> No

Do you have an attorney representing you? <input type="checkbox"/> Yes, <input type="checkbox"/> No If <u>yes</u> , indicate name and address:	Attorney Name: _____ Address: _____ Telephone: _____
-------------------------------------------------------------------------------------------------------------------------------------------------------------	------------------------------------------------------------

Our office will provide insurance billing services for you if you so desire as a courtesy. Remember that **you are ultimately responsible for any charges incurred in this office**. It is your responsibility to pay any deductible amount, co-insurance, and or any other balances not paid by your insurance carrier.

In the event that payment is not made when due and the bill is turned over to a collection agency, You will be responsible to pay the fee charged by the collection agency, as well as any cost/fees assessed should it become necessary to take legal action to collect overdue payment.

IMPORTANT: if your insurance carrier sends you forms that need to be signed for authorization for records, you need to sign these documents and send the completed forms back to the carrier as soon as possible.

Please read the following and sign below:

- I am a responsible party and agree to pay to Mark Davies, D.C. for any outstanding bills incurred in this office. It is my responsibility to pay any deductible, co-insurance, and/or any other balances not paid by your health insurance carrier. Minors must have parent's signature.
- I authorize the release of any medical or other information necessary to process this claim. I authorize the doctor and/or his/her staff to contact my insurance carrier to verify benefits and obtain the necessary information to process all billing. I also request payment of government benefits either to myself or to the party who accepts assignment below.
- I authorize payment of medical benefits to Mark Davies, D.C. or supplier for services described. I authorize the doctor to use "Signature on File" for all future billings and release of medical information to the insurance carrier necessary to process claim.

I hereby affix my signature below to signify I have read or have had read to me the above information in its entirety and fully understand and agree all of the above.

Signature

_____ / _____ / _____
Month Day Year

ACCIDENT INFORMATION

GENERAL INFORMATION

Patient Name _____ Today's date _____

Date of Accident _____ Time of Accident _____ a.m. p.m.

Please describe the accident in your own words _____

Were you the: Driver Front passenger Rear passenger Other _____

How many people were in your vehicle? _____ How many cars were involved in the accident? _____

ACCIDENT SITE

City _____

Road/street name _____

Road conditions Dry Wet
 Icy Other _____

Visibility Good Poor _____

YOUR VEHICLE

Make _____ Model _____ Year _____

Estimated cost of **damage** to your car? \$ _____

Who gave estimate of damage? _____

What **direction** were you headed? _____

Estimated **speed** you were traveling _____ mph

Were you wearing a **seatbelt**? Yes No
If Yes, what type? Lap Shoulder

Did your seat have a **headrest**? Yes No
If Yes, what was the position of the headrest?
 Low Mid-position High

OTHER VEHICLE (if applicable)

Make _____ Model _____ Year _____

Estimated cost of **damage** to their car? \$ _____

Who gave estimate of damage? _____

Direction they were headed? _____

Estimated **speed** they were traveling _____ mph

IMPACT

Was **your car**: Stopped Rolling
 Speeding up Slowing down

Other car was: Stopped Rolling
 Speeding up Slowing down

Was your foot on the **brake**? Yes No

At the time of impact which way were you **looking**?

Straight ahead Behind you
 To the left To the right
 Up Down

Was your body back **against the seat**? Yes No
If No, why not? _____

Direction of impact?
 Front Rear Right Left

Did any part of your **body strike**
anything **inside** the vehicle? Yes No
If Yes, explain _____

Were both hands on the steering wheel Yes No
If No, which was on the steering wheel L R

Did your car have **airbags**? Yes No
If yes, did they inflate? Yes No

Were you: Surprised by impact Braced for impact

During/after the initial crash did you car:

Hit another car / object
 Roll over
 other _____

AFTER THE ACCIDENT

Were you **knocked unconscious** by the accident? Yes No if yes, for how long? _____

Please describe how you felt after the accident

- Immediately after _____
- 3 hours after _____
- later in the day/ night _____

Was a **police report** filed? Yes No if no, why not? _____

Was your **car towed** from the scene? Yes No

PRIOR INJURIES / TRAUMA

Have you been **involved** (driver or passenger) in a **motor vehicle accident** before? Yes No
if yes, please fill out below.

Year: _____	injuries: _____	Treatment: _____
Year: _____	injuries: _____	Treatment: _____
Year: _____	injuries: _____	Treatment: _____
Year: _____	injuries: _____	Treatment: _____

Have you ever had **injuries** or **symptoms** to the **same areas** prior to the accident? Yes No
if yes, please fill out below.

Year: _____	injuries: _____	Treatment: _____
Year: _____	injuries: _____	Treatment: _____
Year: _____	injuries: _____	Treatment: _____
Year: _____	injuries: _____	Treatment: _____

Have you had to **miss any days from work** because of your injuries? Yes No
If yes, how many days have you missed? _____

Have you ever suffered a **work** or **industrial injury**? Yes No

Year: _____	injuries: _____	Treatment: _____
Year: _____	injuries: _____	Treatment: _____
Year: _____	injuries: _____	Treatment: _____
Year: _____	injuries: _____	Treatment: _____

POST-TRAUMATIC SYMPTOM QUESTIONNAIRE

PATIENT INSTRUCTIONS: It is important for this section to be filled out in detail. Look at each symptom listed in the left column and make a single check mark or several check marks in the appropriate columns for the specific symptom which applies to you. Be certain to indicate when you had the beginning of any of the following symptoms. Leave the row blank if the symptom listed below does not apply to you.

SYMPTOM LIST <i>(Check all that apply to you)</i>	FELT RIGHT AFTER INJURY	BEGAN 1 - 14 DAYS AFTER INJURY	YOU HAVE SYMPTOMS NOW	HAD SIMILAR SYMPTOMS 1-3 MONTHS BEFORE THIS INJURY	*** DOCTOR USE ONLY ***
PAIN / STIFFNESS:					
<input type="checkbox"/> Head					
<input type="checkbox"/> Jaw					
<input type="checkbox"/> Neck					
<input type="checkbox"/> Shoulder					
<input type="checkbox"/> Arm					
<input type="checkbox"/> Wrist / hand / fingers					
<input type="checkbox"/> Upper / middle back					
<input type="checkbox"/> Chest / Breast					
<input type="checkbox"/> Rib cage					
<input type="checkbox"/> Low back					
<input type="checkbox"/> Hip					
<input type="checkbox"/> Leg / thigh					
<input type="checkbox"/> Knee					
<input type="checkbox"/> Ankle / foot					
<input type="checkbox"/> Other _____					
NUMBNESS / TINGLING:					
<input type="checkbox"/> Arms					
<input type="checkbox"/> Wrist / hand / fingers					
<input type="checkbox"/> Leg / thigh					
<input type="checkbox"/> Foot / toes					
OTHER:					
<input type="checkbox"/> Weakness in arms / legs					
<input type="checkbox"/> Fatigue					
<input type="checkbox"/> Anxiety					
<input type="checkbox"/> Sleep Disturbance					
<input type="checkbox"/> Sensitivity to noise					
<input type="checkbox"/> Impaired concentration					
<input type="checkbox"/> Blurred vision					
<input type="checkbox"/> Irritability					
<input type="checkbox"/> Difficulty swallowing					
<input type="checkbox"/> Dizziness					
<input type="checkbox"/> Forgetfulness					
<input type="checkbox"/> Tinnitus (ringing in ears)					
<input type="checkbox"/> Loss of coordination					
<input type="checkbox"/> Sensitivity to light					
<input type="checkbox"/> Other: _____					