

Today's Date _____

EMAIL _____

File No: _____

CONFIDENTIAL PATIENT INFORMATION FORM

The information on this form is for Point by Point Myotherapy use only. Information will not be released to any other source unless permitted by the patient/guardian or authorized signature who signs below. Any unauthorized use of this information will be subject to legal prosecution.

Last Name _____ First name _____ MI _____

Address _____ City _____ State _____ Zip _____

Phone _____ Date of Birth _____ Marital Status: S M W D #of Children: _____

Occupation _____ Employer _____ Work Phone # _____

Referred by: _____ Are you currently seeing a Chiropractor? Who? _____

What are you being seen for today? _____

PLEASE CIRCLE ANY OF THE FOLLOWING CONDITIONS YOU HAVE EXPERIENCED OR CURRENTLY HAVE: (Therapist may write additional comments in green ink to clarify responses)

- | | | | |
|--------------------------------------|--------------------------------|-----------------------------------|-----------------------|
| Headaches / Migraines | Heart / Coronary Disease | Asthma / Respiratory Disorder | Cancer: Type _____ |
| Whiplash / Neck Pain | High Blood Pressure | Allergies / Sinus | Pregnancy: Due: _____ |
| Mid / Low Back / Hip / Leg | Diabetes: DX _____ | Arthritis: Where _____ | Epilepsy / Stroke |
| Arm / Shoulder / Knee / Foot / Ankle | Osteoporosis / Menopausal | T.M.J. Dysfunction | Fractures _____ |
| Sports Injuries: _____ | Fibromyalgia / M.S / Scoliosis | Sleep Difficulties / Apnea / CPAP | Other: _____ |

Surgical Procedures: _____

Medications: _____ ALL Accidents (auto, falls, etc) _____

Therapist Notes: _____

On a scale of 1 – 5 (5 = most severe), indicate your level of pain. _____

PLEASE INDICATE WITH AN X YOUR AREAS OF DISCOMFORT.

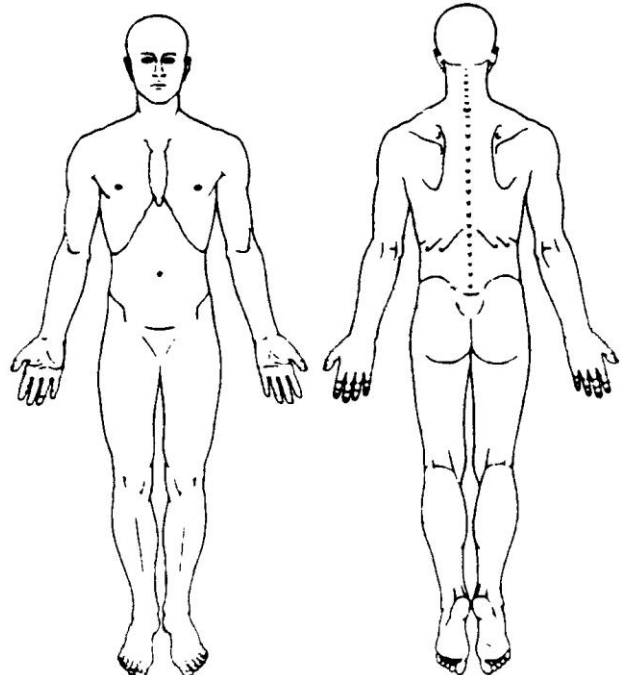
Please take a moment to carefully read the following information and policies and sign where indicated. Let it be known that myotherapy is not a substitute for medical care. Some medical conditions are contraindicated by myotherapy and should not be performed. A referral from your primary care physician may be required prior to services being rendered. I (the patient) therefore affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep Lisa Shelter, L.M.T., of Point by Point Myotherapy updated as to any changes in my medical profile and understand there shall be no liability to Lisa A. Shelter, L.M.T., should I neglect to inform her of any changes or omissions.

Any sexually illicit remarks or advances made will result in immediate termination of the session and the patient will be liable for payment of the scheduled appointment.

Appointments not cancelled within 6 hours will be charged to the patient, unless an emergency occurs which is determined by the Point by Point Myotherapy therapist.

The patient or guardian is ultimately financially responsible for all services rendered. Payment for services rendered shall be VENMO OR CASH OR CHECK ONLY, NO CREDIT CARDS. The returned check fee is \$25.00.

(PLEASE TURN OVER)



THERE IS A SPECIAL COVID FORM TO BE FILLED OUT UPON YOUR ARRIVAL. YOUR TEMPERATURE WILL BE TAKEN EACH VISIT.

IF YOU HAVE HAD ANY VACCINE WITHIN 3 DAYS OF THIS VISIT PLEASE NOTIFY THE THERAPIST IMMEDIATELY TO RESCHEDULE.

TO KEEP BOTH OF US SAFE, IF YOU ARE RUNNING A TEMPERATURE OR, NOT FEELING WELL, OR HAVE BEEN EXPOSED TO COVID, PLEASE CANCEL, AND NOTIFY LISA SHELTER, L.M.T. THAT YOU NEED TO RESCHEDULE, point2health@gmail.com or by phone/text: 901-831-2027. YOU CAN USE WELLNESS LIVING APP TO MAKE ANOTHER APPOINTMENT.

MASKS ARE TO BE WORN IN THE OFFICE BY BOTH US!! IF YOU DO NOT HAVE ONE, I WILL GIVE YOU ONE. THIS WILL MINIMIZE EXPOSURE OF ANY COMMUNICABLE DROPLETS TO KEEP US SAFE.

PLEASE REMOVE YOUR SHOES OUTSIDE THE TREATMENT DOOR.

AS SOON AS YOU PUT DOWN YOUR BELONGINGS AND FINISH SIGNING THE FORMS, YOU WILL BE ASKED TO WASH YOUR HANDS.

PLEASE BRING A CLEAN SHEET. TO EACH VISIT.

A DISPOSABLE MASK AND HAND SANITIZER IS AVAILABLE IF NEEDED.

Lisa Shelter, L.M.T., of Point by Point Myotherapy reserves the right to refuse treatment to anyone who has knowingly given inaccurate information and who does not cooperate with treatment.

I understand the above information and agree to follow Point by Point Myotherapy policies.

Patient/ Authorized Signature: _____ Date _____/2021

THANK YOU FOR YOUR COOPERATION

I LOOK FORWARD POINTING YOU IN THE RIGHT DIRECTION TO ACHIEVE YOU HEALTHCARE GOALS!

THE POINT IS ...TO HELP YOU GET WELL!