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**: _____

Social Security Number: _____ - ____ - _____

☐ Single ☐ Married ☐ Separated

☐ Divorced ☐ Widowed ☐ Minor

EMERGENCY CONTACT

Name: _____

Relationship: _____

Phone: (____)_____

How did you hear about us?

_____

FINANCIAL RESPONSIBILITY

AGREEMENT TO PAY

Thank you for choosing us as your health care provider. We are committed to providing the highest quality of care and services to all of our patient. The following is a statement of our financial policy, which we require every patient to sign prior to any treatment.

By signing here, you agree to the following statements:
I understand that I am financially responsible for all charges, because I am not providing any insurance information to the Dr. Ibolit Clinic.

I understand that the Dr. Ibolit clinic will not provide any services to me without my prior approval, and I will have the ability to discuss prices at any point. If I choose not to receive any of the proposed treatment, I can decline at any time.

By signing below, I acknowledge my clear understanding of my full financial responsibility. I also understand that if I do not pay, this may negatively affect my credit score as the clinic attempts to collect any outstanding balance.

_____

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)

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

_____

_____

_____

_____

_____

Dr. Ibolit

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