TRUMOVE
BETTER HEALTH THROUGH MOTION

PATIENT INFORMATION Today's Date: _____ /_____ /_____

Patient Last Name: _____ First: _____ MI: _____ Sex: M | F

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

Home Phone: ( ) _____ - _____ Work Phone: ( ) _____ - _____ Cell Phone: ( ) _____ - _____

E-Mail Address: _____ Opt out for apt reminders, e-newsletter + special promotions? □

Birth Date: _____ /_____ /_____ Whom may we contact in an Emergency: _____

Relation: _____ Phone: ( ) _____ - _____

How did you hear about TruMove? Word of Mouth | Physician | Google | Other_____

If referred by a friend, please list their name:_____

INSURANCE POLICY HOLDER (If other than yourself)

Insurance Policy Holder Name: _____ Phone: ( ) _____ - _____

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

Relation to Patient: _____ Insured Party's Birth Date: _____ /_____ /_____

CONSENT FOR CARE AND TREATMENT

I, the undersigned, do hereby agree and give my consent for TruMove to furnish medical care and treatment to _____(Patient Name) as considered necessary and proper in diagnosing or treating his/her physical condition. I understand that a PT diagnosis is not a medical diagnosis.

Patient/Guardian_____ Date_____

COMMUNICATION AUTHORIZATION

Please list below any other person(s) authorized by you, (in addition to legal guardian, family or referring physicians) to discuss aspects related to health care provided by TruMove. (i.e. lawyer, coaches, employer, etc.)

Name_____ Relation to Patient_____

Name_____ Relation to Patient_____

I understand and agree to comply with the terms of TruMove's Cancellation Policy. YES NO Initial _____

I have received a copy of TruMove's Notice of Privacy Practices. YES NO Initial _____

I am willing to allow the use of my records for research/marketing purposes? ____Yes ____No

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PATIENT MEDICAL HISTORY

Name:_____ Referring Physician: _____

Date of 1st MD visit for this injury:_____ Date of Next MD visit: _____

Was this an Auto Accident? Y | N Work Accident? Y | N Date of Accident: _____ /_____ /_____

Is an Attorney involved in this case: YES NO

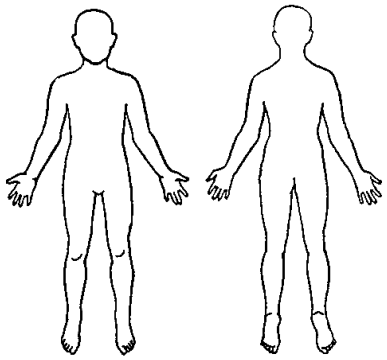
Have you had surgery for this injury: YES NO Type of Surgery:_____ Date: _____

Please list ALL prescription and non-prescription medication you are currently taking:

_____ _____ _____ _____ _____

Do you now have or have you ever had any of the following:

- ❑ Asthma, Bronchitis, or Emphysema
- ❑ Shortness of Breath
- ❑ Chest Pain / Angina
- ❑ Coronary Heart Disease
- ❑ Pacemaker
- ❑ High Blood Pressure
- ❑ Heart Attack or Heart Surgery
- ❑ CVA (Stroke) / TIA (Mini Stroke)
- ❑ Blood Clot / Emboli
- ❑ Epilepsy / Seizures
- ❑ Thyroid Dysfunction / Goiter
- ❑ Anemia
- ❑ Infectious Diseases
- ❑ Diabetes
- ❑ Cancer / Chemotherapy / Radiation
- ❑ Arthritis / Swollen Joints
- ❑ Osteoporosis
- ❑ Gout
- ❑ Sleep Disorders
- ❑ Emotional / Psychological Problems
- ❑ Bowel and/or Bladder Dysfunction
- ❑ Severe or Frequent Headaches
- ❑ Vision or Hearing Difficulties
- ❑ Dizziness or Fainting
- ❑ Numbness or Tingling
- ❑ Weakness
- ❑ Unexplained Weight or Energy Loss
- ❑ Hernia
- ❑ Varicose Veins
- ❑ Allergies
- ❑ Any Pins or Metal Implants
- ❑ Joint replacement
- ❑ Neck Injury / Surgery
- ❑ Shoulder Injury / Surgery
- ❑ Elbow / Hand Injury / Surgery
- ❑ Back Injury / Surgery
- ❑ Knee Injury / Surgery
- ❑ Leg / Ankle / Foot Injury/ Surgery
- ❑ Are you Pregnant?
- ❑ Do you Smoke?



** **Please circle the location of your pain** **

Please provide us with any other information that would assist us in your care: _____

_____

_____

By signing below, I hereby certify that to the best of my knowledge all the information I have furnished on this form is complete, true and accurate.

Patient/Guardian_____ Date_____

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FINANCIAL POLICY CONSENT

I understand and agree to comply with the terms of TruMove's Financial Policy Disclosure. **(If the patient is a minor a signature from the parent or guardian is required.)**

Signature_____ Date_____

Name printed: _____

Relation to the patient: _____

CREDIT CARD ON FILE AUTHORIZATION (optional)

☐ I do not wish to keep a credit card on file with TruMove.

☐ Please keep a credit card on file with TruMove.

Name on Card: _____

Billing Address: _____

_____

Credit Card Type (Please Circle):

Amex Visa Discover Mastercard

Credit Card Number: _____

Expiration Date: _____ Security ID #: _____

Card Holder's Signature: _____ Date: _____

I agree to keep my my credit card on file with TruMove for outstanding co-payments or balances due for treatment or services rendered while I was a client at TruMove. I also authorize TruMove to take payments over the phone using this information or when marked on my statement.