Asheville Pain & Performance Intake Form

Initial Appointment Date_____
Last Name_____ First Name_____
Address_____
City_____ State_____ Zip_____
Country_____
Home Phone (____)_____ Work (____)_____ Cell (____)_____
E-mail (office use only)_____ Fax (____)_____
would you like me to contact you with updates, special offers, etc.? Yes____ no___
Occupation_____
Date of Birth _____ Height_____ Weight_____ Sex _____
Children, if any:_____
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 your condition been diagnosed by a physician?
If so, what is it, and by who?

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?)

How did it start the first time and this time, if this is not the first? (Sudden or gradual onset and mechanism of injury)

How often does it bother you? (Constant all the time, everyday, __x per week __x per month)
How long does it last once it is there? (Always there, __ minutes/hours, no pattern)
What specifically makes it worse? (Certain movements/activities, stress, time of day, no pattern)
What makes it feel better? (Certain movements/activities, heat/ice, time of day, therapies, nothing)

Other therapies/remedies tried and results:

Please list all surgeries and approximate dates:

Were they beneficial?

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List any other health problems for which you are being treated:

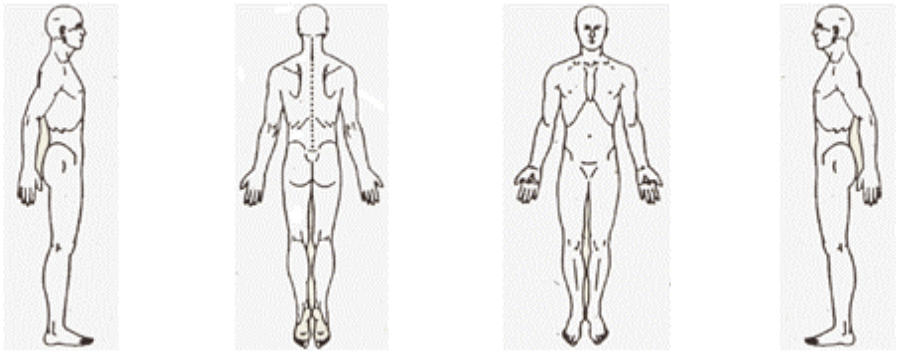
Do you have any preexisting conditions that relate to this present injury? YES☐ NO ☐
If yes, please explain:

Current Pharmaceutical Medications _____
_____

Current herbs, supplements or homeopathic medicines _____
_____

Do you exercise regularly?
What type, and how often?
Do you stretch regularly?
Other Activities/Hobbies:
Do you believe it is possible to heal 100%? If not, what %?
How long do you feel it will take?
On a scale of 0-10, how much effort are you willing to put in to achieve maximum healing? 1 2 3 4 5 6 7 8 9 10
Circle the level of stress you are experiencing on a regular basis on a scale of 1 to 10 (1 being the lowest): 1 2 3 4 5 6 7 8 9 10

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



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Please review this list and check (√) current or (X) past conditions that have affected you:

Achilles Tendon Contracture □ Tendonitis □ Sciatica □
Arthritis □ Frozen Shoulder □ Thoracic Outlet
Syndrome □ Knee Pain □ Trigger Finger □
Piriformis Syndrome □ Whiplash Injury □ TMJ disorder □
Frequent Headaches □ Migrane headaches □ Chronic Low Back Pain □
Scoliosis □ Stroke □ Carpel Tunnel Syndrome □
Muscle Strain/Sprain □ Heart conditions □ Herniated/Bulging Disk □
Varicose Veins □ Seizures □ Plantar Fasciitis □
Shin Splints □ High Blood Pressure □ Chronic fatigue syndrome □
Fibromyalgia□ Sinus Problems□ Liver or gallbladder disease (stones) □
Thyroid trouble□ Auto-immune condition* □ *(Fibromyalgia, chronic fatigue, lupus, etc.)
Infectious Disease □ (HIV/AIDS, chronic bronchitis, etc) □ Other

(Women)
□ Menstrual Irregularities □ Endometriosis □ Fibrocystic breasts
□ Fibroids/ovarian cysts □ PMS □ Breast Cancer
□ Surgical Menopause □ Menopause □ Other

If any of the above information needs to be detailed, or if you have suffered from any other form of chronic pain, please explain.

_____

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

Health Habits:
Do you use tobacco?
What form and how frequently?

How frequently do you drink alcohol?

Nutrition and Diet
Do you have a special diet?
If yes, please explain:

Specific Food Restrictions
□ Dairy □ Wheat
□ Eggs □ Soy
□ Corn □ Oil □ Gluten
□ Other:

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)_____