

Welcome to Dr. Ibolit

PATIENT INFORMATION

First Name: _____

Last Name: _____ Middle Initial: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (____) _____

Cell Phone: (____) _____

Email: _____

Sex: M F Birth Date: _____

Single Married Separated

Divorced Widowed Minor

EMERGENCY CONTACT

Name: _____

Relationship: _____

Phone: (____) _____

How did you hear about us?

INSURANCE INFORMATION

Insurance Company: _____

Insurance Company Phone Number: (____) ____ - _____

Insured's Name: _____

Insurance ID#: _____

Insured's DOB: ____/____/____

Relationship to Insured:

Self Spouse Child Other

ASSIGNMENT AND RELEASE

I understand that I am financially responsible for all charges whether or not paid by my insurance. If I provide insurance, I authorize the use of my signature on all insurance submissions.

I certify that I, and/or my dependent(s), have insurance coverage with the above named insurance, and assign directly to the Dr. Ibolit Manual Medicine Clinic all insurance benefits, if any, otherwise payable to me for services rendered.

The above-named clinic may use my health care information and may disclose such information to the above-named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services.

PrintName

Signature

Date

PURPOSE OF VISIT

What is the reason for your visit today?(Choose any that apply)

New injury Recurring or chronic condition Improve sport performance Difficulties with daily activities / hobbies

Other: _____

What therapies are you seeking? (Choose any that apply)

Physical Therapy Chiropractic Massage Therapy Anything that will help my condition

Briefly describe your complaint:

Treating Physician (if applicable): _____

Phone: (____) _____

Primary Care Physician (if applicable): _____

Phone: (____) _____

HEALTH HISTORY

Previous Surgeries: None Yes: _____ Year: _____
_____ Year: _____

Medications: None Yes: _____

Are you experiencing any unexplained: Malaise Weight Loss Energy Loss Weakness

Previous Injuries: None Neck Back Knee Leg/Ankle/Foot Elbow/Hand

Are you pregnant: No Yes **Due Date:** _____

Who have you seen for this injury/episode? N/A Yes: _____

What diagnostics have you received for this injury/episode?(Check all that apply)

None CT Scan MRI X-Rays Other: _____

Have you ever had any of the following?(Check all that apply)

- | | | |
|---|---|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Anemia | <input type="checkbox"/> Arthritis/Swollen Joints |
| <input type="checkbox"/> Asthma, Bronchitis, or Emphysema | <input type="checkbox"/> Blood Clot | <input type="checkbox"/> Bowel or Bladder Problems |
| <input type="checkbox"/> Breast Implants | <input type="checkbox"/> Cancer/Chemo | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Difficulty Sleeping | <input type="checkbox"/> Dizziness or Fainting |
| <input type="checkbox"/> Emotional/Psychological Problems | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Infectious Diseases | <input type="checkbox"/> Joint Replacement |
| <input type="checkbox"/> Metal Implants | <input type="checkbox"/> Numbness or Tingling | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Skin Conditions |
| <input type="checkbox"/> Severe or Frequent Headaches | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Thyroid Trouble/Goiter | <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Vision or Hearing Difficulties |
| <input type="checkbox"/> Other: _____ | | |

WORK ACTIVITY

Occupation: _____

- Sitting Standing
 Light Labor Heavy Labor

HABITS

- Smoking Packs/Day: _____
 Alcohol Drinks/Week: _____
 Coffee/Caffeine Drinks Cups/Day: _____
 High Stress Level Reason: _____

Please list any additional information that would assist us in providing care to you:
