Name: _____ **Date of Birth**: _____

Email: _____ **Phone Number:** _____

Emergency Contact (name, phone number, relationship): _____

Medical History

List all medications (prescription & non-prescription): _____

_____

_____

List all allergies: _____

Have you had a fall in the past year? (circle) YES NO

Do you now or have you ever had any of the following? Please include all history:

__ Coronary Heart Disease
__ Pacemaker
__ Shortness of breath
__ High/low blood pressure
__ Stroke/TIA/Blood clot
__ Chest pain (angina)
__ Heart attack
__ Congestive heart failure
__ Anemia
__ Pins or metal implants
__ Cancer
__ Hepatitis
__ Do you smoke?
__ Asthma/Bronchitis/Emphysema
__ Epilepsy or seizures
__ Thyroid disease
__ Diabetes
__ Gout
__ Osteoporosis
__ Bowel/bladder changes
__ Numbness or tingling
__ Vision/hearing problems
__ Arthritis
__ Dizziness
__ Are you pregnant?
__ Sleeping difficulty
__ Weakness
__ Unexplained weight loss
__ Fatigue
__ Depression/anxiety
__ Shoulder injury
__ Back injury
__ Elbow/hand injury
__ Knee injury
__ Neck injury
__ Foot/ankle injury
__ Hip injury

Surgical history (including year): _____

_____

_____

Other: _____

_____

_____

Patient/Guardian Signature: _____ **Date**: _____

Patient Health Questionnaire

Name: _____

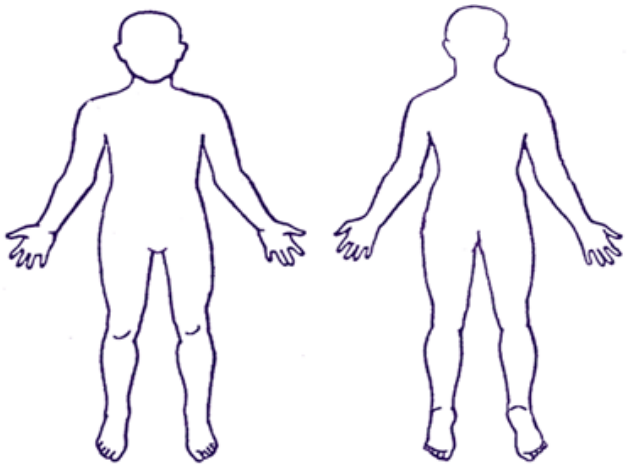
Describe your symptoms: _____

_____

When did your symptoms start? _____

How did your symptoms start? _____

Indicate below where you have pain or symptoms:



How often do you experience your symptoms?

__ Constantly (75-100% of the day)
__ Frequently (50-75% of the day)
__ Occasionally (25-50% of the day)
__ Intermittently (0-25% of the day)

What describes your symptoms?

__ Sharp __ Shooting __ Dull ache
__ Burning __ Throbbing __ Numb/tingling

How are your symptoms changing? (circle)

Getting better Getting worse Not changing

During the last month:

1. Circle the average intensity of symptoms: (none) 0 1 2 3 4 5 6 7 8 9 10 (severe)
2. How much has pain interfered with your normal work (including housework and occupation)?
   a. __ Not at all __ A little bit __ Moderately __ Quite a bit __ Extremely
3. How much of the time has your condition interfered with your social activities?
   a. __ Not at all __ A little bit __ Some of the time __ Most of the time__ All the time

In general, how would you describe your current overall health?

__ Excellent __ Very good __ Good __ Fair __ Poor

What have you tried to improve your symptoms?

__ Physical therapy __ Chiropractic __ Medical doctor __ Injections __ Cold/hot packs
__ CBD/alternative __ Medication __ Other: _____

What tests have you had for your symptoms and when were they performed?

X-rays: _____ MRI: _____ CT scan: _____ Other: _____

What is your occupation? _____

Patient/Guardian Signature: _____ **Date:** _____

Acknowledgment of Notice of Privacy Practices

____ (Initial) I acknowledge and agree that I have been informed to read the Notice of Privacy Practices Policy on BOOST SPORTS PERFORMANCE, LLC's website. In addition, I acknowledge I can request a copy of the Notice of Privacy Practices in writing at any time.

Acknowledgment of Surprise Billing Disclosure

____ (Initial) I acknowledge and agree that I have been informed to read the Surprise Billing Disclosure on BOOST SPORTS PERFORMANCE, LLC's website. In addition, I acknowledge I can request a copy of the Surprise Billing Disclosure in writing at any time.

Cancelation and No-Show Policy

____ (Initial) It is the patient's responsibility to give BOOST SPORTS PERFORMANCE, LLC at least 24 hours' notice if they are unable to attend an appointment. All efforts will be made to reschedule a canceled appointment within the same week to stay on the patient's recommended plan of care. Our time is valuable to our patients and this policy allows us to offer appointments to all patients in a timely and effective manner. If a patient has 3 or more canceled or no-showed appointments, they will be changed to "Day-Of Scheduling" status and not allowed to schedule appointments on future days.

Informed Consent

"Informed Consent" is a process for getting permission before we provide therapeutic services to you, the patient. A sound informed consent includes an explanation of the potential risks, benefits, and alternatives to any treatment that has been proposed to you or, in the case of a minor, your representative. We will discuss the Plan of Care established for you and give you ample time to ask questions about it; your consensus is a critical part of achieving a successful outcome.

Potential Benefits: You may experience improvement in your symptoms and functional activities as well as resolution of other key complaints or problems. In addition to treatment, we provide education to you about your condition throughout your episode of care. This education is often accompanied by handout material that you can refer to regarding proper techniques and home program execution. These resources will help you maintain a sound level of function and will also help you minimize symptoms, should they reoccur.

Potential Risks: You may experience an increase in your current level of pain, if pain is part of your complaints. Many times increased activity or therapy interventions will bring on some discomfort, this is usually temporary. If your pain or discomfort does not subside within twenty-four (24) hours, you should discontinue any home program involving that particular activity, if applicable, and contact your therapist.

Alternatives: We establish a Plan of Care based on the best interventions for your condition, but on occasion our choice of treatment is not well tolerated. You are asked to voice any unfavorable reaction you experience to any aspect of your treatment so that we can modify or terminate it promptly and progress your rehabilitation. If you decide not to continue your participation in your therapy program you will be asked to consult with your physician about other treatment alternatives.

No Warranty: Please note that we cannot make any promises or guarantees regarding a full resolution of and/or correction of your condition. We will, however, work in conjunction with you to achieve optimal improvement.

I have read the above information, and I consent to the evaluation(s) and treatment provided by Boost Sports Performance, LLC

Name: _____

Signature: _____ Date: _____