Function First
Confidential Client Information Sheet

Name_____ Today's Date_____
(last) (first)

Address_____ Apt. No._____

City_____ State_____ Zip_____

Email_____ Age_____ Date of Birth_____ Weight _____

Phone Numbers- home(_____)_____ work(_____)_____

mobile(_____)_____ fax(_____)_____

Occupation_____ Employer_____

Employer's Address_____ Suite No._____

City_____ State_____ Zip_____

Personal Physician_____ Phone
Number(_____)_____

Emergency contact & relationship_____Phone Number(_____)_____

Who can we thank for this referral?_____

Why have you chosen to work with Function First?_____

_____

List 3 things you would like to be able to do after your sessions with Function First, that you can not do now (i.e. golf, pick up grandchild, sit through a movie etc.).

1._____2._____3._____

If you would like us to contact a friend or family member about our service, please provide their name and best way to contact them:

Name_____ Contact (phone or email)_____

Initial_____

Present Problems

Location & Type (i.e. sharp, dull, etc)	Pain Rating (0=no pain, 10=worst possible pain ever)	Date of Onset
1. _____	_____	_____-_____-_____
2. _____	_____	_____-_____-_____
3. _____	_____	_____-_____-_____
4. _____	_____	_____-_____-_____

Do you have any recommendations or restrictions from you physician? □ Yes □ No

If yes, please explain_____

Do you have a specific diagnosis from your physician?_____

Mechanism of Primary Problems_____
Problems are getting: □ Better □ Worse □ Same

What makes you feel better? _____

What makes you feel worse?_____

What care are you currently under?
- □ Acupuncturist
- □ Chiropractor
- □ Massage Therapist
- □ Nutritionist
- □ Personal Trainer
- □ Physical Therapist
- □ Physician
- □ Other:_____

If employed, what are you current job activities?
- □ Bending/Stooping
- □ Driving/Traveling
- □ Extensive phone time
- □ Lifting
- □ Prolonged sitting
- □ Prolonged standing
- □ Sitting at computer
- □ Walking
- □ Other:_____

Do you currently wear orthotics? □ Yes □ No

Do you currently take any medications? □ Yes (If yes, please list) □ No

_____

Do you currently smoke?: □ Yes □ No If yes,_____ packs a day

Initial_____

On average, how many hours of sleep do you get each night? _____

Are you aware of any eye dominance? □ Yes □ No If yes, _____ eye

Are you currently working out at a gym? □ Yes □ No

Do you have any home exercise equipment?
□ Balance Board
□ Physioball
□ Stationary Bike
□ Treadmill
□ Tubing
□ Weights
□ Other:_____

Past Medical History

Do you have a history of:
□ Arthritis
□ Balance Problems or Disturbances
□ Broken Bones
□ Burning or tingling in arms or legs
□ Cardiac Risk Factors
□ Childbirth
□ Natural □ C-Section
□ Fibromyalgia
□ Gastrointestinal Issues
□ High Blood Pressure
□ Hip Dysplasia
□ Inner Ear Infections and/or Damage
□ Joint Replacement
□ Leg Length Discrepancy
□ Low Back Pain
□ Osteoporosis
□ Plantar Fasciitis
□ Sciatica
□ Scoliosis
□ Significant weight gain in past year
□ Tendinitis
□ Visual Problems
□ Other(s):_____
_____

What past treatments have you tried to treat your pain?	**Did it help?**
□ Acupuncture	□ Yes □ No
□ Chiropractic	□ Yes □ No
□ Exercise	□ Yes □ No
□ Massage	□ Yes □ No
□ Medication	□ Yes □ No
□ Physical Therapy	□ Yes □ No
□ Surgery	□ Yes □ No
□ Other(s):_____	□ Yes □ No

Surgeries: _____

Accidents/Injuries**:**_____

I declare that the above information is true and accurate to the best of my knowledge.

Signature_____**Today's Date**_____

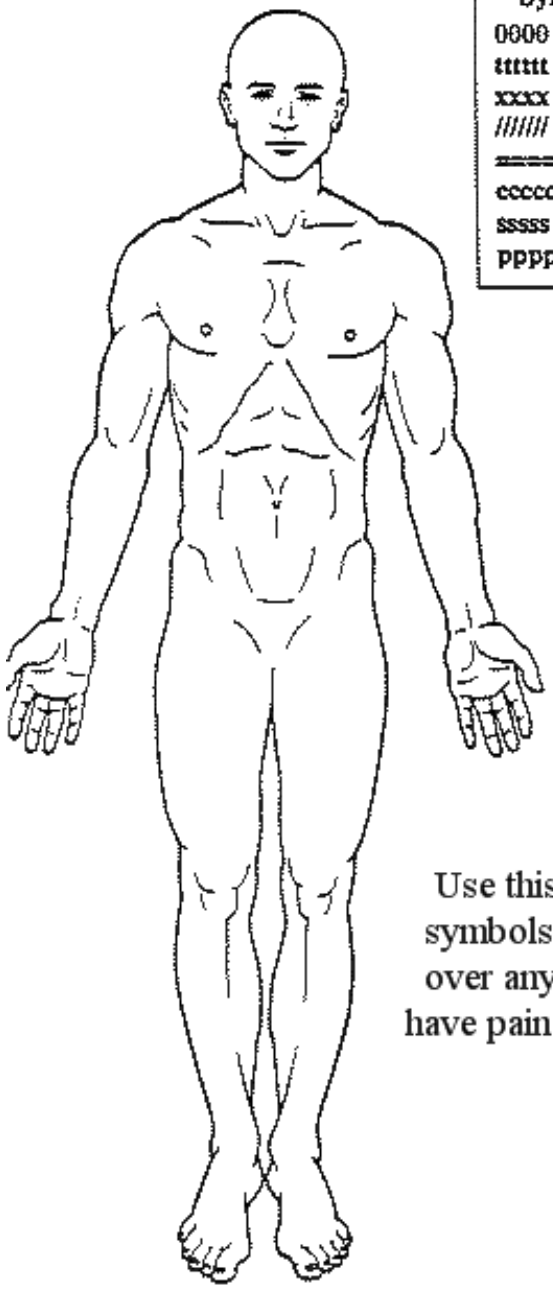
Parent/Guardian (if a minor)_____

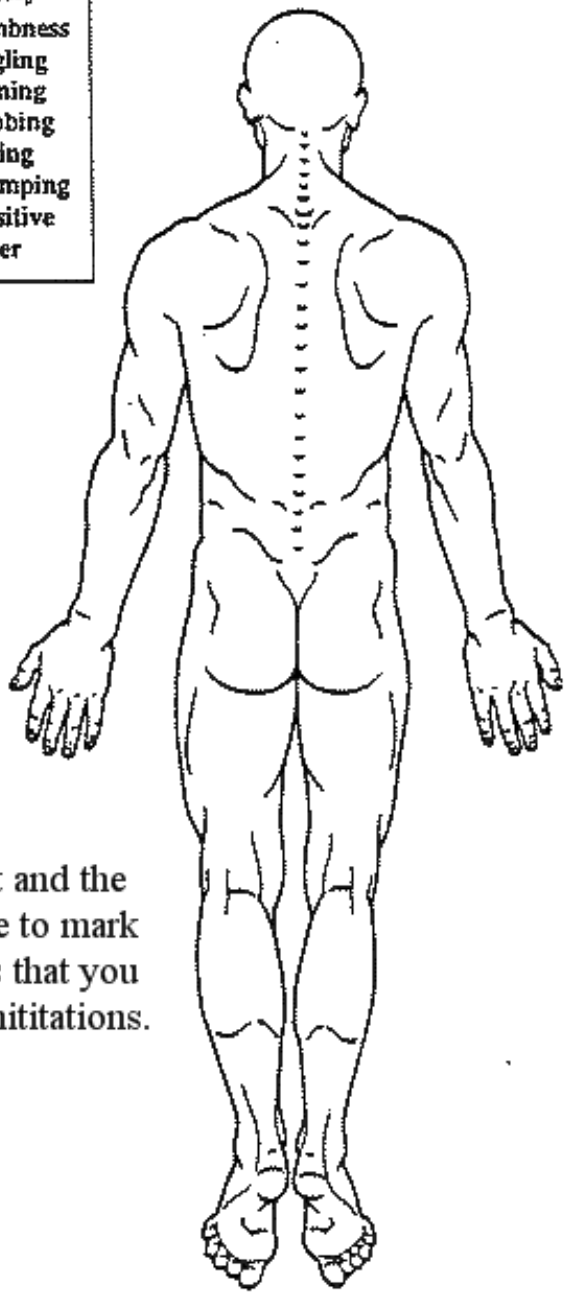
Name _____ Date _____

WHOLE BODY SYMPTOM DESCRIPTION

© EPIC 1/94

Symptom Key	
0000	Numbness
ttttt	Tingling
xxxx	Burning
//////	Stabbing
====	Aching
ccccc	Cramping
sssss	Sensitive
pppp	Other





Use this chart and the symbols above to mark over any areas that you have pain or limititations.

Anthony Carey, Inc. DBA Function First

CONSENT TO PARTICIPATE IN AN EXERCISE PROGRAM
ACKNOWLEDGEMENT OF INFORMED CONSENT
AUTHORIZATION TO RELEASE INFORMATION
ASSIGNMENT OF BENEFITS

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1. CONSENT TO PARTICIPATE: I voluntarily authorize and give consent to Anthony Carey, Inc. to provide its services to me. This includes, but is not limited to, assessments, exercise prescription, and other corrective procedures.

I acknowledge that no guarantees have been, or can be, made to me as to the result of the services provided at Anthony Carey, Inc..

I understand that the services provided by Anthony Carey, Inc. are not a substitute for medical examination or diagnosis, and it is recommended that a physician be consulted for that service.

2. ACKNOWLEDGMENT OF INFORMED CONSENT: I understand that I will be informed of the potential risks and benefits of all services provided by Anthony Carey, Inc.. I understand that I have the right to consent, or to refuse consent, to any procedure, exercise, movement or service offered or suggested by Anthony Carey, Inc..

3. AUTHORIZATION TO RELEASE INFORMATION: I authorize the release of any information contained in my Anthony Carey, Inc. record for the following purposes:

a. at my request, to assist in processing my insurance claims,
b. provide information to my health professional referral source,
c. provide information to my personal physician.

4. ASSIGNMENT OF BENEFITS: I understand that payment for services provided by Anthony Carey, Inc. will be made at the time services are rendered or in advance of services rendered by agreement, unless, other financial arrangements are made in advance.

_____ (initial) I understand that if I am covered by **Worker's Compensation Insurance** that pre-authorization is required before any services can be rendered. I authorize and assign the payment of medical benefits to Anthony Carey, Inc..

5. _____ (initial) **CANCELLATION POLICY**: I understand that Anthony Carey, Inc. requires a minimum of 24 hours notice for any cancelled appointment. This is necessary to meet the needs of all our clients and to provide the best possible service. I understand that a **$25.00 fee** will be charged to me for the first cancellation that occurs with less than 24 hour notice or for the first "no-show" or missed appointment. I also understand any future occurrences will be e billed to me at the **full cost of the appointment.**

_____ (initial) **6. PREPAYMENT for 12 or 16 Session Package**: I understand upon completion of the 4th visit that there will be no refund for the remaining balance. However, Anthony Carey, Inc. will honor any remaining visits for up to 6 months from the date of payment. In addition, any prepayment made for future sessions will be honored up to 6 months from the date of payment. Any unused portion will not be refunded or honored.

Signature**:** _____Date: _____

Parent / Guardian: _____Date: _____(if a minor)

***A photocopy of this form shall be considered as valid as the original.**