MUSCLE RESTORATION THERAPY

Rapid Pain Relief ... for a Better Life!

Muscle Restoration New Client Intake Form

PATIENT INFORMATION

Name: _____ *Gender: M/ F Birth Date:* _____ / _____ / _____

Address: _____

City: _____ *State:* _____*Zip:* _____

Email Address: _____

Best number to reach you: (_____) _____ - _____

Emergency contact name: _____ *Phone: (_____) _____ - _____*

Main Duties of your occupation: _____

Primary Care Physician: _____

Who referred you to Muscle Restoration?

Name _____

MEDICAL HISTORY

Are you currently under a physicians care for acute or chronic illness? **Yes ( ) No ( )** If Yes, please explain: _____

_____

Are you currently under any form of therapy or treatment? **Yes ( ) No ( )** If Yes, please explain: _____

_____

Have you ever had acupuncture before? **Yes ( ) No ( )**

Do you have any allergies or hypersensitivities? **Yes ( ) No ( )** If Yes, please list all allergies:

_____

_____

Are you currently Pregnant? **Yes ( ) No ( )** If Yes, how far along/any high risk factors? _____

_____

Do you suffer from chronic pain? **Yes ( ) No ( )** If Yes, please explain: : _____

_____

- What makes your chronic pain worse? _____
- What makes your chronic pain better? _____

Have you had any orthopedic injuries? **Yes ( ) No ( )** If Yes, please explain: : _____

_____

Have you had x-rays, MRIs, or CT scans? **Yes ( ) No ( )** If yes, when and what areas: _____

_____

List all surgeries whether related to current problem or not: _____

_____

Are you currently taking any medications? **Yes ( ) No ( )** If yes, please list all prescription medications, over the counter medications, vitamins, supplements, and herbs you are currently taking. Please include dosage and frequency:

Medication/Supplement Name	**Dosage**	**Frequency**

Please check all the following that apply to you:

( ) Osteoporosis
( ) Recent Infection
( ) Recent fever
( ) HIV / AIDS
( ) Diabetes
( ) Corticosteroid Use
( ) Birth Control Pills
( ) High Blood Pressure
( ) Stroke (date:) _____)
( ) Dizziness / Fainting

( ) Osteopenia
( ) Numbness in groin/buttocks
( ) Urinary Retention
( ) Aortic Aneurysm
( ) Cancer/Tumor
( ) Recent Trauma
( ) Prostate Problems
( ) Frequent Urination
( ) Pregnancy (# of births _____)
( ) Abnormal Weight ( ) Gain ( ) Loss

( ) Epilepsy/Seizures
( ) Visual Disturbances
( ) History of Low/Mild Back Pain
( ) History of Low/Mild Back Pain
( ) History of Alcohol Use
( ) History of Tobacco Use

Family History:
( ) Cancer ( )Diabetes ( ) High Blood Pressure ( ) Cardiovascular Problems / Stroke

Do you wear orthotics or inserts in your shoes? _____ If yes for how long? _____.

If you wear orthotics or inserts, what was your reason for getting them:
_____
_____

Do you have Neuropathy or experience any tingling, numbness or burning in your feet or hands? If so, when did it begin?
_____
_____

CHIEF COMPLAINT

Please describe your current problem and when it began?_____
_____
_____

Are your symptoms: **Getting better ( ) Remaining the same ( ) Getting worse ( )**

Can you describe activities or movements that make you feel worse?
_____
_____

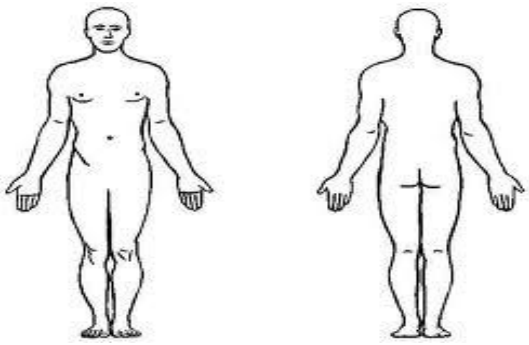
Can you describe activities or movements that make you feel better?
_____
_____

How do you feel today? _____

0 1 2 3 4 5 6 7 8 9 10

No pain Unbearable pain

Please circle areas on the body with pain and **indicate the level of the pain with a number (see rating system above).**



How often are your symptoms present: **( ) 0-25% ( ) 26-50% ( ) 51-75% ( ) 76-100%**

Can you perform your daily activities? **Yes ( ) No ( )**

Please describe:

_____

_____

Please check any of the following conditions that apply to you today:

☐ Headache ☐ Cuts, Bruises, Abrasions, or Sunburn ☐ Consumed Alcohol, Recreational Drugs, or Heavy Metals

☐ Rash or Hives ☐ Undiagnosed Lumps, Bumps, or Pain ☐ Broken Bones in the Last 3 Months

☐ Diarrhea or Vomiting ☐ Suffering from Fever, or Contagious or Infectious Disease

(If you checked any of the above boxes, today's treatment may have to be modified to avoid certain areas of your body.)

Notes to Therapist: _____

_____

_____

_____

_____

Please check any/all conditions that apply to your health currently or that you have experienced in the past.					
HEAD, EYES, EARS, NOSE, THROAT					
☐ Headaches / Migraines	☐ Vertigo / Dizziness	☐ Ringing in Ears	☐ Hearing Loss	☐ Earaches	☐ Vision Loss
☐ Eye Strains	☐ Eye Pain	☐ Glasses / Contacts	☐ Night Blindness	☐ Blurry Vision	☐ Cataracts
☐ Macular Degeneration	☐ Facial Pain	☐ Excess Mucus	☐ Nose Bleeds	☐ Sinus Problems	☐ Lip / Tongue Sores
☐ Gum Problems	☐ Excess Saliva	☐ Dry Throat	☐ Grinding Teeth	☐ Frequent Sore Throat	☐ Dry Mouth
☐ Jaw Clicks					
RESPIRATORY					
☐ Asthma	☐ Sinusitis	☐ Chronic Cough	☐ Bronchitis	☐ Emphysema	☐ Shortness of Breath
☐ Coughing Blood	☐ Pneumonia	☐ Frequent Colds	☐ Smoker	☐ Phlegm Production	☐ Family History of Respiratory Issues
NEUROLOGIC					
☐ Sensory Loss / Change	☐ Numbness / Tingling	☐ Sciatica	☐ Epilepsy	☐ Seizures	☐ Multiple Sclerosis
☐ Fainting	☐ Memory Loss	☐ Easily Stressed	☐ Paralysis	☐ Tremors / Twitches	☐ Loss of Balance
MUSCULOSKELETAL SYSTEM					
☐ Arthritis	☐ Joint Pain	☐ Gout	☐ Stiffness	☐ Weakness	☐ Family History of Arthritis
☐ Osteoporosis	☐ Tendinitis	☐ Bursitis	☐ Jaw Pain (TMJ)	☐ Muscle Spasms	☐ Broken Bones
☐ Pins / Plates / Wires / Artificial Joint					
FEMALE REPRODUCTIVE					
☐ Pregnant	☐ Given Birth	☐ Gynecological Problems			
CARDIOVASCULAR					
☐ High Blood Pressure	☐ Low Blood Pressure	☐ Heart Attack	☐ Stroke	☐ Heart Disease	☐ Poor Circulation
☐ Chest Pain	☐ Pacemaker	☐ Hemophilia	☐ Blood Clots	☐ Phlebitis / Varicose Veins	☐ Irregular Heartbeat
☐ Murmurs	☐ Calf Pain	☐ Swelling in Ankles	☐ Chronic Congestive Heart Failure	☐ Family History of Cardiovascular Problems	
SKIN/HAIR & INFECTIONS					
☐ Hepatitis	☐ HIV / AIDS	☐ Herpes	☐ Tuberculosis	☐ Rashes	☐ Lumps / Bumps
☐ Acne / Boils / Cores	☐ Itching	☐ Eczema	☐ Hair Loss	☐ Mole Changes	☐ Hives
☐ Lyme Disease	☐ Infectious Skin Conditions				

SWEAT					
☐ Easily Perspire	☐ Rarely Perspire	☐ Night Sweats			
SLEEP					
☐ Cannot Fall Asleep	☐ Wake Too Early	☐ Tossing / Turning	☐ Tired Upon Waking	☐ Wake Up Easily	☐ Excessive Sleep
☐ Snoring					
APPETITE					
☐ Large	☐ Average	☐ None	☐ Snacks Between Meals		
OTHER CONDITIONS					
☐ Cancer	☐ Diabetes	☐ Unexplained Weight Loss	☐ Hernia	☐ Fibromyalgia	☐ Depression
☐ Chronic Fatigue Syndrome	☐ Anxiety	☐ Psychiatric Disorder	☐ Digestive Conditions	☐ Other Conditions: _____	

HABITS/ENVIRONMENT

Do you exercise? **Yes ( ) No ( )** If yes, what kind and how often? _____

Do you follow a special diet? **Yes ( ) No ( )**

Daily water intake: _____ per day.

Do you use tobacco? **Yes ( ) No ( )** If Yes, how much per day? _____

Do you drink alcohol? **Yes ( ) No ( )** If Yes, how often do you drink? _____

I certify that the above information is complete and accurate. I understand that I am liable for all charges for services rendered and that my insurance coverage will most likely not include such services. I understand that my provider may need to contact my physician if my condition needs to be co-managed. Therefore, I give authorization to my provider to contact my physician, if necessary.

Signature: _____ Date: _____ / _____ /_____

CANCELLATION POLICY

Our appointment times are limited and are reserved just for you. If you need to reschedule your appointment for any reason, we require 24-hour notice so we may have time to schedule someone else.

****If a 24-hour notice is not provided, you may be charged for that appointment. If you do not show up for your appointment, you will be charged for that appointment.**

_____ _____

Client Printed Name Date

_____

Client Signature

INFORMED CONSENT TO TREAT

I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding the care recommended, the benefits and risks associated with the care, alternatives, and the potential effect on my health if I choose not to receive the care. Services provided by Muscle Restoration Therapy (MRT) are not intended to substitute for diagnosis or treatment by medical doctors or to be used as an alternative to necessary medical care. It is expected that you are under the care of a primary care physician or medical specialist, that pregnant patients are being managed by an appropriate healthcare professional, and that patients seeking adjunctive cancer support are under the care of an oncologist.

I hereby request and consent to the performance of treatments and procedures within the scope of services offered by MRT on me (or on the patient named below, for whom I am legally responsible) by the practitioner indicated below and/or other licensed professionals who now or in the future treat me while employed by, working or associated with, or serving as back-up for the practitioner named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, Muscle Restoration Therapy, SoftWave Therapy, PEMF therapy, Class IV laser therapy, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, nutritional counseling, and other therapeutic modalities. I understand that some therapies may involve physical manipulation, the application of heat or cold, use of devices, and other techniques. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with these treatments.

I appreciate that it is not possible to consider every possible complication to care. I have been informed that the treatments provided are generally safe, but, as with all types of healthcare interventions, there are some risks, including, but not limited to: bruising; numbness or tingling near the treatment site that may last a few days; dizziness or fainting; burns or scarring from heat-based therapies; and infection. Other uncommon risks may include nerve damage or organ puncture (in the case of acupuncture). Infection is a possible risk, although the clinic uses sterile, disposable needles and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. Some treatments may not be appropriate during pregnancy or while nursing. I will notify a clinical staff member who is caring for me if I am, or become, pregnant or if I am nursing.

While I do not expect the clinical staff to anticipate and explain all possible risks and complications of treatment, I wish to rely on the clinical staff to exercise judgment during the course of treatment which they believe is in my best interest. I understand that, as with all healthcare approaches, results are not guaranteed, and there is no promise to cure.

I understand that I must inform, and continue to fully inform, this office of any medical history, family history, medications, and/or supplements being taken currently (prescription and over-the-counter). I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

I understand that there are treatment options available for my condition other than the services offered at MRT. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, I understand that I have the right to a second opinion and to secure other options about my circumstances and healthcare as I see fit.

By voluntarily signing below, I confirm that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of services provided by MRT, and have had an opportunity to ask questions. I agree with the current or future recommendations for care. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

PATIENT NAME: _____

PATIENT SIGNATURE: _____ DATE: _____

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate:
It is understood that any dispute related to services provided by Muscle Restoration Therapy (MRT), including, but not limited to, claims of medical malpractice, whether any services rendered under this agreement were unnecessary, unauthorized, improperly, negligently, or incompetently provided, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process, except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this agreement are giving up their constitutional right to have any such dispute decided in a court of law before a jury and instead are accepting the use of arbitration. Further, the parties agree that there will be no right to participate in a class action or collective proceeding. An arbitration can only decide a dispute between the parties to this agreement and may not consolidate or join claims of other individuals or entities.

Article 2: All Claims Must be Arbitrated:
This agreement encompasses all disputes, whether related to medical malpractice or other issues, including disputes over the validity, enforceability, or applicability of this arbitration agreement. It is the intention of the parties that this agreement binds all parties to all claims, including claims arising out of or relating to services provided by MRT, its practitioners, or any other staff employed by, associated with, or serving as a back-up for MRT. This includes, but is not limited to, claims by the patient, their heirs, or past, present, or future spouses in connection with services provided by MRT.
This agreement also applies to any claims against MRT's associates, employees, agents, or estate, including, but not limited to, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages. All claims for monetary damages exceeding the jurisdictional limit of small claims court must also be arbitrated under this agreement.

Article 3: Procedures and Applicable Law:
A demand for arbitration must be communicated in writing to all parties involved. Each party shall select an arbitrator ("party arbitrator") and provide the contact information of the arbitrator to National Arbitration and Mediation ("NAM") within thirty (30) days of filing an initial responsive pleading. A third arbitrator ("neutral arbitrator") shall be selected by the party arbitrators from a list provided by NAM. Each party is responsible for an equal share of the neutral arbitrator's fees and expenses. Either party retains the absolute right to bifurcate liability and damages upon written request to the neutral arbitrator.
The arbitration will adhere to the applicable state and federal laws, including any provisions limiting non-economic damages or requiring judgments for future damages to be paid periodically. Where not in conflict with this agreement, the Healthcare Malpractice Dispute Resolution Rules and Procedures of NAM will govern the arbitration process.

Article 4: General Provisions:
All claims arising from the same incident, transaction, or related circumstances shall be arbitrated in a single proceeding. A claim is waived and barred if it is not pursued with reasonable diligence or if it would be barred by the statute of limitations applicable to a civil court action.

Article 5: Revocation:
This agreement may be revoked by delivering a written notice to MRT within thirty (30) days of signing. If not revoked, this agreement will apply to all services rendered by MRT and any disputes arising thereafter.

Article 6: Retroactive Effect:
If the patient wishes this agreement to apply to services rendered before the date of signature (e.g., emergency treatments), the patient must initial here: _____. This agreement is effective as of the date of the first professional service provided by MRT.
If any part of this agreement is found invalid or unenforceable, the remaining provisions shall remain in full force and effect.

NOTICE: BY SIGNING THIS AGREEMENT, YOU AGREE TO RESOLVE ANY CLAIMS AGAINST MUSCLE RESTORATION THERAPY THROUGH BINDING ARBITRATION. YOU ARE WAIVING YOUR RIGHT TO A TRIAL BY JURY OR COURT PROCEEDINGS.

Patient Name (Print):_____ Signature: _____ Date:_____

Parent or Guardian (Print):_____ Signature: _____ Date:_____