Myofascial Treatment Center of Modesto

PATIENT INFORMATION SHEET
(please print)

*PATIENT NAME*____ Date of Birth___________________ Age________ Sex____
Last First Middle

( ) Child ( ) Single ( ) Married ( ) Separated ( ) Divorced ( ) Widowed Driver's Lic. # ___________________________

New Patient New Information Is your condition the result of a work injury? Yes No An auto accident? Yes No
Date of Injury _______________ Time of Injury ______________ Date Last Worked _____________ Place of Injury ___________________________

Email Address____

Address____ Phone (____)____________________________
Number & Street City State Zip

Patient's Employer____ Phone (____)____________________________
Name Address City State Zip

Patient Soc. Sec. # __________________ Parent /Spouse Name __________________________________ Soc. Sec. # ______________________________

Parent /Spouse Employer ____ Phone (____)____________________________
Name Address City State Zip

RELATIVE WHOM WE CAN CONTACT IN EVENT OF EMERGENCY

Name _____________________________________ Address ____
Last First Middle Number & Street City State Zip

Phone: Home (___)____________________ Work (___)_______________________ Relationship________________________________

OTHER INFORMATION

Are you represented by an attorney for this injury? ( ) No ( )Yes Attorney Name_______________ Address______________________
City_______________ Phone (____)________________

Referred by ____ Primary Care Physician _________________________________

FINANCIAL INFORMATION

Insurance Type (please circle) Workman's Compensation Medicare Medi-Cal Private Pay PPO HMO

Primary Insurance Name ____ Subscriber Name _____________________________________

Insurance Address ____ Adjuster __________________________ Phone (_____)________________________

Group /Certificate # ____________________________ ID # _______________________ Effective Date ____________________ % Coverage ___________

Secondary Insurance Name ____ Subscriber Name _____________________________________

Insurance Address ____ Adjuster __________________________ Phone (_____)________________________

Group /Certificate # ____________________________ ID # _______________________ Effective Date ____________________ % Coverage ___________

FINANCIAL AGREEMENT , ASSIGNMENT OF BENEFITS AND AUTHORIZATION FOR TREATMENT: I authorize treatment of the person named above and agree, irrevocably, whether signing as agent or as patient, that in consideration of the services to be rendered to the patient that I hereby individually obligate myself to pay the account in accordance with the regular rates and terms of the provider. I hereby give authorization for payment of insurance benefits directly to the provider named above, and any assisting physicians for services rendered. As required by law, you are hereby notified that a negative credit report reflecting on your credit record may be submitted to a credit reporting agency if you fail to fulfill the terms of your credit obligations. Should the account be referred to an attorney or collection agency for collection, the undersigned agrees to pay actual attorney's fees and collection expenses. It is agreed that payments will not be delayed or withheld because of any insurance coverage or the pendency of claims thereon, and all proceeds of insurance are assigned to this office where applicable, but without their assuming responsibility for the collection thereof. (A copy of this assignment is as valid as the original.)
RELEASE OF INFORMATION: The provider may disclose all or part of the patient's record to any person or corporation which is or may be liable under a contract to the provider or to the patient, family member, or the employer of the patient or the family member for all or part of the providers charge, including but not limited to, medical service companies, workman's compensation carriers, welfare funds, or the patient's employer. I further authorize my employer to release employment information to the provider or the provider's agents.

Signature____ Date __________________________________

Patient Information

Myofascial Treatment Center of Modesto
1317 Oakdale Road Suite 610
Modesto, CA 95355
(209) 492-0355 Fax (209) 521-0955

Name ______________________________________ Social Security Number __________________________
E-mail Address____
Address____ City________________ Zip____________
Date of Birth ________________ Home Phone (____)_______________ Work Phone (____)______________
Age ______ Sex _____Male ______Female
In case of emergency____ Telephone (____)_______________
Referred by____ Attorney _____________________

1) Is this the first time you have had this pain/complaint? Yes No

2) How many episodes of your pain/complaint have required treatment?
0___ 1-3____ 4 up_____

3) Have you been hospitalized or had surgery for this same or similar pain/complaint before? Yes No

4) Please indicate you usual level of pain during the past week:
No pain 0 1 2 3 4 5 6 7 8 9 10 Worst possible pain

5) Did you see a health professional within 7 days of the onset of your pain/complaint? Yes No

6) How long ago did your **current** episode begin? ☐ Less than 2 weeks ago
☐ 2 weeks to < 8 weeks ago ☐ 8 weeks to < 3 months ago ☐ 3 months to < 6 months ago
☐ 6 to 12 months ago ☐ > 12 months ago

7) Do you use tobacco? Yes No Smoke ☐ <one pack ☐ > one pack Chew? Yes No

8) Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

10) How physically demanding is your job – include housework if not employed outside to home?
Not demanding 0 1 2 3 4 5 6 7 8 9 10 Very demanding

11) How anxious (e.g. tense, uptight, irritable, fearful, difficulty in concentrating/relaxing) have you been feeling during the past week? Not at all 0 1 2 3 4 5 6 7 8 9 10 Extremely anxious

12) How much have you been able to control (i.e., reduce/help) pain/complaint on your own during the past week? I can reduce my pain 0 1 2 3 4 5 6 7 8 9 10 I can't reduce it at all

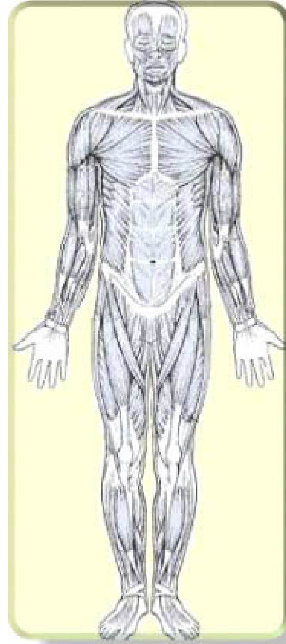
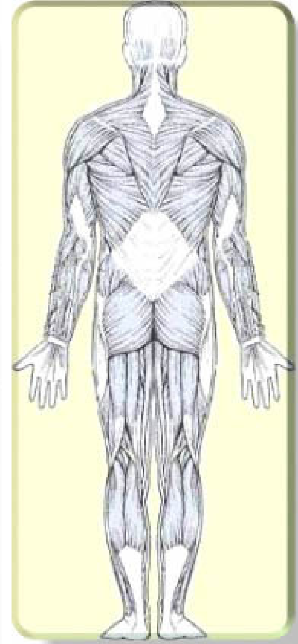
13) Please indicate how depressed you have been feeling the past week
Not depressed at all 0 1 2 3 4 5 6 7 8 9 10 Extremely depressed

14) During the last week how often have you taken medication for your pain/complaint?
☐ 3 plus times a day ☐ Once or twice a day ☐ Once every couple days ☐ Once a week ☐ Not at all

15) If you had to spend the rest of your life with your condition as it is right now, how would you feel about it?
☐ Delighted ☐ Pleased ☐ Mostly satisfied ☐ Mixed ☐ Mostly dissatisfied ☐ Unhappy ☐ Terrible

If you answer "yes to the following questions,
Please explain as clearly as possible.

Yes No Have you ever experienced hands on therapies, i.e., Myofascial Release or Soft Tissue?
Yes No Do you frequently suffer from stress?
Yes No Do you have diabetes?
Yes No Do you have frequent headaches?
Yes No Are you pregnant?
Yes No Do you suffer from arthritis?
Yes No Are you wearing contact lenses?
Yes No Do you have high blood pressure?
If "yes" to previous question, are you taking medication for this?
What is the name of the medication?
____
Yes No Do you suffer from epilepsy or seizures?
Yes No Do you suffer from joint swelling?
Yes No Do you have varicose veins?
Yes No Have you ever had surgery?
Yes No Do you have any contagious diseases?
Yes No Do you have osteoporosis?
Yes No Do you have any allergies?
What are they? _________________________
Yes No Do you bruise easily?
Yes No Have you had any broken bones?
Please list. _____________________________
Yes No Do you have any cardiac or circulatory problems?
Yes No Does your pain/condition limit you ability to sleep?
Yes No Does your pain/condition increase with activity?
Yes No Does your pain/condition cause difficulty with intercourse?
Yes No Do you have any other medical condition I should be aware of? If yes: ___________________________

Please indicate the appropriate location of the pain and the symbol that best describes your pain/complaint

Sharp and stabbing	++++
Dull and achy	VVVV
Pins and needles	OOOO
Numbness	////

Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical or specific symptoms, Myofascial Release/Soft Tissue Therapy may be contraindicated. A referral from your primary care provider may be required prior to treatment.

I understand that the Myofascial Release/Soft Tissue Therapy I receive is provided for the purpose of relief of muscular tension and relaxation. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and /or strokes may be adjusted to my level of comfort. I further understand that Myofascial Release/Soft Tissue Therapy should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that Myofascial Release/Soft Tissue Therapy therapists are not qualified to perform spinal or skeletal adjustments, diagnosis, prescribe or treat any physical or mental illness, and that nothing said in the course of treatment should be constructed as such. Because Myofascial Release/Soft Tissue Therapy should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I forget to do so. It is also understood that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

Patient Signature____ Date_____________________

Therapist Signature____ Date_____________________

Consent of Treatment of Minor: By my signature below, I hereby authorize __________________________ to administer treatment techniques to my child or dependent as they deem necessary.

Signature of Parent or Guardian_________________________________ Date_____________________

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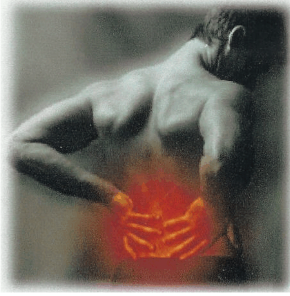
With my signature, I (print name)________________________________ give my consent to be photographed for medical record purposes. These pictures will be used to accurately record progress and be used by the therapist, doctor and insurance representative. Pictures will be taken as needed to show progress in the chart. My signature does not give permission for publication or circulation other than in above mentioned circumstances.

____________________________________ ________________________

Signature Date

____

Date placed in chart



Soft Tissue and Myofascial Treatment, Inc.
Myofascial Treatment Centers
http://mfr4painrelief.com

1317 Oakdale Road, Suite 610 Modesto, California 95355 (209) 492.0355 Fax 521.0955

Cancellation/No Show Policy

It is the policy of the Myofascial Treatment Center that scheduled appointments that are canceled with a 24 hour notice or more, there will be no charge. Appointments that are canceled with less than 24 hours will be charged at half the cost of the scheduled visit.

No Show Appointments: if you have a scheduled appointment and you no show the appointment (do not come in for the appointment) and do not call **you will be billed for the full cost of that visit**. This includes workers compensation patients. Although we can not bill workers compensation for your no show appointment we can and will bill you.

Payment of Service Fee's

PAYMENT IS DUE AT THE TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.

Insurance Co-payments Policy

Insurance co-payments are due at the time of your visit. In some cases we do not know what your co-pay will be until we receive reimbursement back from your insurance company. We will charge a standard co-pay of $35.00 per visit until we determine your co-pay and coverage. At that time we will refund any overpayments back to you or present you with the amount you may owe the Myofascial Treatment Center due to a short fall by your insurance. **Because of administrative costs and overhead all insurance reimbursements must meet our cost per visit.** If you need clarification on this policy please ask us and we will be happy to explain in greater detail.