AMERICAN HEALTH

Muscular Therapy Clinic, Inc.
Lic #MT20900118
228 W. Edison * Suite 700 * Mishawaka, IN 46545
Phone: (574) 255-2706

CONFIDENTIAL

CLIENT REGISTRATION

Client Name*(First, Middle Initial, Last)*: _____ Male/Female

Street Address:_____**City, State, Zip Code:** _____

Birthdate: _____ **Home Phone:** _____ **Cell Phone:** _____

E-Mail Address: _____

Marital Status: Married / Widow / Single / Student **Spouse/Parent (s) Name:** _____

Employer Name: _____ **Work Phone:** _____

Referring Doctor or Person of Reference: _____

Nearest Relative or emergency contact person:

Name *(First, Last)* _____ **Home Phone:** _____

Relationship *(if any)* _____ **Work Phone:** _____

AUTHORIZATION AND RELEASE: I, the undersigned release Kevin W. Miller, CMT, American Health Muscular Therapy Clinic, Inc., and all other associates of American Health from any responsibility for pre-existing conditions I have not revealed, or any consequential changes to those conditions that arise subsequent to treatment. I hereby give my consent for treatment by American Health Muscular Therapy Clinic Inc. for myself or guardianship of minor under eighteen.

I authorize American Health Muscular Therapy Clinic, Inc., to release any and all required therapy notes, progress reports, and other medical records to my referring physician, and to furnish medical records to my attorney and insurance when deemed necessary, for myself or my dependent. I acknowledge that changes may be made to the release of records upon my written request. I also acknowledge responsibility for payment of services regardless of any insurance I may have to assist me in this responsibility. If for any reason the account should become delinquent, I agree to pay for all collection and legal fees.

American Health Muscular Therapy Clinic, Inc. is committed to keeping all client records and information confidential.

Signature: _____ **Date:** _____

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INFORMATION

Why are you seeing the therapist today? _____

Current problem is a result of a (n): *check all that apply*

Auto Accident _____ Work Accident _____ No Accident _____ Other _____

This occurred during: *check all that apply*

Lifting _____ Pulling _____ Pushing _____ Twisting _____
Squatting _____ Hit by an object _____ Other (explain) _____

Medications:	**Dose:**	**How long?**	**Side effects:**

Medication Allergies:_____

_____

_____

Other Allergies:

_____

_____

_____

Review of Symptoms

Are you currently having or had problems with:

	Circle One		**Describe all YES responses**
AIDS	No	Yes	
Arthritis	No	Yes	
Balancing Problems	No	Yes	
Black out/Fainting	No	Yes	
Bladder Problems	No	Yes	
Bleeding Problems	No	Yes	
Bowel Problems	No	Yes	
Cancer (malignancies)	No	Yes	
Cardiac Problems	No	Yes	
Diabetes	No	Yes	
Digestion/Reflux	No	Yes	
Ears, Nose, Throat	No	Yes	
Eyes	No	Yes	
Fibromyalgia	No	Yes	
High Blood Pressure	No	Yes	
Lungs, Breathing	No	Yes	
Migraines/Headaches	No	Yes	
Numbness/Tingling	No	Yes	
Past Fractures	No	Yes	
Polio	No	Yes	
Psychological Problems	No	Yes	
Skin Problems	No	Yes	
Swelling	No	Yes	
TB	No	Yes	

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PAST MEDICAL HISTORY

Surgeries/Hospitalizations: (*please list year and any complications):*_____
_____
_____
_____
_____
_____

Illnesses for which you are currently being treated: _____
_____
_____
_____
_____
_____

SOCIAL HISTORY:

Employer: _____ Occupation: _____

Full time Student: _____ Do you live alone? _____

Children: circle one: YES/NO (if yes, please list ages) _____

Exercise:

Daily:_____Weekly:_____Monthly:_____Rarely:_____Never:_____

Diet(s) that you follow: _____

Habits:

Hours of sleep:_____ Smoke: _____ if yes, packs per day _____ Alcohol _____ weekly

The above information is accurate and complete to the best of my knowledge.

X:_____ **Date:**_____
Client signature or Parent/Guardian of a minor

Reviewed by:_____ **Date:**_____

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FINANCIAL POLICY

We at American Health Muscular Therapy Clinic, Inc. are committed to providing you with the best possible care. We are pleased to discuss our professional fees with you during office hours. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about this Financial Policy.

We accept Cash or Checks only. There is a Service Charge of $32.00 for returned checks.

No Insurance: Payment agreement plans are available. Please discuss this with the Office Manager before your scheduled therapy appointment.

Insurance: You are responsible for payment in full. You may obtain receipts, upon your request for insurance purposes. However, insurance is a contract between you and your insurance company. Please be advised that not all insurance companies cover this type of therapy. We will not become involved in disputes between you and your insurance company regarding deductibles, co-insurance, covered charges, secondary insurance, "usual and customary" charges, etc. other than to supply factual information as necessary.

Minor Clients: For clients under the age of 18, a parent or guardian must accompany them and sign below (exception: clients under the age of 18 declared emancipated minors). It is the parent or guardians responsibility for full payment of medical services. The agreement for child support and payment of medical services is between the judge, the mother and father, **NOT** American Health Muscular Therapy Clinic, Inc.

Cancellation Policy: American Health Muscular Therapy Clinic, Inc. firmly believes that a good client/therapist relationship is based upon understanding and communication. Therefore we require a 12 hours notice when canceling an appointment. Please be advised that you will be charged in full for the missed appointment in not cancelled within 12 hours.

I HAVE READ AND UNDERSTAND THIS FINANCIAL POLICY.

X_____ Date: _____
Client signature or Parent/Guardian of a Minor

AMERICAN HEALTH MUSCULAR THERAPY CLINIC, INC
228 W. Edison Road, Suite 700
Mishawaka, IN 46545
Kevin W. Miller, MT Lic. MT20900118

Phone: (574) 255-2706 Fax: (574) 255-2106

PAIN REFERRAL AREAS
MARKED WITH "X" OR SHADED

PATIENT:

DOB:

PHYSICIAN: **FAX:**

DX:

TX:

RIGHT CERVICAL ROM _____
LEFT CERVICAL ROM_____

RIGHT SHOULDER ROM _____
LEFT SHOULDER ROM _____

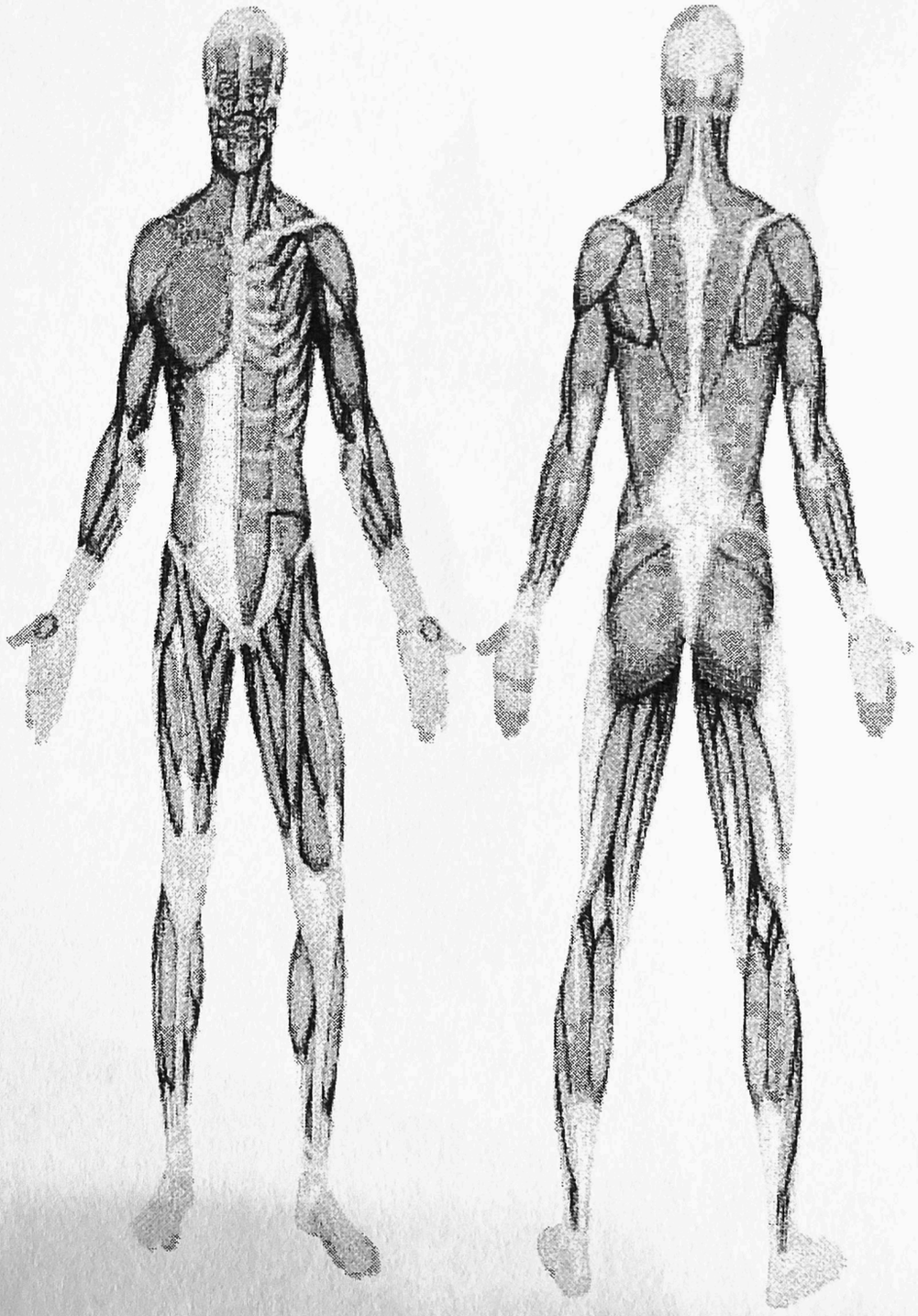
RIGHT ARM ROM _____
LEFT ARM ROM _____

RIGHT THORACIC ROM _____
LEFT THORACIC ROM _____

RIGHT LUMBAR ROM _____
LEFT LUMBAR ROM _____

RIGHT LEG ROM _____
LEFT LEG ROM_____

RIGHT FOOT ROM_____
LEFT FOOT ROM _____



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Client S.O.A.P Notes

Client Name: _____ **Date:** _____

Past Medical History: *see History Form In File*

Subjective Findings: *(patients)* _____

Objective Findings: *(diagnostic testing)* _____

Assessment: *(conclusion or positive findings)* _____

Plan: *(further diagnostic or therapy action)* _____

These notes contain confidential information and are for the sole use of American Health Muscular Therapy Clinic, Inc. or to whom the client has given signed permission to be released.