



Who may we thank for referring you: _____

Reason for your visit today: _____

Demographics and personal Information

Title: Mr. Mrs. Ms.

Last: _____ First: _____ MI: _____

Birth Date: ___/___/___ Age: ___ Sex: ___

Address: _____ Apt: _____

City: _____ State: _____ Zip code: _____

Best Phone: (____)____-____

**** You will be contacted via text message as a reminder of your appointments.**

Please let us know if you would like to opt out of these reminders.**

Email Address: _____

Emergency Contact

Last: _____ First: _____

Relationship: Spouse Relative Friend Other

Phone Number: (____)____-____

Employment Information:

Business Name: _____

Occupation/ Job Title: _____

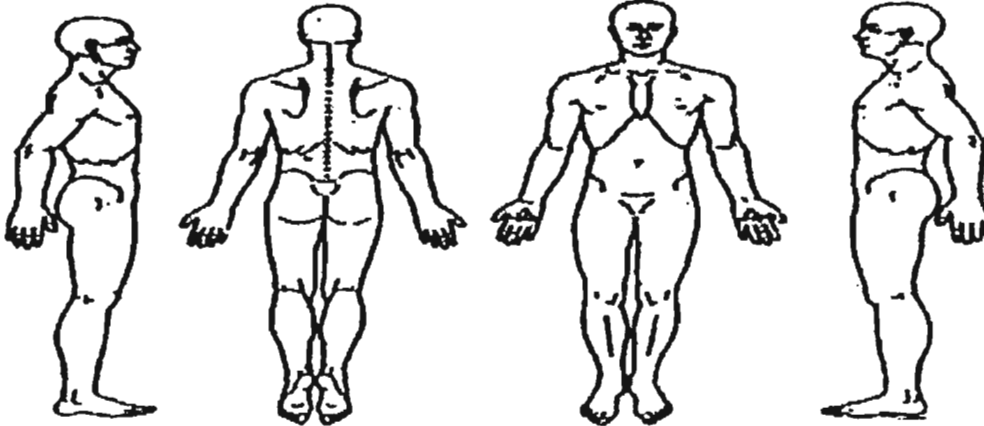
Job Description: _____

PATIENT INTAKE FORM

Patient Name: _____ Date: _____

1. Is today's problem caused by: Auto Accident Workman's Compensation

2. Indicate on the drawings below where you have pain/symptoms



3. How often do you experience your symptoms?

- Constantly (76-100% of the time) Occasionally (26-50% of the time)
 Frequently (51-75% of the time) Intermittently (1-25% of the time)

4. How would you describe the type of pain?

- Sharp Numb
 Dull Tingly
 Diffuse Sharp with motion
 Achy Shooting with motion
 Burning Stabbing with motion
 Shooting Electric like with motion
 Stiff Other: _____

5. How are your symptoms changing with time?

- Getting Worse Staying the Same Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (Please circle)

7. How much has the problem interfered with your work?

- Not at all A little bit Moderately Quite a bit Extremely

8. How much has the problem interfered with your social activities?

- Not at all A little bit Moderately Quite a bit Extremely

9. Who else have you seen for your problem?

- Chiropractor Neurologist Primary Care Physician
 ER physician Orthopedist Other: _____
 Massage Therapist Physical Therapist No one

10. How long have you had this problem? _____

11. How do you think your problem began?

12. Do you consider this problem to be severe?

- Yes Yes, at times No

13. What aggravates your problem? What improves it?

14. What concerns you the most about your problem; what does it prevent you from doing?

15. What is your: Height _____ Weight _____ Date of Birth _____

Occupation _____

16. How would you rate your overall Health?

Excellent Very Good Good Fair Poor

17. What type of exercise do you do?

Strenuous Moderate Light None

18. Indicate if you have any immediate family members with any of the following:

Rheumatoid Arthritis Diabetes Lupus
 Heart Problems Cancer ALS

19. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present	Past	Present	Past	Present
<input type="checkbox"/>	<input type="checkbox"/> Headaches	<input type="checkbox"/>	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/> Diabetes
<input type="checkbox"/>	<input type="checkbox"/> Neck Pain	<input type="checkbox"/>	<input type="checkbox"/> Heart Attack	<input type="checkbox"/>	<input type="checkbox"/> Excessive Thirst
<input type="checkbox"/>	<input type="checkbox"/> Upper Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Chest Pains	<input type="checkbox"/>	<input type="checkbox"/> Frequent Urination
<input type="checkbox"/>	<input type="checkbox"/> Mid Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Stroke	<input type="checkbox"/>	<input type="checkbox"/> Smoking/Tobacco Use
<input type="checkbox"/>	<input type="checkbox"/> Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Angina	<input type="checkbox"/>	<input type="checkbox"/> Drug/Alcohol Dependence
<input type="checkbox"/>	<input type="checkbox"/> Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/> Allergies
<input type="checkbox"/>	<input type="checkbox"/> Elbow/Upper Arm Pain	<input type="checkbox"/>	<input type="checkbox"/> Kidney Disorders	<input type="checkbox"/>	<input type="checkbox"/> Depression
<input type="checkbox"/>	<input type="checkbox"/> Wrist Pain	<input type="checkbox"/>	<input type="checkbox"/> Bladder Infection	<input type="checkbox"/>	<input type="checkbox"/> Systemic Lupus
<input type="checkbox"/>	<input type="checkbox"/> Hand Pain	<input type="checkbox"/>	<input type="checkbox"/> Painful Urination	<input type="checkbox"/>	<input type="checkbox"/> Epilepsy
<input type="checkbox"/>	<input type="checkbox"/> Hip Pain	<input type="checkbox"/>	<input type="checkbox"/> Loss of Bladder Control	<input type="checkbox"/>	<input type="checkbox"/> Dermatitis/Eczema/Rash
<input type="checkbox"/>	<input type="checkbox"/> Upper Leg Pain	<input type="checkbox"/>	<input type="checkbox"/> Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/>	<input type="checkbox"/> Knee Pain	<input type="checkbox"/>	<input type="checkbox"/> Abnormal Weight Gain/Loss		
<input type="checkbox"/>	<input type="checkbox"/> Ankle/Foot Pain	<input type="checkbox"/>	<input type="checkbox"/> Loss of Appetite		For Females Only
<input type="checkbox"/>	<input type="checkbox"/> Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/> Birth Control Pills
<input type="checkbox"/>	<input type="checkbox"/> Joint Pain/Stiffness	<input type="checkbox"/>	<input type="checkbox"/> Ulcer	<input type="checkbox"/>	<input type="checkbox"/> Hormonal Replacement
<input type="checkbox"/>	<input type="checkbox"/> Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Hepatitis	<input type="checkbox"/>	<input type="checkbox"/> Pregnancy
<input type="checkbox"/>	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Liver/Gall Bladder Disorder		
<input type="checkbox"/>	<input type="checkbox"/> Cancer	<input type="checkbox"/>	<input type="checkbox"/> General Fatigue		
<input type="checkbox"/>	<input type="checkbox"/> Tumor	<input type="checkbox"/>	<input type="checkbox"/> Muscular Incoordination		
<input type="checkbox"/>	<input type="checkbox"/> Asthma	<input type="checkbox"/>	<input type="checkbox"/> Visual Disturbances		
<input type="checkbox"/>	<input type="checkbox"/> Chronic Sinusitis	<input type="checkbox"/>	<input type="checkbox"/> Dizziness		
<input type="checkbox"/>	<input type="checkbox"/> Other: _____				

20. List all prescription medications you are currently taking:

21. List all of the over-the-counter medications you are currently taking:

22. List all surgical procedures you have had:

23. What activities do you do at work?

<input type="checkbox"/> Sit:	<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half the day	<input type="checkbox"/> A little of the day
<input type="checkbox"/> Stand:	<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half the day	<input type="checkbox"/> A little of the day
<input type="checkbox"/> Computer work:	<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half the day	<input type="checkbox"/> A little of the day
<input type="checkbox"/> On the phone:	<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half of the day	<input type="checkbox"/> A little of the day

24. What activities do you do outside of work?

25. Have you ever been hospitalized? No Yes
if yes, why _____

26. Have you had significant past trauma? No Yes

27. Anything else pertinent to your visit today? _____

Patient Signature _____ Date: _____

Innovative Back Solutions
919 NW 57th Street
(Park Avenue)
Gainesville, FL 32605

Cancellation Notice
Massage Therapy, Decompression, And Strength/Conditioning

Dear Patient,

Massage therapy, decompression, and strength/conditioning are all valuable components of patient care and recovery. Pairing patients with appointments that fit their busy schedules is always a challenge with today's hectic lifestyles. We therefore respectfully ask that patients who will be unable to attend a scheduled massage, decompression, and strength/conditioning appointment provide us with 24 hour notice prior to the scheduled appointment, so that our therapists' and doctor limited time maybe allocated to another patient in need of a treatment. Patients who are unable to give sufficient advance notice of cancellation or fail to show for their scheduled appointment will be billed \$35.00 for a missed appointment. We appreciate your cooperation in this matter.

Patient Name (Print name)

Patient Signature

Date

Innovative Back Solutions
919 NW 57th Street
(Park Avenue)
Gainesville, FL 32605

Insurance Information on file: Yes No

Primary Insurance: _____

Secondary Insurance: _____

ASSIGNMENT OF BENEFITS/INSURANCE ASSIGNMENT

I hereby assign Innovative Back Solutions, insurance benefits and causes of action on all insurance policies payable to me. I authorize Innovative Back Solutions to submit insurance claims to my insurance company and apply insurance proceeds to my bill and make refunds to insurance companies, as refunds are due, under the provision of the insurance policies. I authorize Innovative Back Solutions or its billing agents or suppliers, to release information necessary to apply for payment for these benefits. I direct my insurance carrier to accept a photocopy of the assignment in lieu of the original.

Print name

Sign (Responsible party)

Witness

Date

Date of accident



Date: _____

I, _____, give Dr. Robert Ruano permission to use emails and or text messages as a way of communication with me regarding my appointments and treatment plan.

I understand that all emails and texts between individuals are not recognized as secure communications.

All patient medical information is private and will be protected.

Print Name: _____

Signature: _____

Print Witness Name: _____

Witness Signature: _____

**Dr. Robert Ruano
919 NW 57th St. Gainesville, FL 32605
Office: 325-505-3993 Fax: 1(352) 364-4163**