MEDICAL HISTORY FORM

Patient Name: _____

Area of Symptoms: _____ Age: _____

Date of Onset: _____

Please take a moment to complete the questions below. Depending on your answers, we may modify our treatment procedures for their effectiveness and your safety. Thank you.

Any known results of recent x-rays or tests: _____

_____

Chronic Conditions: Yes ☐ No ☐ If yes, please list: _____

_____

Allergies: Yes ☐ No ☐ If yes, please list: _____

_____

List surgeries and dates: _____

Medications: Yes ☐ No ☐ If yes, please list: _____

_____

Do you have or have you had any of the following:

Cancer	Yes ☐ No ☐	High Blood Pressure	Yes ☐ No ☐
Diabetes	Yes ☐ No ☐	Metal Implants	Yes ☐ No ☐
Epilepsy or Seizures	Yes ☐ No ☐	Respiratory Problems	Yes ☐ No ☐
Heart Disease	Yes ☐ No ☐	Are you pregnant?	Yes ☐ No ☐

1. How would you rate your ability to perform routine daily activities:

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

Unable to perform No Problems

2. How would you rate your ability to perform the activities associated with you job:

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

Unable to perform No Problems

3. How would you rate your current pain:

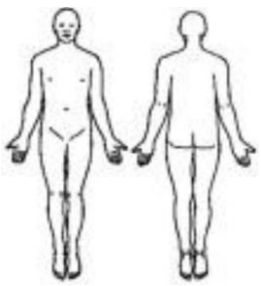
0 1 2 3 4 5 6 7 8 9 10

None Emergency Room

4. How many days since your current injury? ☐ 0-30 days ☐ 31-90 days ☐ 90+ days

Please draw your pain on the body to the right using the following symbols:

///	Stabbing pain
xxx	Burning
ooo	Pins and needles
===	Numbness



Patient Registration Form

First Name _____ MI _____ Last Name _____

Preferred Name _____ Pronoun ☐He ☐She ☐Per ☐They ☐Xe ☐Ze

Date of Birth ____/____/____ Birth Sex ☐Male ☐Female

Mailing Address

_____

_____

Physical Address

_____

_____

Cell Phone _____ Email _____

Home Phone _____ Work Phone _____

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Other

Interpreter required? ☐ Yes No Language _____

Emergency Contact _____

Phone _____ Relationship _____

Was your injury a result of an accident? ☐ Yes ☐ No *If yes, please answer the questions below...

*Type of accident ☐ Work ☐ Auto ☐ Other

If work related...

*Employer _____

*Job Title _____

*Address _____

_____

*Phone _____

If accident related & have an attorney...

*Attorney _____

*Address _____

_____

*Phone _____

*Employment Status ☐ Full Time ☐ Part Time ☐ Disabled ☐ Student
☐ Self Employed ☐ Active Duty ☐ Retired ☐ Other

If you are eligible for Medicare benefits, please complete this section.

Please check all applicable boxes below if you are receiving any of the following benefits.

☐ Black Lung Benefits
☐ Government benefits (i.e. Research Grant)
☐ Department of Veteran's Affairs
☐ Group Health Plan Coverage
☐ Medicare due to disability
☐ Medicare due to ESRD or kidney transplant
☐ HMO or Group Health Plan
☐ Medicare while employed or spouse employed
☐ Medicare due to age

Patient Name _____

AUTHORIZATION TO RELEASE/OBTAIN INFORMATION

I hereby authorize the release of any and all information to my insurance company or other appropriate party, as required, pertaining to treatment rendered to me by H2 Health and its affiliates. Further, I authorize H2 Health and its affiliates to obtain needed information from my physician, employer or insurance company.

CONSENT TO TREATMENT

I hereby consent to the treatment as prescribed by my physician and provided by H2 Health and its affiliates, its employees, or representative.

NOTICE OF PRIVACY PRACTICES (NPP)

I acknowledge that I have been shown the posted Notice of Information Practices by H2 Health and its affiliates. This notice explains how H2 Health and its affiliates may use and disclose my protected health information. Upon request, I will be provided a copy so I may read it in full or I can download the latest version from the company's website, www.h2health.com. By signing below, I acknowledge the presentation/availability of the NPP. If I have questions regarding this NPP, I can contact the Privacy Officer at PrivacyOfficer@h2health.com .

ASSIGNMENT OF BENEFITS & FINANCIAL RESPONSIBILITY

I hereby assign all medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to H2 HEALTH and its affiliates for medical services rendered to myself and/or my dependents. I understand that I am responsible for any amount not covered by insurance. All accounts are due and payable upon receipt of the bill. All accounts are subject to a $5.00 supply charge for supplies and equipment such as lotions, gels, therabands, theraputty, modality and infection control supplies, etc. that are not generally reusable and are prepared and used on an individual basis. The cost will be included as a one time charge on your initial visit as permitted by your medical plan.

PHOTO CONSENT

☐ I grant permission and give my consent to H2 Health and affiliates (the "Releasee") for the use of photograph(s) or electronic media for presentation under any legal use. I understand that I may revoke this authorization at any time by notifying H2 Health in writing. The revocation will not affect any actions taken before the receipt of this written notification.

☐ I decline the use of any photograph(s) or electronic media.

_____ _____

Patient Signature Date

I do hereby voluntarily consent to and authorize care encompassing all diagnostic and therapeutic activities considered necessary in the judgment of my therapist for the minor child/principal _____.
This form has been fully explained to me and I certify that I understand and accept its contents as noted.

_____ _____

Patient Representative (Guardian or POA) Date

**For Office Use Only*

Reasons why the acknowledgment was not obtained.

☐ Patient refused to sign NPP ☐ Other _____

_____ _____

H2/Affiliate Representative Name (Print) H2/Affiliate Representative Signature