



# Flexibly Fit™

*"Where restoration of functional design begins"*

(916) 834-1711

FLEXIBLYFIT.COM

A Subsidiary of Knowmor, Inc.

## PATIENT REGISTRATION FORM

Patient's Name \_\_\_\_\_ Sex: M F (circle one)

Patient's Address \_\_\_\_\_  
Street Apt # City State Zip

Mailing Address (if different from above) \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Patient's Date of Birth \_\_\_\_\_ Driver's License #: \_\_\_\_\_

Patient Referred By \_\_\_\_\_  
Name Address Phone # Fax #

Current Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Marital Status (circle one)    Single    Married    Widowed    Divorced    Separated

Name of Spouse \_\_\_\_\_ Spouse's Phone # \_\_\_\_\_

### **If Patient is a Minor**

Responsible Party \_\_\_\_\_

Relationship to Patient:    Parent    Step-Parent    Other \_\_\_\_\_ (circle one)

Street Address \_\_\_\_\_  
Street Apt. # City State Zip

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Mailing Address (if different from above) \_\_\_\_\_

### **Emergency Contact**

Name and phone number of relative/friend who **does not** live with the patient

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Phone \_\_\_\_\_

### **Primary Care Practitioner**

Patient's PCP \_\_\_\_\_  
Name Address Phone # Fax #

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## FINANCIAL POLICY

Payment for services rendered are due at the time of service. Acceptable forms of payment: Cash, Check, Visa, Mastercard, and ATM/Debit. I understand there is a \$25.00 service charge for all returned checks. Balances older than 30 days may be subject to additional collection fees and interest charges of 1.5% per month.

**You are responsible for the timely payment of your account. In the event any legal fees are incurred, as a result of non-payment for services rendered, they are the express responsibility of the client/patient.**

## NO-SHOW / CANCELLATION POLICY

This office has a no-show policy. Patients who do not call at least 24 hours before their appointment or do not show to their appointment will be charged the full therapy fee. I understand that I will be **charged** for not showing up to an appointment or not calling at least 24 hours in advance.

I have read and understand the statements above.

\_\_\_\_\_  
Signature of Patient / Responsible Party

\_\_\_\_\_  
Date

## MEDICAL / LEGAL CARE

If your symptoms or presenting problem relates in any way to an existing motor vehicle accident for which you are being treated, your care is considered medical/legal. In that event, this information should be brought to the attention of the office management and/or your therapist and any care should be approved before therapy can be scheduled or performed. There are no exceptions. Thank you.

I have read and understand the statement above. \_\_\_\_\_(Please initial)

## RELEASE OF INFORMATION

I hereby authorize the release of medical information requested by my insurance company or workers' compensation carrier. I also authorize the release of information to any hospital or physician I may be referred to by this office. I authorize assignment of payment directly to Flexibly Fit™ for any covered major medical benefits due to me.

\_\_\_\_\_  
Signature of Patient / Responsible Party

\_\_\_\_\_  
Date

I understand that Flexibly Fit™ practitioners do not diagnose illness, disease, or any physical or mental disorder, nor do they prescribe medical treatment, pharmaceuticals, or perform spinal thrust manipulations. I acknowledge that this therapy is not a substitute for medical examination or diagnosis, and that it is recommended that I see a primary health care provider for that service.

I have stated all medical conditions that I am aware of and will update the Bowen practitioner of any changes in my health status.

\_\_\_\_\_  
Signature of Patient / Responsible Party

\_\_\_\_\_  
Date

## FOR OFFICE USE ONLY

Therapist Assigned \_\_\_\_\_

Date \_\_\_\_\_

HIPA Information to Patient \_\_\_\_\_

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## CONFIDENTIAL HEALTH INFORMATION

Name \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Age \_\_\_\_\_ Date \_\_\_\_\_

*In order that we may serve you better, please answer the following questions as best as you can.*

Requesting or Attending Practitioner or  Recommended By \_\_\_\_\_

Have you had therapeutic bodywork before?

Yes  No If yes, how long ago? \_\_\_\_\_

Where?  Professional Massage Office  Chiropractor's Office  Health Spa  Other

Do you exercise regularly?  Yes  No What type of exercise or sport? \_\_\_\_\_

How many times per week? \_\_\_\_\_

*Please check any of the following that apply to you. Have you had or do you now have?*

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Headaches/Shooting Pains        | <input type="checkbox"/> Grating in Neck                      | <input type="checkbox"/> Indigestion/Gas                           |
| <input type="checkbox"/> Sinus Trouble                   | <input type="checkbox"/> Tightness in Shoulder Muscles        | <input type="checkbox"/> Constipation/Diarrhea                     |
| <input type="checkbox"/> Loss of Smell/Taste             | <input type="checkbox"/> Nerve pain in Shoulders & Arms       | <input type="checkbox"/> Gallbladder Trouble                       |
| <input type="checkbox"/> Hayfever/Asthma                 | <input type="checkbox"/> Pins & Needles in Arms & Hands       | <input type="checkbox"/> Smoker / Packs per day _____              |
| <input type="checkbox"/> Tightness in Throat             | <input type="checkbox"/> Cold Hands/Feet                      | <input type="checkbox"/> Liver Trouble                             |
| <input type="checkbox"/> Thyroid Trouble                 | <input type="checkbox"/> History of Tuberculosis              | <input type="checkbox"/> Alcoholism                                |
| <input type="checkbox"/> Face Flushed                    | <input type="checkbox"/> Anemia                               | <input type="checkbox"/> Kidney/Bladder Trouble                    |
| <input type="checkbox"/> Twitching of Face               | <input type="checkbox"/> Rheumatic Fever                      | <input type="checkbox"/> Dialysis / History of<br>Transplant _____ |
| <input type="checkbox"/> Loss of Memory                  | <input type="checkbox"/> Nervous Stomach                      | <input type="checkbox"/> Diabetes                                  |
| <input type="checkbox"/> Fatigue                         | <input type="checkbox"/> Ulcers                               | <input type="checkbox"/> Cancer                                    |
| <input type="checkbox"/> Head Feels Too Heavy            | <input type="checkbox"/> Nerves & Nervousness                 | <input type="checkbox"/> Sleeping Problems                         |
| <input type="checkbox"/> Dizziness/Loss of Balance       | <input type="checkbox"/> Inner Tension/Irritability           | <input type="checkbox"/> Painful/Swollen Joints                    |
| <input type="checkbox"/> Fainting                        | <input type="checkbox"/> Cold Sweats/Hot flashes              | <input type="checkbox"/> Arthritis                                 |
| <input type="checkbox"/> Ringing in Ears                 | <input type="checkbox"/> High Blood Pressure                  | <input type="checkbox"/> Disc/Herniated Disc                       |
| <input type="checkbox"/> Wear Glasses/Contacts           | <input type="checkbox"/> Low Blood Pressure                   | <input type="checkbox"/> Pinched Nerves in Back                    |
| <input type="checkbox"/> Dentures/Periodontal/Implants   | <input type="checkbox"/> Chest Pains                          | <input type="checkbox"/> Pins & Needles in Legs                    |
| <input type="checkbox"/> Lights Bother Eyes              | <input type="checkbox"/> Shortness of Breath                  | <input type="checkbox"/> Pains in Legs & Feet                      |
| <input type="checkbox"/> Muscle Spasm in Neck & Shoulder | <input type="checkbox"/> Heart Palpitations/Chest<br>Pounding | <input type="checkbox"/> Broken Bones, Fractures                   |
| <input type="checkbox"/> Depression                      | <input type="checkbox"/> History of Heart Disease             | <input type="checkbox"/> Other _____                               |
| <input type="checkbox"/> Panic Attacks/High Anxiety      |   |  |

Please list your current medications: \_\_\_\_\_

Please list any supplements you are taking: \_\_\_\_\_

Are you...  pregnant  currently under chemotherapy  
 recovering from any recent surgery (within the last 12 months) If so, date? \_\_\_\_\_

Do you sleep on your...  side  back  stomach

Do you wear...  heel lifts  sole lifts  arch supports  inner soles

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Name \_\_\_\_\_ Date \_\_\_\_\_

Date of Birth \_\_\_\_\_

Show by marking and drawing on the figures below where you are having most of your...

Aching or Pain **XXXX**

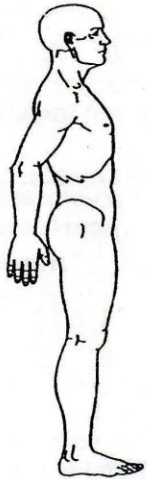
Pins and Needles.....

Cramping **AAAA**

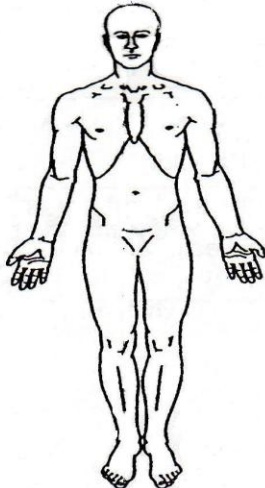
Numbness or Tingling **OOOO**

Burning **////**

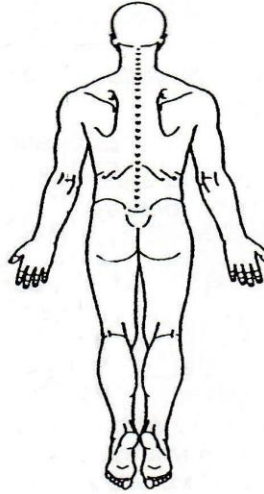
Pain Movement or Shooting Pain **→→→→**



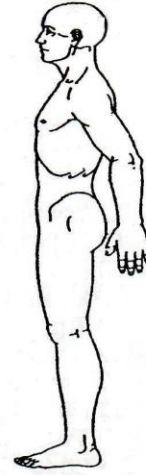
Right Side



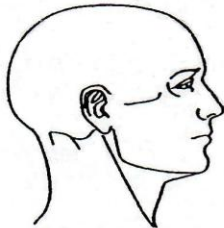
Front



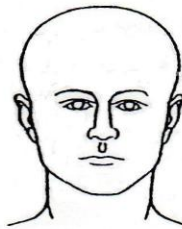
Back



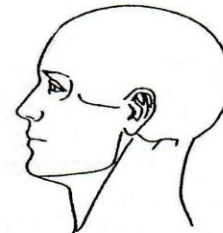
Left Side



Right Head



Front Head



Left Head

The following questions are only an approximate assessment of your pain problem. We understand that exact descriptions are impossible. Please choose the responses that **BEST** approximate your **PAIN PRESENTLY** (over the last few weeks or months or longer).

1. Do you have more pain in your:

- \_\_\_ Back    R    L    (circle)
- \_\_\_ Hip(s)    R    L    (circle)
- \_\_\_ Leg(s)    R    L    (circle)
- \_\_\_ Other \_\_\_\_\_

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2. How often are you having pain now? (check only one):
- No pain or rarely have pain now
  - Occasional pain (about once or twice per year or so)
  - Recurrent pain (a few days every few months or more often)
  - Frequent pain (a few days or more at least every month)
  - Pain every single day (Is it constant?  yes or  no)
3. When having pain, it is generally (check only one):
- A mild discomfort or less
  - A dull pain, worse at times
  - A harder aching pain, frequently worse at times
  - A severe pain, sharp and shooting at times
  - A very severe pain, frequently very sharp, shooting and disabling
  - An extremely severe and disabling pain
4. How is the pain now limiting your job, housework and social/recreational activities? (check only one):
- Not limited in any way
  - Pain not bad enough to really limit me very much
  - Able to work with pain all of the time by modifying my activities
  - Must stop and limit activities, but able to work most of the time
  - Frequently unable to work for several or more days at a time
  - Unable to work at all – totally disabled by pain

Circle on number in each row below that most closely describes your level of pain at its LEAST BOTHERSOME and MOST BOTHERSOME.

Least Bothersome

0 1 2 3 4 5 6 7 8 9 10  
No Pain Extreme Pain

Most Bothersome

0 1 2 3 4 5 6 7 8 9 10  
No Pain Extreme Pain

**Pain Factors**

What makes the pain worse?

- |   |                                   |
|---|-----------------------------------|
| <input type="checkbox"/> Prolonged Standing                       | <input type="checkbox"/> Lifting  |
| <input type="checkbox"/> Prolonged Sitting                        | <input type="checkbox"/> Bending  |
| <input type="checkbox"/> Twisting                                 | <input type="checkbox"/> Coughing |
| <input type="checkbox"/> Sneezing                                 | <input type="checkbox"/> Walking  |
| <input type="checkbox"/> Straining at Stool                       |                                   |
| <input type="checkbox"/> Getting in and out of cars and/or chairs |                                   |
| <input type="checkbox"/> Movement of _____                        |                                   |
| <input type="checkbox"/> Calf cramping: walking or at night       |                                   |

How far can you walk w/out stopping? \_\_\_\_\_ (distance)

Other: \_\_\_\_\_

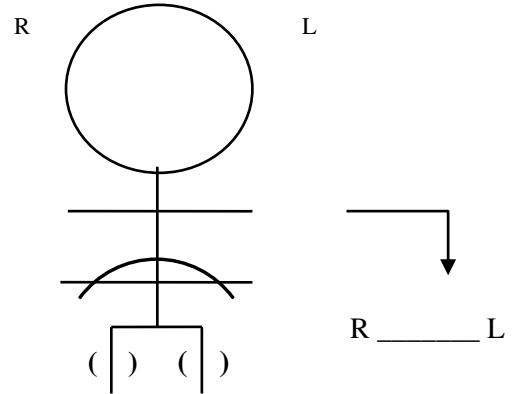
\_\_\_\_\_

What must you do to get relief? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## THERAPIST'S ASSESSMENT



The following muscles/muscle groups are found to be hypertonic and will be addressed as needed:

- TMJ Joint
- Temporalis
- Occipitalis
- Suboccipitalis
- Sternocleidomastoid
- Ptergoid
- Masseter
- Scalenes
- Trapezius
- Rhomboid major
- Rhomboid minor

Rotator Cuff

- Teres minor
- Supraspinatus
- Infraspinatus
- Subscapularis

IT Band

- Tensor fascia latae
- Gluteus maximus

- A/C Joint
- Levator scapula
- Teres major
- Splenius group
- Deltoids
- Biceps brachii
- Triceps brachii
- Extensors of the arm
- Flexors of the arm
- Pectoralis major
- Pectoralis minor
- Latissimus dorsi
- Quadratus lumborum
- Erector spinae C / T / L
- Serratus anterior

- Gluteus medius
- Gluteus minimus
- Psoas
- Iliacus

Hip Rotators

- Gemellus's (2)
- Obturators (2)
- Piriformis
- Quadratus femoris

- Adductors
- Gracilis
- Sartorius

Quads

- Rectus femoris
- Vastus lateralis
- Vastus medialis
- Vastus intermedius

Hamstrings

- Semitendinosus
- Semimembranosus
- Biceps femoris

- Gastrocnemius
- Soleus
- Tibialis posterior
- Tibialis anterior
- Flexors of the calf
- Extensors of the calf
- Peroneals group
- Inguinal ligament
- Sacrotuberous ligament

Personal Pain Assessment
Pre session _____
Post session _____

Assessment Outcome:

\_\_\_\_\_ Cervical-hyoid torsion/tension with restriction of: \_\_\_\_\_

\_\_\_\_\_ Contra-lateral hip torsion/tension with restriction R or L (circle one)

\_\_\_\_\_ Impingement syndrome with restriction of: \_\_\_\_\_

Home-based therapeutics discussed with good feedback demonstrated.  
Client/patient to return for follow-up as agreed.

Therapist's signature \_\_\_\_\_

Date \_\_\_\_\_