



# FALLING WATERS

INJURY & HEALTH MANAGEMENT CENTER

## APPOINTMENT CHECKLIST

**ARRIVAL TIME:**

Please ensure that you come to your appointment at your scheduled arrival time. If needing to reschedule, please contact the office no less than 24 hours prior to your scheduled appointment.

**PAPERWORK:**

Please have this packet completed prior to arriving for your appointment. If unable to do so, our front desk staff will instruct you on an earlier arrival to ensure this can be done in the office.

**UNDER 18 YEARS OF AGE:**

If patient is under 18 years old, parental signatures are required on all paperwork.

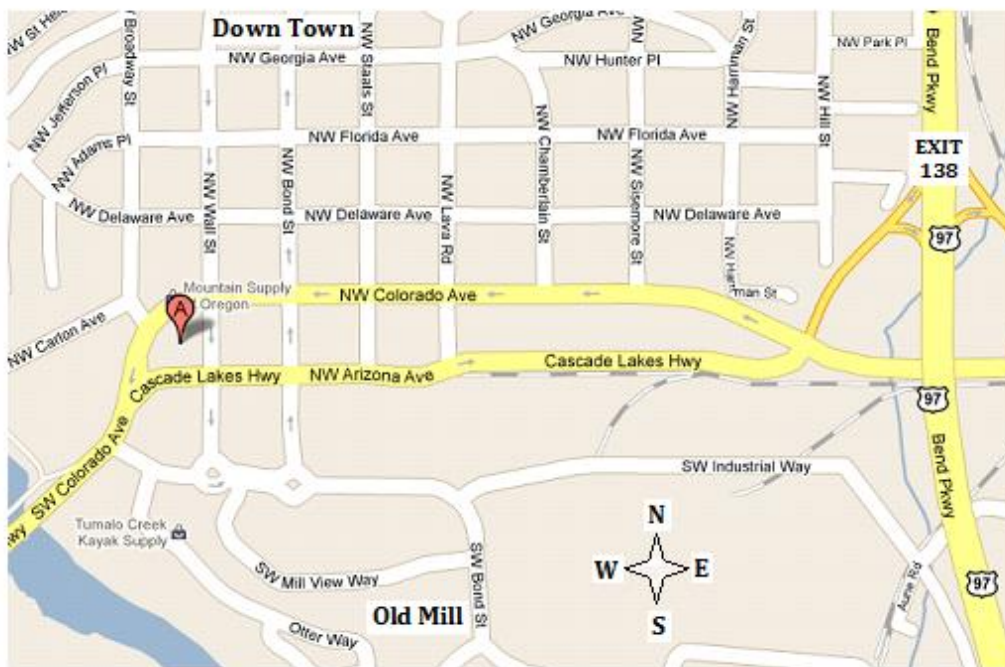
**REFERRAL / PRESCRIPTION:**

If you are being referred to our office by another doctor or practitioner, please bring the referral or prescription with you to your appointment.

**INSURANCE CARD AND DRIVER'S LICENSE:**

Please ensure you bring these cards with you to your appointment as we will need copies for our records.

## AREA MAP



Please print the “**DIRECTIONS TO FALLING WATERS**” page from our website for more specific directions on how to locate our clinic, or if using a GPS, enter the address below.



**GENERAL INTAKE**

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_ SS#: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Email: \_\_\_\_\_

Current Gender Identity:  M  F  Other: \_\_\_\_\_ Sex Assigned at Birth:  M  F DOB: \_\_/\_\_/\_\_\_\_

Age: \_\_\_\_\_ Marital Status:  Single  Married/Partnered  Divorced  Widowed  Other: \_\_\_\_\_

Children:  No  Yes  Decline to answer, if yes, how many children: \_\_\_\_\_ What are their ages: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Do you give permission for our office 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? \_\_\_\_\_

*In compliance with the governmental EHR incentive program and CMS requirements, we ask the following:*

Race (select one):  American Indian or Alaska Native  Asian  Black or African American  
 Native Hawaiian or Pacific Islander  White (Caucasian)  Other  I Decline to Answer

Ethnicity (select one):  Hispanic or Latino  Not Hispanic or Latino  I Decline to Answer

Preferred Language: \_\_\_\_\_

**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  Time of Service (Cash)

This injury is related to a Work Injury  This injury is related to an auto accident Date of Injury/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 Falling Waters, LLC and/or provider to bill my insurance company as a courtesy and permit the release of medical records necessary to process my claims. I authorize Falling Waters, LLC to initiate a complaint to the Insurance Commissioner for any reason on my behalf. I authorize payments to be made directly to Falling Waters, LLC and/or provider for treatment rendered. I understand that co-payments and time of service fees are due at the time of service, I may receive an additional bill for services not covered by my insurance and any fees incurred by sending to collections will be added.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

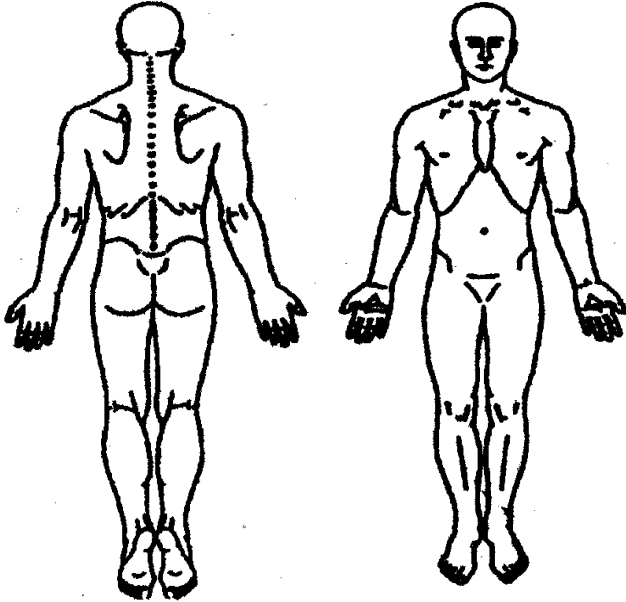
*Parent or guardian signature needed if patient under 18*

*mm / dd / yyyy*

# CHIEF COMPLAINT FORM

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Please list, describe, and indicate on the body diagram below, the primary reason(s) for your visit, in order of severity.



**#1 Problem:** \_\_\_\_\_

When did it start? \_\_\_\_\_

Was there any trauma involved?  YES  NO

If yes, describe: \_\_\_\_\_

Are your symptoms:

Constant  Frequent  Intermittent  Occasional

Would you describe it as (check all that apply):

Deep  Dull  Achy  Sharp  Shooting  Burning

Stiff  Tight  Throbbing  Numb  Tingly  Weak

Other: \_\_\_\_\_

How severe is it from 0 (*none*) to 10 (*worst imaginable*)? \_\_\_\_\_

What makes it worse? \_\_\_\_\_ Better? \_\_\_\_\_

Please list any other symptoms you feel are related to this complaint: \_\_\_\_\_

Have you had any previous evaluation or treatment for this?  YES  NO (if yes, please complete the following table)

Date	Provider	Diagnostic Tests	Diagnoses/Findings	Treatment	Outcome

**#2 Problem:** \_\_\_\_\_

When did it start? \_\_\_\_\_ Was there any trauma involved?  YES  NO

If yes, describe: \_\_\_\_\_

Are your symptoms:  Constant  Frequent  Intermittent  Occasional

Would you describe it as (check all that apply):  Deep  Dull  Achy  Sharp  Shooting  Burning  Stiff

Tight  Throbbing  Numb  Tingly  Weak  Other: \_\_\_\_\_

How severe is it from 0 (*none*) to 10 (*worst imaginable*)? \_\_\_\_\_

What makes it worse? \_\_\_\_\_ Better? \_\_\_\_\_

Please list any other symptoms you feel are related to this complaint: \_\_\_\_\_

Have you had any previous evaluation or treatment for this?  YES  NO (if yes, please complete the following table)

Date	Provider	Diagnostic Tests	Diagnoses/Findings	Treatment	Outcome

**What are your Goals for care?** (check all that apply)

- |   |                                       |  |  |
|---|---------------------------------------|--|--|
| <input type="checkbox"/> ↑ Strength / Endurance | <input type="checkbox"/> ↑ Energy     | <input type="checkbox"/> Injury Rehab: _____             | <input type="checkbox"/> Reduce medication use |
| <input type="checkbox"/> ↑ Flexibility          | <input type="checkbox"/> ↑ Balance    | <input type="checkbox"/> Sport Specific: _____           | <input type="checkbox"/> Other: _____          |
| <input type="checkbox"/> ↓ Pain                 | <input type="checkbox"/> Feel Better  | <input type="checkbox"/> ↓ Weight: _____ lbs             | _____  |
| <input type="checkbox"/> ↓ Stress               | <input type="checkbox"/> Sleep Better | <input type="checkbox"/> Achieve ideal weight: _____ lbs | _____  |

# REVIEW OF SYSTEMS

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Today's Date: \_\_\_\_\_

**CONSTITUTIONAL** Rate your overall health (compared to others in your age group)

- |              |         |                |
|--------------|---------|----------------|
| 1. Excellent | 3. Good | 5. Poor        |
| 2. Very Good | 4. Fair | 6. Other _____ |

**HEIGHT & WEIGHT** If known, what is your:

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Please indicate any **current** or **past** symptoms of concern. Check all that apply, and **leave blank if not applicable**.

	Current	Past		Current	Past		Current	Past
<b>1. GENERAL</b>			<b>6. GASTROINTESTINAL</b>			<b>10. URINARY</b>		
Fever/sweats			Appetite/diet change			Pain with urination		
Fatigue			Constipation			Urinary urgency		
Fainting/dizziness			Diarrhea			Incontinence		
Chills			Heartburn/reflux			Nighttime urination		
Recent/recurrent infections			Stomach pain/bloating			Urinary tract infections		
Unexplained weight loss/gain			Nausea/vomiting			Blood in urine		
Difficulty losing/gaining weight			Belching or gas			Other:		
Other:			Bowel changes					
			Hemorrhoids					
<b>2. EYES / EARS / NOSE / THROAT</b>			Rectal bleeding			<b>IF APPLICABLE</b>		
Loss or change in vision			Jaundice (yellowing)			<b>11. Do you currently, or have you in the last 3 months experienced:</b>		
Hearing loss or change			Ulcers			Menstrual cramps		
ringing/buzzing in ears			Other:			Irregular cycle		
Changes in smell						Breast soreness		
Sinus problems			<b>7. MUSCULOSKELETAL</b>			Pain with intercourse		
Changes in taste			Multiple joint pain			Hot flashes		
Voice changes/loss			Joint swelling			Genital discharge		
Trouble swallowing			Limited mobility			Breast lumps/discharge		
Other:			Reduced muscle mass			Low libido		
			Muscle weakness			Other:		
<b>3. SKIN</b>			Muscle spasm			Are you currently pregnant? Y N		
Dry skin			Other:			If yes, what is your due date? _____		
Skin rash/lesions						Total number of pregnancies: _____		
Change in nails/hair			<b>8. PSYCHOLOGICAL</b>			Total number of births: _____		
Other:			Personality changes			Have you reached Menopause? Y N		
			Mood swings					
<b>4. CARDIOVASCULAR</b>			Poor concentration			<b>IF APPLICABLE</b>		
Chest pain			Poor memory			<b>12. Do you currently, or have you in the last 3 months experienced:</b>		
Irregular heartbeat			Prone to stress			Erectile difficulties		
Cold fingers/toes			Prone to depression			Enlarged prostate		
Leg or ankle swelling			Anxiety			Genital sores/lesions		
Leg cramps			Anger/short temper			Penile discharge		
Hot/cold intolerance			Drug/alcohol abuse			Low libido		
Other:			Disordered eating			Other:		
			Other:					
<b>5. RESPIRATORY</b>			<b>9. NEUROLOGICAL</b>			<b>OTHER CONCERNS NOT SPECIFIED?</b>		
Difficulty breathing			Numbness/tingling			_____		
Chronic cough			Poor coordination			_____		
Chest congestion			Balance problems					
Sleep apnea			Muscle atrophy					
Allergies			Changes in speech					
Asthma/wheezing			Other:					
Other:								

### 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 signature needed if patient under 18

mm / dd / yyyy

# HISTORY

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Today's Date: \_\_\_\_\_

## HEALTH HISTORY

Do **you** currently, or have you ever suffered from any of the following? (if yes please circle)

Anemia	Colitis	Herpes	Liver disease/Cirrhosis	YES	NO
Aneurysm	Depression	High blood pressure	Lyme's disease		
Arthritis	Diabetes	Low blood pressure	Osteoporosis		
Asthma	Emphysema	High cholesterol	Pneumonia		
Bleeding disorder	Gallbladder disorder	HIV/AIDS	Pancreatitis		
Bronchitis	Gout	Injured/pinched nerve	Recurrent sprains		
Bursitis	Heart disease/attack	Irritable bowel disease	Rheumatoid arthritis		
Cancer	Hepatitis	Kidney stones/problems	Seizure disorder		
					Other: _____

### SURGICAL HISTORY / HOSPITALIZATIONS None

Year	Reason	Procedure(s)

### MEDICATIONS / SUPPLEMENTS None

Med/Supp	Dosage	Reason

### TRAUMATIC INJURY / ACCIDENTS None

Year	Trauma	Treatment

### ALLERGIES None

Allergy	Allergic Response

### SPECIAL TESTING (X-ray, CT, MRI, etc.) None

Year	Test/Area	Results

Do you have a **PRIMARY CARE PROVIDER**? YES NO

If yes, who? \_\_\_\_\_

When was your **LAST PHYSICAL**? Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Note any concerns, if applicable:

## FAMILY HISTORY

Has **anyone** in your **immediate family** suffered from any of the following? (if yes, please circle)

Aneurysm	Colon cancer	Gout	Irritable bowel disease	YES	NO
Arthritis	Depression	Heart disease/attack	Kidney stones/problems		
Bleeding disorder	Diabetes	High/low blood pressure	Osteoporosis		
Cancer	Gallbladder disorder	High cholesterol	Seizure disorder		
					Other: _____

## PERSONAL HISTORY

Do your **DAILY ACTIVITIES** consist of any of the following?

- |   |   |
|---|---|
| <input type="checkbox"/> Prolonged Sitting  | <input type="checkbox"/> Prolonged Postures |
| <input type="checkbox"/> Prolonged Standing | <input type="checkbox"/> Awkward Positions  |
| <input type="checkbox"/> Light Labor        | <input type="checkbox"/> Repetitive Motions |
| <input type="checkbox"/> Heavy Labor        | <input type="checkbox"/> Mental Stress      |

Do you **EXERCISE** outside of your typical **YES NO** daily activities?

What type? \_\_\_\_\_  
 How many days per week? 1 2 3 4 5 6 7  
 How many minutes per session? 15-30 30-60 60-90 90+  
 What is the intensity level? Low Moderate High

Do you feel you **SLEEP WELL** at night? YES NO

Do you have trouble falling asleep?    
 Does pain impair your sleep?    
 If so, how many interruptions per night? \_\_\_\_ Time lost: \_\_\_\_  
 Do you feel rested in the morning?

Please note the following **HABITS**

	None	Light	Moderate	Heavy
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"/>
Recreational Drugs	<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"/>

**SMOKING STATUS:**  Never Smoked  Former Smoker  Occasionally  Smoke Daily If smoking, start date: \_\_\_\_/\_\_\_\_/\_\_\_\_

### 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 signature needed if patient under 18 mm / dd / yyyy

# PROTECTED HEALTH INFORMATION DISCLOSURE

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Today's Date: \_\_\_\_\_

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

- My health information may be created or received by Falling Waters, LLC and may be in the form of written or electronic records, or spoken words. My health record may include information of my health history, health status, test results, diagnoses, treatments, procedures, prescriptions and similar types of health-related information.
- We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, office staff, personnel or anyone who is involved in taking care of you and your health.
- I understand that I have the right to receive and review a written description of how Falling Waters, LLC will handle my health information. This written description is known as a Notice of Privacy Practices and describes the uses and disclosures of health information made and the information practices followed by employees, staff and other office personnel of Falling Waters, LLC and my rights regarding my health information.
- I understand the Notice of Privacy Practices may be revised periodically and my health information will not be disclosed unless I have given written consent. I understand a copy of the most recent version of Falling Waters, LLC's Notice of Privacy Practices will be posted in the reception area.

By signing this agreement I attest that I understand the information above. 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.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

### Special Permission Request:

I give my permission for Falling Waters, LLC to leave messages regarding appointments on my home/mobile telephone.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

I give my permission to have messages regarding treatment, billing and/or appointment status left with my spouse, partner, caregiver \_\_\_\_\_  
Name of spouse/partner/caregiver Date of birth Telephone #

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

This release will revoke by written permission only. I understand that I must send a written request to Falling Waters, LLC in order to revoke this release.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

# TREATMENT CONSENT, FINANCIAL POLICY & DISCLOSURE

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Please read this agreement and sign at the end indicating that you have understood and agree to the following. Please feel free to 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 treatment interventions (medications, nutraceuticals, therapies, spinal manipulation, injections, minor surgical procedures, etc.) carry with them both risks and benefits. Risks include, but are not limited to injury, fracture, burns, worsening of condition, adverse reactions, stroke and/or death. Not receiving or accepting treatment recommendations also carries inherent risks, including but not limited to possible worsening of condition or disease progression, which may result in reduced quality of life and/or premature death. If unsure regarding a recommended treatment or procedure, there may be additional or alternative treatments available. Therefore, you are encouraged to ask questions if you would like additional information. No guarantees can be assured regarding the outcomes of any treatment(s) or procedure(s) recommended or performed.
- **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, this is not a guarantee of payment and each insurance plan offers different levels of reimbursement and/or coverage for services. Many "preventive 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.
- 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 provider of your concerns.
- Treatments with other physicians or healthcare providers are not necessarily to be discontinued. Please let the doctor / provider 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 new injuries, symptoms, conditions, treatments, medications, supplements, surgeries or diagnostic procedures performed, as well as any changes in your symptoms, conditions, medications, supplements, 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. Only registered support animals are allowed to accompany you into the clinic.
- 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 treatment recommendations may involve encouraging you to make changes to your diet and lifestyle that can help you improve your level of health.
- Falling Waters, LLC is owned by Shawndi Stahl, PT, MPT, David McClintock, DC, and Amanda Guy whom have financial interest in its ancillary services. If you would prefer to have any ancillary services performed elsewhere we will assist you to make arrangements.

## CERTIFICATE OF CONSENT

My signature below signifies my consent to treatment and assures that the contact information, health history, and other information that I have provided on my intake forms is complete and accurate. I have read, understand and agree to the information in this packet and my questions, if any, were answered to my satisfaction.

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_  
*Parent or guardian signature needed if patient under 18* *mm / dd / yyyy*