Asheville Pain & Performance Intake Form

Initial Appointment Date_____

Last Name_____ First Name_____

Home Phone (____)_____ Work (____)_____ Cell (____)_____
E-mail (office use only)_____
Occupation_____
Date of Birth _____ Height_____ Weight_____ Sex _____
How did you find out about me?
_____
If referred by someone, may I thank them?

What are your specific goals in working with me?

Are you
seeking treatment for a specific injury?

Has it been getting better or worse? (Circle one)

Describe how it feels: (aching, cramping, dull, sore, deep, sharp, shooting, stabbing, stinging, tingling, burning,numbness, radiating - if so where?)

Please list all surgeries and approximate dates:

Were they beneficial?

Do you wear orthotic inserts in your shoes? _____ Yes ____
_ No

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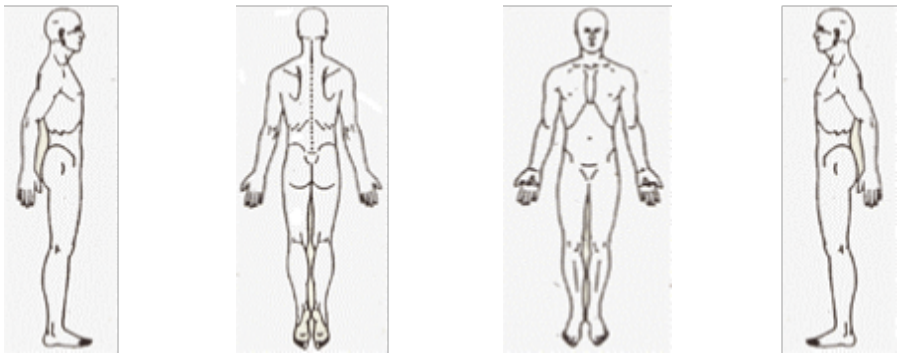
Please circle on the figure below your primary areas of pain/discomfort/restriction



Voluntary and informed consent

I understand that I am not required to have a physicians referral to receive neuromuscular therapy and manual medicine. By signing this document, I assume all responsibility and risk for my health and well being, and hold Stephen Opper,LMBT harmless and indemnify him from any and all claims, losses, costs, expenses, damages, and liabilities arising out of the delivery and receipt of his therapeutic services, other than that which is due to gross negligence or willful misconduct.

I understand that Stephen Opper,LMBT uses manual therapy techniques requiring him to place his hands directly on my body, and may include the use of deep and sustained pressure. I agree that if I experience pain or discomfort during my session I will let Stephen know so that he can adjust his technique accordingly.

Signed_____Date_____

Guardian signature (if under 18)_____

Cancellation policy

Payment for services received from Stephen Opper,LMBT is due at the time of treatment. Stephen Opper will provide invoices & receipts for third-party insurance reimbursement or Flexible Spending Accounts upon request.

• 24 hours notice of cancellation is required for all scheduled appointments. Cancellations with more than 24 hours notice not will not be subject to a fee.

• Cancellations with less than 24 hours notice will be subjected to one-half of the cost of treatment: $35 for a 1 hr appointment, $50 for a 90 min appointment.

• Missed appointments without prior notice will be responsible to pay the full visit amount.

I have read and agree to the payment and cancellation policy explained above.

_____ _____

Signature Date

Guardian signature (if under 18)_____