Prototype Health Patient Demographics

NAME:	**DATE OF BIRTH:**
ADDRESS:	
SEX: ☐ MALE ☐ FEMALE	**MARITAL STATUS:**
MOBILE PHONE NUMBER:	**HOME PHONE NUMBER:**
EMAIL:	**WORK PHONE NUMBER:**
EMERGENCY CONTACT:	**EMERGENCY PHONE #**
Do you give consent for our staff to discuss your medical condition with this person if needed? ☐ YES ☐ NO	

REFERRING PHYSICIAN:	**PHYSICIAN PHONE #:**
Have you had any Home Health or therapy elsewhere THIS year? ☐ YES ☐ NO **Provider:**	

LATE/CANCELLATION POLICY

If you know you will be late for an appointment, please give us a call to be sure you can still be seen and to check if rescheduling is necessary. Excessive last-minute cancellations will be subject to a $50.00 fee per appointment.

If you miss your appointment, we miss out on the opportunity to help you or someone else who may need our service. Please consider this when making appointments.

Three (3) consecutive late-cancel/no-shows will result in patient having to pre-pay for your next scheduled visits as well as the late/cancellation fee of $50

SIGNATURE: _____ DATE: _____

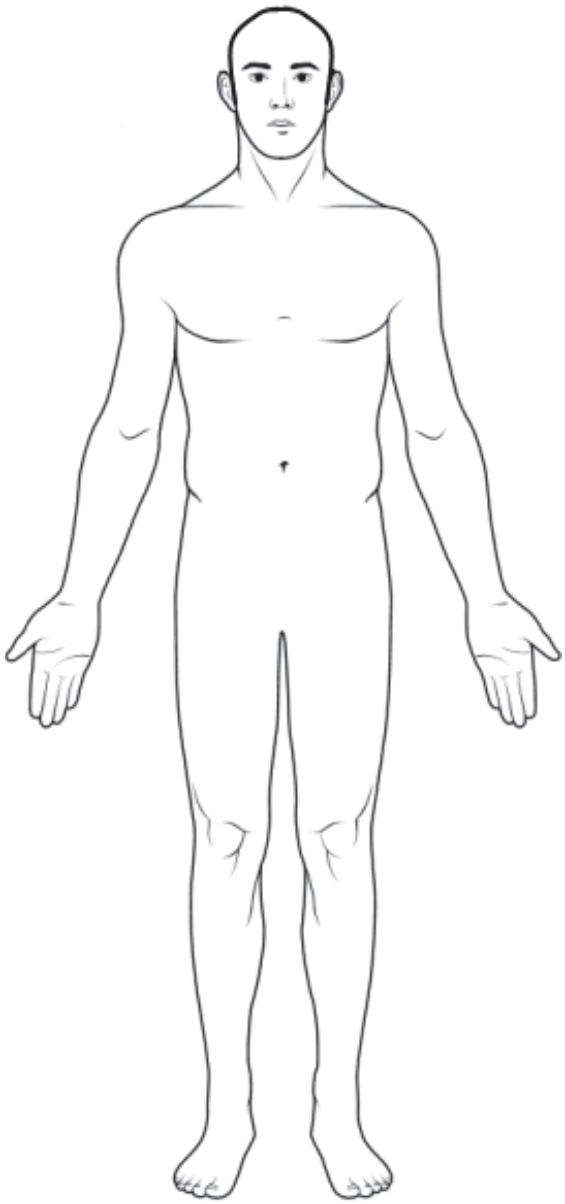
FRISCO Nuetral Grounds
207 King Rd #205 Frisco, TX 75036

MCKINNEY Crossfit Mckinney
8404 Stacy Rd #300 McKinney, TX 75070

Info@PrototypeHeal.com **CALL/TEXT (214) 210.0203**

PATIENT NAME:_____ **DOB**:_____

Where is your pain located <u>now</u>? Mark the areas below where you feel the described sensations using the symbols provided. Include all affected areas.



^^^ Ache

ooo Numbness

=== Pins & Needles

/ / / Stabbing

x x x Burning

When did it start?

_____

What makes it feel better?

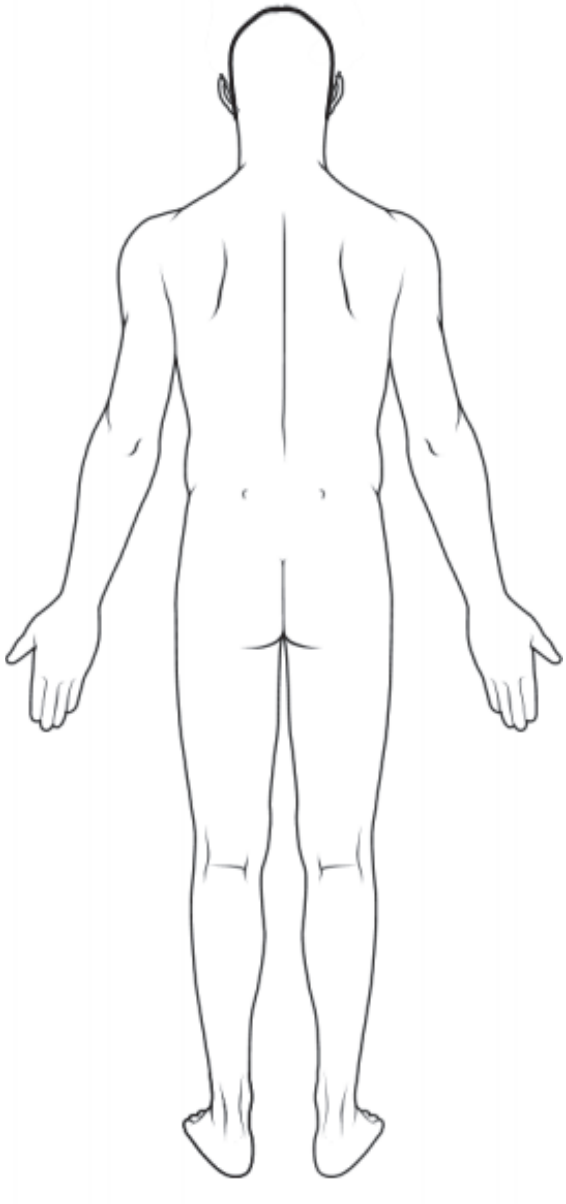
_____

What makes it feel worse?

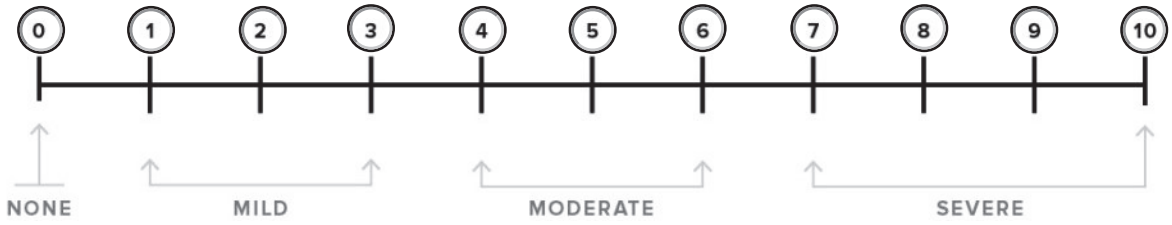
_____

What time of day is your pain the worst?

_____



PLEASE INDICATE BELOW: How bad is your pain on a scale from 0 to 10?



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PATIENT NAME: _____ **DOB**: _____

Where are you currently having symptoms? _____

What treatment have you already received for this condition? ☐ Medication ☐ Surgery ☐ Physical Therapy ☐ Chiropractic ☐ Other (please specify): _____

FAMILY HEALTH HISTORY

Have any immediate family members ever had any of the following?

FATHER	☐ Diabetes	☐ Heart Attack	☐ Kidney Disease	☐ Cancer	☐ Other:	
MOTHER	☐ Diabetes	☐ Heart Attack	☐ Kidney Disease	☐ Cancer	☐ Other:	
SIBLINGS	☐ Diabetes	☐ Heart Attack	☐ Kidney Disease	☐ Cancer	☐ Other:	

PATIENT HEALTH HISTORY

Please indicate if you have been treated or are presently being treated for any of the following conditions.
(CHECK ALL THAT APPLY)

☐ AIDS/HIV	☐ Kidney Disease	☐ Sitting	☐ None
☐ Allergies/ Asthma	☐ Liver Disease	☐ Light Labor	☐ Moderate
☐ Angina/ chest pain	☐ Lung Disease	☐ Heavy Labor	☐ Daily
☐ Cancer	☐ Osteoarthritis	☐ Standing	☐ Heavy
☐ Diabetes	☐ Osteoporosis	☐ Not Currently Working	**ALLERGIES:**
☐ Epilepsy	☐ Pacemaker	**HABITS:**	
☐ Fibromyalgia	☐ Rheumatoid Arthritis	☐ Smoking - (_____packs/day)	
☐ Heart Disease	☐ Stroke	☐ Alcohol - (_____ drinks/week)	
☐ Hepatitis	☐ Thyroid	☐ Caffeine - (_____cups/day)	
☐ High Blood Pressure	☐ Ulcer	☐ High stress level Reason:	

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REVIEW OF SYSTEMS (check all that apply)

HEAD & NECK	CARDIOVASCULAR	MUSCULOSKELETAL	DERMATOLOGICAL	RESPIRATORY
☐ Blurred/double vision	☐ Shortness of breath	☐ Backache	☐ Bruising	☐ Chronic cough
☐ Loss of hearing	☐ Palpitation	☐ Neck ache	☐ Rashes	☐ Wheezing
☐ Sinus infection	☐ Chest pain on	☐ Fractures	☐ Itching	☐ Asthma
☐ Difficulty	☐ Resting chest pain	☐ Leg pain w/	☐ Skin cancer	☐ Pain w/ breathing
☐ Lump in neck	☐ Heart murmur	☐ Swelling of joints	☐ Abnormal moles	☐ Flu
		☐ Masses/ lumps	☐ Breast mass	☐ Pneumonia
			☐ Burns	☐ Difficulty sleeping

GENITOURINARY	NEUROLOGIC	PSYCHOLOGICAL	GASTROINTESTINAL	GENERAL
☐ Urinary frequency	☐ Loss of consciousness	☐ Anxiety	☐ Heartburn	☐ Recent illness
☐ Urgency	☐ Paralysis	☐ Depression	☐ Ulcer	☐ Fever
☐ Dribbling	☐ Tremors	☐ Suicidal Ideation	☐ Jaundice	☐ Chills
☐ Bladder infection	☐ Gait disturbances	☐ Binge eating	☐ Hepatitis	☐ Night sweats
☐ Increased amount of urine	☐ Headaches	☐ Bulimia	☐ Blood in stool	☐ Weight loss/gain
☐ Inability to urinate	☐ Dizziness	☐ Anorexia	☐ Nausea	☐ Abnormal bleeding
	☐ Falling	☐ Bipolar	☐ Vomiting	
	☐ Stroke	☐ Schizophrenia	☐ IBS	

SURGERIES (include dates)	MEDICATIONS	

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CONSENT TO TREAT

I, the undersigned, give permission to the practitioners of Prototype Health to administer evaluation and treatment necessary and advisable for my condition. If patient is a minor, a parent or guardian must sign. **Consent must be signed before we begin treatment.**

_____ _____

Signature of Patient (or Responsible Party) **Date**

HIPAA ACKNOWLEDGEMENT

The Health Insurance Portability and Accountability Act (HIPAA) is a federal government regulation designed to ensure that you are aware of your privacy rights and how your medical information can be used by our staff in providing and arranging your medical care. Prototype Health will furnish you with a notice (by request only) which provides information about how Prototype Health may use and/or disclose protected health information about you for treatment, payment, health care operations and as otherwise allowed by law.

By signing this form, you acknowledge that you have been informed/offered a copy of Prototype Health's Notice of Privacy Practices.

_____ _____

Signature of Patient (or Responsible Party) **Date**

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Prototype Health to release any information necessary to insurance carriers regarding my or my dependent's illness and treatments, to process insurance claims generated in the course of examination or treatment and to allow a photocopy of my signature to be used to process insurance claims for the period of life-time. This order will remain in effect until revoked by me in writing.

_____ **Patient Initials**

FINANCIAL RESPONSIBILITY

All professional services rendered are charged to the patient and are due at the time of service unless other arrangements have been made in advance with our office.

_____ **Patient Initials**

SOCIAL MEDIA AUTHORIZATION, RELEASE & CONSENT

I, authorize and grant Prototype Health to take my photo's regarding my experiences with Prototype Health and it's employees. I grant Prototype Health to use my photos on Facebook, Twitter, Instagram, and other social media platform. I allow Prototype Health to edit, alter, copy, or distribute the photos for social media advertising and marketing. I agree that the photos belong to Prototype Health. I understand that I will not receive any monetary compensation.

_____ _____

Signature of Patient (or Responsible Party) **DATE**

PATIENT NAME:_____ DOB:_____

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Previous Name (if applicable):_____ Social Security #: _____

I request and authorize_____ to release healthcare information for the patient named above to:

Name: **Prototype Health**

Address: **Info@PrototypeHeal.com**

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Other:_____

This request is for the purpose of:

☐ Treatment/Continuing Medical Care

☐ Billing or Claims

☐ Insurance

☐ Other: _____

EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional):
Month_____ Day_____ Year _____

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named above. I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosure of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state privacy laws.

_____ _____

Patient Signature Date