Ayelet Connell Wellness

Helping you live a healthy life!

Client Information: Client Name: _____ Date of Birth: _____ Date of Evaluation: _____

Single ___ Married ___ Divorced ___ Separated ___ Widowed ___ Partnered ___

Street Address: _____ City: _____ State: ____ Zip Code: _____

Home Phone: _____ Work: _____ Cell: _____ Email Address: _____

If Child, Parent/Guardian's Name: _____

Employer: _____ Occupation: _____

Referring Physician: _____ Phone: _____ Address: _____

How did you hear about us? _____

In case of emergency, please list best contact information:

Name: _____ Phone: _____ Relationship: _____

Insurance Information:

Are you submitting to insurance? Yes ____ No ____

If yes, please provide your insurance information below:

Insurance carrier: _____ ID Number: _____

Policy Holder: _____ Policy Holder's date of birth: ___/___/____

Chief Complaint(s)/Diagnosis(es):

Please share with us your chief complaint(s)/diagnosis(es) that brought you here today:

1. _____
2. _____
3. _____

Was it because of a: Car accident? Yes __ No __ / Work-related injury? Yes __ No __ / Fall? Yes __ No __

When did your current pain / problem begin? _____

Past Medical History: (Include all surgeries and traumas)

1. _____
2. _____
3. _____

Medications:
Please list your current medications, over the counter medications and/or supplements you are taking:

_____

_____

□ Attach a piece of paper if needed.

Pain/Symptoms:
Location of pain / symptoms: _____

_____

Pain Level (0-10): Now _____ Best _____ Worst _____

Is the pain (please circle one): Constant / Intermittent / Improving / Worsening / Not Changing

What makes pain/symptoms worse? _____

What makes pain/symptoms better? _____

Please tell us about any areas of your body where you feel numbness, pins and needles, and burning:

_____

Work: Occupation/job requirements: _____

When did you last go to work? _____
Function:

Current Exercise and frequency/duration: _____

_____

Previous Level of Exercise and frequency/duration: _____

_____

Current Health Habits:

☐ Tobacco ☐ Alcohol ☐ Caffeine ☐ Soda w/caffeine ☐ Diet Sodas ☐ Other:_____

Nutrition and Diet:

☐ Gluten Free ☐ Salt Restriction ☐ Low Fat Diet ☐ Low Carbohydrate Diet ☐ Vegetarian/Vegan
☐ Paleo Diet ☐ Other: _____

Specific Food Restrictions:

☐ Dairy ☐ Eggs ☐ Soy ☐ Corn ☐ All Gluten ☐ Wheat ☐ Sugar ☐ Other: _____

Activities of daily living are compromised as follows:

Bed Activities: ☐ Painful ☐ Difficult ☐ Not Possible
Transfer Activities: ☐ Lying to sit is ☐ Painful ☐ Difficult ☐ Not Possible
☐ Sit to lying is ☐ Painful ☐ Difficult ☐ Not Possible
☐ Sit to stand is ☐ Painful ☐ Difficult ☐ Not Possible
Standing is: ☐ Painful ☐ Difficult ☐ Not Possible Present **comfortable** tolerance: _____ min/hours
Sitting is: ☐ Painful ☐ Difficult ☐ Not Possible Present **comfortable** tolerance: _____ min/hours
Driving is: ☐ Painful ☐ Difficult ☐ Not Possible Present **comfortable** tolerance: _____ min/hours
Sitting in a car is: ☐ Painful ☐ Difficult ☐ Not Possible Present **comfortable** tolerance: _____ min/hours
Walking is: ☐ Painful ☐ Difficult ☐ Not Possible Present **comfortable** tolerance: _____ min/hours
Running is: ☐ Painful ☐ Difficult ☐ Not Possible Present **comfortable** tolerance: _____ min/hours
Work is: ☐ Painful ☐ Difficult ☐ Not Possible Present **comfortable** tolerance: _____ min/hours
Stairs are: ☐ Painful ☐ Difficult ☐ Not Possible
Bending and lifting activities are: ☐ Painful ☐ Difficult ☐ Not Possible
Reaching activities (with arms) are: ☐ Painful ☐ Difficult ☐ Not Possible
Sport and leisure activities are: ☐ Compromised ☐ Not Possible
Other: _____ ☐ Painful ☐ Difficult ☐ Not Possible
☐ **All activities/ADL's** are performed despite ☐ pain ☐ fatigue ☐ lack of energy

Current Goals for Therapy:

1. _____
2. _____
3. _____
4. _____
5. _____

Acknowledgement of Receipt of Notice of Privacy Practices (HIPAA):

I, (print) _____, hereby acknowledge that I received a copy of the Notice of Privacy
(Patient/Parent/Guardian)
Practices. I further acknowledge that I may request a copy of any amended Notice of Privacy Practices at each appointment.

Patient Name (print): _____ Date: ___/___/_____

Signature: _____ Relationship to Patient: _____

Financial Policy: Please read and initial:

_____ Ayelet Connell Wellness LLC does not participate with private insurance carriers. It is our policy to collect payment at time of service. Patients are financially and legally responsible for charges incurred. We accept Checks, Cash, Visa, MasterCard, American Express, and Discover.

Cancellations and Missed Appointments: Please read and initial:

_____ Patients are responsible for all appointments they have scheduled. Patients who choose not to attend or call to cancel their appointments are still responsible for these appointment times. Fees for missed appointments and/or late cancellations are expected at or before the patient's next scheduled appointment. Insurance does not cover these fees.

_____ 48 HOURS NOTICE IS REQUIRED TO CANCEL EACH APPOINTMENT YOU HAVE SCHEDULED.

_____ FOR ANY LATE CANCELLATION OR MISSED APPOINTMENT, THE CHARGE WILL BE: $120.00/hour

Authorization for Release of Records: Please read and initial:

_____ I authorize Ayelet Connell Wellness LLC to release pertinent clinical and account information to the following insurance companies and/or healthcare providers to facilitate my reimbursement and/or to facilitate my clinical well-being and coordination of care:

1. _____
2. _____
3. _____
4. _____

Ayelet Connell Wellness LLC Agreement: I, (print) _____, understand and agree to all of the terms and conditions that have been explained herein and acknowledge that the agreement will be in full force and effect. Patient Name: _____;

Patient/Guardian Signature: _____ Date: ___/___/_____