Apple Day Spa
& Hair Restoration Salon

(570) 253-4770
www.AppleDaySpa.com

PATIENT REGISTRATION FORM

Patient's Name _____ Sex: M F (circle one)

Patient's Address _____
Street Apt # City State Zip

Mailing Address (if different from above) _____

Home Phone _____ Cell Phone _____ Work Phone _____

Patient's Date of Birth _____ Driver's License #: _____

Patient Referred By _____
Name Address Phone # Fax #

Current Employer _____ Occupation _____

Marital Status (circle one) Single Married Widowed Divorced Separated

Name of Spouse _____ Spouse's Phone # _____

If Patient is a Minor

Responsible Party _____

Relationship to Patient: Parent Step-Parent Other _____ (circle one)

Street Address _____
Street Apt # City State Zip

Home Phone _____ Cell Phone _____ Work Phone _____

Mailing Address (if different from above) _____

Emergency Contact

Name and phone number of relative/friend who does not live with the patient

Name _____ Relationship _____

Phone _____

Primary Care Practitioner

Patient's PCP _____
Name Address Phone # Fax #

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FINANCIAL POLICY

Payment for services rendered are due at the time of service. Acceptable forms of payment: Cash, Check, Visa, Mastercard, and Debit. I understand there is a $25.00 service charge for all returned checks.

You are responsible for the timely payment of your account. In the event any legal fees are incurred, as a result of non-payment for services rendered, they are the express responsibility of the client/patient.

NO-SHOW / CANCELLATION POLICY

This office has a no-show policy. Patients who do not call at least 24 hours before their appointment or do not show to their appointment will be charged the full therapy fee. I understand that I will be **charged** for not showing up to an appointment or not calling at least 24 hours in advance.

I have read and understand the statements above.

_____ _____

Signature of Patient / Responsible Party Date

MEDICAL/LEGAL CARE

If your symptoms or presenting problem relates in any way to an existing motor vehicle accident for which you are being treated, your care is considered medical/legal. In that event, this information should be brought to the attention of the office management and/or your therapist and any care should be approved before therapy can be scheduled or performed. There are no exceptions. Thank you.

I have read and understand the statement above. _____(Please initial)

RELEASE OF INFORMATION

I hereby authorize the release of medical information requested by my insurance company or workers' compensation carrier. I also authorize the release of information to any hospital or physician I may be referred to by this office. I authorize assignment of payment directly to Apple Day Spa for any covered major medical benefits due to me.

_____ _____

Signature of Patient / Responsible Party Date

I understand that Apple Day Spa practitioners do not diagnose illness, disease, or any physical or mental disorder, nor do they prescribe medical treatment, pharmaceuticals, or perform spinal thrust manipulations. I acknowledge that this therapy is not a substitute for medical examination or diagnosis, and that it is recommended that I see a primary health care provider for that service.

I have stated all medical conditions that I am aware of and will update the Bowen practitioner of any changes in my health status.

_____ _____

Signature of Patient / Responsible Party Date

FOR OFFICE USE ONLY

Therapist Assigned _____ Date_____

HIPAA Information to Patient _____

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CONFIDENTIAL HEALTH INFORMATION

Name _____ Height_____ Weight_____ Age_____ Date_____

In order that we may serve you better, please answer the following questions as best as you can.

☐ Requesting or Attending Practitioner or ☐ Recommended By _____

Have you had therapeutic bodywork before?

☐ Yes ☐ No If yes, how long ago? _____

Where? ☐ Wellness Spa ☐ Chiropractor's Office ☐ Resort Spa ☐ Other

Do you exercise regularly? ☐ Yes ☐ No What type of exercise or sport? _____
How many times per week? _____

Please check any of the following that apply to you. Have you had or do you now have?

☐ Headaches/Shooting Pains
☐ Sinus Trouble
☐ Loss of Smell/Taste
☐ Hayfever/Asthma
☐ Tightness in Throat
☐ Thyroid Trouble
☐ Face Flushed
☐ Twitching of Face
☐ Loss of Memory
☐ Fatigue
☐ Head Feels Too Heavy
☐ Dizziness/Loss of Balance
☐ Fainting
☐ Ringing in Ears
☐ Wear Glasses/Contacts
☐ Dentures/Periodontal/Implants
☐ Lights Bother Eyes
☐ Muscle Spasm in Neck & Shoulder
☐ Depression
☐ Panic Attacks/High Anxiety

☐ Grating in Neck
☐ Tightness in Shoulder Muscles
☐ Nerve pain in Shoulders & Arms
☐ Pins & Needles in Arms & Hands
☐ Cold Hands/Feet
☐ History of Tuberculosis
☐ Anemia
☐ Rheumatic Fever
☐ Nervous Stomach
☐ Ulcers
☐ Nerves & Nervousness
☐ Inner Tension/Irritability
☐ Cold Sweats/Hot flashes
☐ High Blood Pressure
☐ Low Blood Pressure
☐ Chest Pains
☐ Shortness of Breath
☐ Heart Palpitations/Chest Pounding
☐ History of Heart Disease

☐ Indigestion/Gas
☐ Constipation/Diarrhea
☐ Gallbladder Trouble
☐ Smoker/Packs per day_____
☐ Liver Trouble
☐ Alcoholism
☐ Kidney/Bladder Trouble
☐ Dialysis/History of Transplant_____
☐ Diabetes
☐ Cancer
☐ Sleeping Problems
☐ Painful/Swollen Joints
☐ Arthritis
☐ Disc/Herniated Disc
☐ Pinched Nerves in Back
☐ Pins & Needles in Legs
☐ Pains in Legs & Feet
☐ Broken Bones, Fractures
☐ Other _____

Please list your current medications:_____

Please list any supplements you are taking:_____

Are you… ☐ pregnant ☐ currently under chemotherapy
☐ recovering from any recent surgery (within the last 12 months) If so, date?_____

Do you sleep on your…☐ side ☐ back ☐ stomach

Do you wear… ☐ heel lifts ☐ sole lifts ☐ arch supports ☐ inner soles

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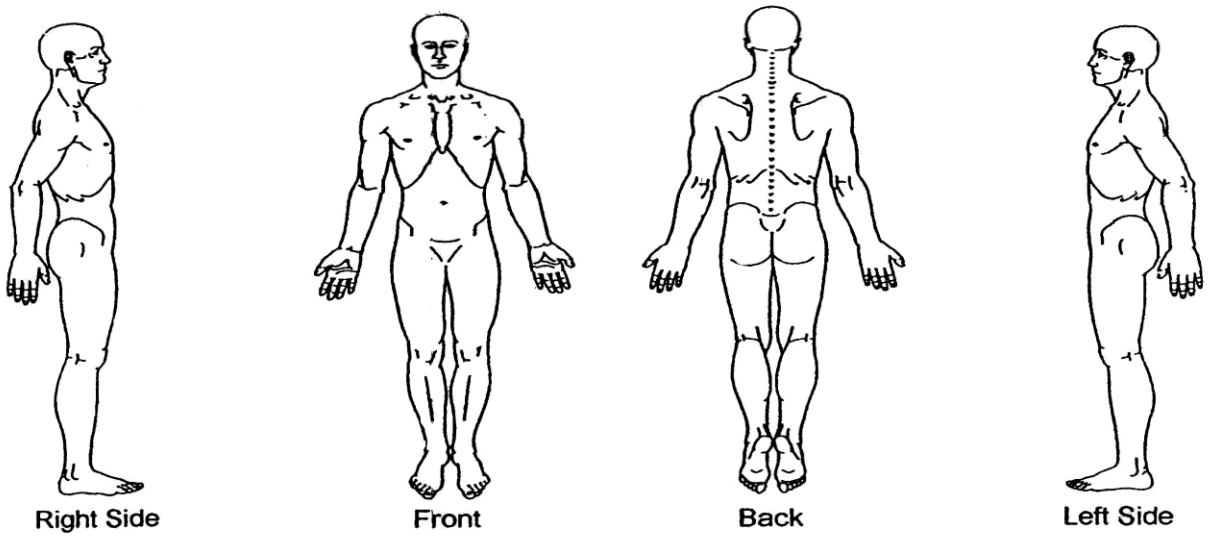
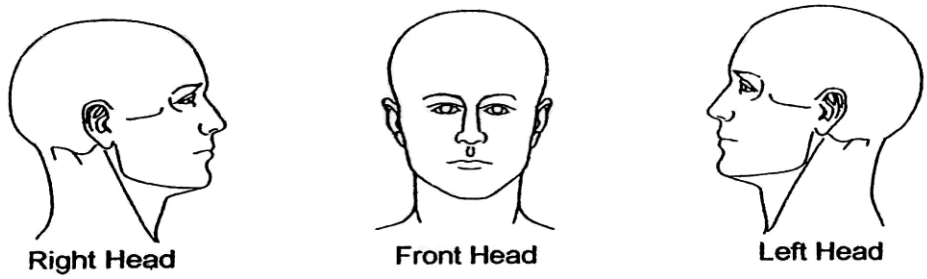
Name _____ Date_____
Date of Birth _____

Show by marking and drawing on the figures below where you are having most of your…

Aching or Pain **XXXX**
Numbness or Tingling **OOOO**
Pins and Needles **.....**
Burning ////
Cramping **AAAA**
Pain Movement or Shooting Pain ➔➔➔➔





The following questions are only an approximate assessment of your pain problem. We understand that exact descriptions are impossible. Please choose the responses that BEST approximate your PAIN PRESENTLY (over the last few weeks or months or longer).

1. Do you have more pain in your:

_____ Back R L (circle)
_____ Hip(s) R L (circle)
_____ Leg(s) R L (circle)
_____ Other _____

2. How often are you having pain now? (check only one):
   ____ No pain or rarely have pain now
   ____ Occasional pain (about once or twice per year or so)
   ____ Recurrent pain (a few days every few months or more often)
   ____ Frequent pain (a few days or more at least every month)
   ____ Pain every single day (Is it constant? ____ yes or ____ no)

3. When having pain, it is generally (check only one):
   ____ A mild discomfort or less
   ____ A dull pain, worse at times
   ____ A harder aching pain, frequently worse at times
   ____ A severe pain, sharp and shooting at times
   ____ A very severe pain, frequently very sharp, shooting and disabling
   ____ An extremely severe and disabling pain

4. How is the pain now limiting your job, housework and social/recreational activities? (check only one):
   ____ Not limited in any way
   ____ Pain not bad enough to really limit me very much
   ____ Able to work with pain all of the time by modifying my activities
   ____ Must stop and limit activities, but able to work most of the time
   ____ Frequently unable to work for several or more days at a time
   ____ Unable to work at all — totally disabled by pain

Circle on number in each row below that most closely describes your level of pain at its LEAST BOTHERSOME and MOST BOTHERSOME.

Least Bothersome

0 1 2 3 4 5 6 7 8 9 10
No Pain Extreme Pain

Most Bothersome

0 1 2 3 4 5 6 7 8 9 10
No Pain Extreme Pain

Pain Factors

What makes the pain worse?

____ Prolonged Standing
____ Prolonged Sitting
____ Twisting
____ Sneezing
____ Lifting
____ Bending
____ Coughing
____ Walking
____ Straining at Stool
____ Getting in and out of cars and/or chairs
____ Movement of _____
____ Calf cramping: walking or at night

How far can you walk w/out stopping? _____(distance)

Other: _____

_____

_____

What must you do to get relief? _____

_____

_____

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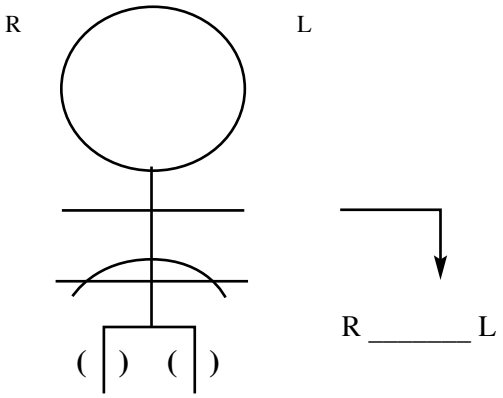
THERAPIST'S ASSESSMENT



The following muscles/muscle groups are found to be hypertonic and will be addressed as needed:

- ☐ TMJ Joint
- ☐ Temporalis
- ☐ Occipitalis
- ☐ Suboccipitalis
- ☐ Sternocledomastoid
- ☐ Ptergoid
- ☐ Masseter
- ☐ Scalenes
- ☐ Trapezius
- ☐ Rhomboid major
- ☐ Rhomboid minor

Rotator Cuff
- ☐ Teres minor
- ☐ Supraspinatus
- ☐ Infraspinatus
- ☐ Subscapularis

IT Band
- ☐ Tensor fascia latae
- ☐ Gluteus maximus

- ☐ A/C Joint
- ☐ Levator scapula
- ☐ Teres major
- ☐ Splenius group
- ☐ Deltoids
- ☐ Biceps brachii
- ☐ Triceps brachii
- ☐ Extensors of the arm
- ☐ Flexors of the arm
- ☐ Pectoralis major
- ☐ Pectorais minor
- ☐ Latissimus dorsi
- ☐ Quadratus lumborum
- ☐ Erector spinae C / T / L
- ☐ Serratus anterior

- ☐ Gluteus medius
- ☐ Gluteus minimus
- ☐ Psoas
- ☐ Iliacus

Hip Rotators
- ☐ Gemellus's (2)
- ☐ Obturators (2)
- ☐ Piriformis
- ☐ Quadratus femoris

- ☐ Adductors
- ☐ Gracilis
- ☐ Sartorius

Quads
- ☐ Rectus femoris
- ☐ Vastus lateralis
- ☐ Vastus medialis
- ☐ Vastus intermedius

Hamstrings
- ☐ Semitendinosis
- ☐ Semimembranosis
- ☐ Biceps femoris

- ☐ Gastrocnemius
- ☐ Soleus
- ☐ Tibialis posterior
- ☐ Tibialis anterior
- ☐ Flexors of the calf
- ☐ Extensors of the calf
- ☐ Peroneals group
- ☐ Inguinal ligament
- ☐ Sacrotuberous ligament

Personal Pain Assessment

Pre session_____

Post session _____

Assessment Outcome:

_____ Cervical-hyoid torsion/tension with restriction of: _____

_____ Contra-lateral hip torsion/tension with restriction R or L (circle one)

_____ Impingement syndrome with restriction of: _____

Home-based therapeutics discussed with good feedback demonstrated.
Client/patient to return for follow-up as agreed.

Therapist's signature _____ Date _____