

# BREAKTHROUGHS IN HEALING

Client Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ zip \_\_\_\_\_  
Home ph# \_\_\_\_\_ cell# \_\_\_\_\_ wk# \_\_\_\_\_  
Emergency contact \_\_\_\_\_ (relationship) \_\_\_\_\_  
DOB \_\_\_\_\_ age \_\_\_\_\_  
If client is a dependent, please state name \_\_\_\_\_ relationship \_\_\_\_\_  
Occupation: \_\_\_\_\_ employer: \_\_\_\_\_

**Name of clients medical insurance** \_\_\_\_\_  
Phone# \_\_\_\_\_ address of primary insurance company \_\_\_\_\_

Name of primary subscriber: \_\_\_\_\_ Relationship to you: \_\_\_\_\_  
Primary subscriber's employment: \_\_\_\_\_  
Address: \_\_\_\_\_  
Subscriber# \_\_\_\_\_ Policy# Plan/group# \_\_\_\_\_  
Secondary insurance information (subscriber, company, numbers, etc.)  
\_\_\_\_\_

Referring Physician/Practitioner: (MD, DO, ND, DC, PAC, AARP)  
\_\_\_\_\_ Ph# \_\_\_\_\_

Is your injury/condition work related? Yes \_\_\_ No \_\_\_ Do you have an L&I claim opened? \_\_\_\_\_

If this is a personal injury case please provide name and phone number of your attorney.  
\_\_\_\_\_

I, the undersigned certify that I (or my dependent) have insurance coverage with \_\_\_\_\_

And assign directly to Breakthroughs in healing all insurance benefits, if any, otherwise payable to me for services rendered.  
I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the release of all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.  
Responsible Party Signature \_\_\_\_\_  
Date \_\_\_\_\_ Relationship \_\_\_\_\_

**MOTOR VEHICLE ACCIDENT ONLY (fill out this part\*\*)**  
**If your treatments are covered by motor vehicle insurance, please provide us with:**  
**Date of accident** \_\_\_\_\_, **Name, address and phone # of the insurance company** \_\_\_\_\_

**Claim#** \_\_\_\_\_ **claim manager** \_\_\_\_\_  
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**PERSONAL HEALTH HISTORY**

*Please give Date of Accident or Injury and Diagnosis/Pain description* \_\_\_\_\_

Reason for present visit: \_\_\_\_\_

To what extent does your condition interfere with your daily activities? (Work, sleep, quality of life, etc.) \_\_\_\_\_

Are you seeing a medical practitioner at this time? Yes \_\_\_No\_\_\_ Please explain \_\_\_\_\_

Have you received any treatment for your condition? (I.e. chiropractic, PT, massage, acupuncture, counselor, etc.?) \_\_\_\_\_

Name and address of doctor(s) or other healthcare practitioner(s) who have treated you for your condition:

Name \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

May we contact them to discuss your condition? Yes\_\_\_ please initial \_\_\_ No \_\_\_

Please list any medications you are currently taking \_\_\_\_\_

Supplements/vitamins/minerals \_\_\_\_\_

**Dental History:** Do you wear a dental night guard, appliance, or dentures, bridges, implants? Yes \_\_\_No\_\_\_ Explain \_\_\_\_\_

Have you had braces or a bridge placed on upper teeth across midline of upper palate? Yes \_\_\_No \_\_\_ Explain \_\_\_\_\_

Do you engage in stress reduction activities i.e. meditation, hobbies? \_\_\_\_\_

**PAST HISTORY** (Please list year and treatment received)

Was your birth traumatic i.e. c-section, vacuum extraction, tongs, unusually long/short labor? \_\_\_\_\_

Was the birth of any of your children traumatic (c-section, suction, tongs, unusually long/short. \_\_\_\_\_

Are you currently pregnant? Yes \_\_\_ No \_\_\_ If yes, how many weeks? \_\_\_\_\_

Hospitalizations \_\_\_\_\_

Serious injuries/accidents: \_\_\_\_\_

Do you have diagnostic x-rays, CAT scan, MRI, etc.? List and give approximate dates:

\_\_\_\_\_  
\_\_\_\_\_

**PERSONAL HABITS**

Do you have a regular exercise program?

\_\_\_\_\_  
\_\_\_\_\_

Is there any other additional information you feel I should know about? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

What do you hope for and what are your expectations from this treatment today and long-term? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Yes \_ No \_ Do you have tension or soreness in a specific area? Please explain

\_\_\_\_\_  
\_\_\_\_\_

Yes \_ No \_ Are you wearing contact lenses? \_\_\_\_\_

Yes \_ No \_ Do you have cardiac or circulatory problems? \_\_\_\_\_

Yes \_ No \_ Do you experience back pain? \_\_\_\_\_

Yes \_ No \_ Do you have numbness or tingling anywhere? \_\_\_\_\_

Yes \_ No \_ Do you have any contagious diseases? \_\_\_\_\_

Any Additional comments \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Authorization:**

I certify that the above information is correct to the best of my knowledge. I affirm that I have stated all my known medical conditions and answered all questions honestly. I will notify Heidi if changes in my condition occur.

Signature \_\_\_\_\_

**Medical Information**

**If you answer yes to any of the following questions, please explain as clearly as possible.**

- Yes \_ No \_ Do you frequently experience stress? \_\_\_\_\_
- Yes \_ No \_ Do you experience frequent headaches/migraines? \_\_\_\_\_
- Yes \_ No \_ Are you pregnant? Due Date \_\_\_\_\_
- Yes \_ No \_ Do you have arthritis? \_\_\_\_\_
- Yes \_ No \_ Do you have high blood-pressure? \_\_\_\_\_
- Yes \_ No \_ if yes to previous question, are you taking medication for this? \_\_\_\_\_
- Yes \_ No \_ Do you have diabetes? \_\_\_\_\_
- Yes \_ No \_ Do you have a history of epilepsy or seizures? \_\_\_\_\_
- Yes \_ No \_ Do you have joint swelling? \_\_\_\_\_
- Yes \_ No \_ Do you have osteoporosis? \_\_\_\_\_
- Yes \_ No \_ Do you have any allergies? If yes \_\_\_\_\_
- Yes \_ No \_ Do you have any prosthesis? \_\_\_\_\_
- Yes \_ No \_ Do you bruise easily? \_\_\_\_\_
- Yes \_ No \_ Have you had any broken bones in the past? \_\_\_\_\_

I agree to keep the practitioner updated as to any changes in my medical profile and I understand that there shall be no liability on the practitioner's Part should I fail to do so.

Client Signature \_\_\_\_\_ Date \_\_\_\_\_

**Consent to Treatment of Minor:** By my signature below, I hereby authorize Heidi Gould, OTR/L to give treatment to my child or dependent as they deem necessary.  
Signature of Parent or Guardian \_\_\_\_\_ date \_\_\_\_\_

**\*Please be aware that I request a 24-hour notice of cancellation unless an emergency occurs, and will charge my regular fee for missed appointments. I honor your time as well as mine and make attempts to call those on my waiting list upon You're Cancellation. Please initial \_\_\_\_\_**