ASTR | ADVANCED SOFT TISSUE RELEASE®

*Please Fill-Out Entire Form Completely & Legibly.*

______________________ Last Name
______________________ First Name
________ Age
☐ Male ☐ Female

______________________ Street Address
______________________ City
________ State
________ ZIP

(______)______________ Home Phone
(______)______________ Cellular
______________________ Email Address (Required for appointment reminder)

______________________ Occupation
______________________ Employer Name
(__________)______________ Phone #

______________________ Emergency Contact Person
(______)______________ Phone #
______________________ Relationship

Social Security #______________________ Date of Birth________/________/________ ☐ Single ☐ Married

Work Status: ☐ Employed ☐ Retired ☐ Disabled ( __Total or __Temporary) ☐ Student

Appointment Reminder: ☐ Text ☐ Voice ☐ Email

*****ALL INFO REQUIRED*****

AUTO/PERSONAL INJURY: Date of accident:_______/_______/________

WORK INJURY: Complete all information below.

Date of injury:_______/_______/________

Your Company HR person name ______________________________________

Insurance adjustor name ______________________________________

Insurance adjustor Phone#______________________________________

OTHER INJURY: What do you think may have Caused it?

__________________________________________________________________

SURGERY: When and what type? ______________________________________

Physical Therapy Before: When and where? ______________________________________

Home Health Care: Are you still receiving it? ____ YES ____ NO

OTHER Care: What? ______________________________________

How did you hear about us?

___ Friend or Family
___ Internet
___ Insurance
___ Doctor
___ Brochure
___ Other

Give details:

______________________ Referring Physician/Person's Name

______________________ City State

______________________ Phone #

**Signature** ______________________________ **Date** ____________________

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# Medical History

Are you currently experiencing or have you experienced any of the following problems:
(Check each applicable box)

Yes
__ Headaches
__ Heart Disease
__ High Blood pressure
__ Stroke
__ Heart Attack
__ Pacemaker
__ Asthma
__ Arthritis
__ Osteoporosis
__ Osteopenia
__ Recent Weight Loss/Gain
__ Deep Vein Thrombosis (DVT)

Yes
__ Shortness of Breath
__ COPD
__ Hernia
__ Balance Problems
__ Thyroid Problems
__ Head injury / Concussion
__ Previous Fractures
__ Metal / Implant
__ Kidney / Bladder Problems
__ Fibromyalgia
__ Neurological Disease
__ History of Falls

Yes
__ Diabetes
__ Depression
__ Anxiety
__ Substance Abuse
__ HIV / AIDS
__ Hepatitis
__ Multiple Sclerosis
__ Seizure / Epilepsy
__ Cancer / Tumor
__ Current Infections (s)
__ Sensitive to Heat / Cold
__ Other: ____________

If you answered "yes" above, please explain:

______________________________________________

______________________________________________

**Pain Types:** __ Sharp __ Burning __ Throbbing __ Spasm __ Stinging __ Aching __ Numbing

__ Shooting __ Tingling __ Cramping __ Pounding __ Dull __ Other:________

List Previous **Surgeries**:

______________________________________________

______________________________________________

Have you been in an **accident** or sustained any **injury** recently? Provide complete description of the event(s):

______________________________________________

______________________________________________

______________________________________________

List all **medications** you are currently taking:

______________________________________________

______________________________________________

Do you have any **allergies**? __ No __ Yes, list allergies:

______________________________________________

______________________________________________

Do you have any **transferable diseases**? __ No __ Yes
Could you be or are you **pregnant**? __ No __ Yes

______________________________
Patient/Parent/Guardian Signature

______________________________
Date

## Important Company Policies for a Successful Relationship

We strive to provide you the best personalized care available. To make this possible we adhere to a set of very important guidelines. Please read them carefully, **indicate your agreement by initialing all the boxes**.

☐ **Late Policy "10-minutes"**

Being late by more than 10 minutes will require you to either reschedule or wait for the next available opening. There are no guarantees since openings due to cancellations are unpredictable. We do not allow appointment overlap because this undeservedly compromises the care of another patient.

☐ **24-Hour Advance Notice Fee**

If you wish to change or cancel an appointment we require a minimum **24-hour advance notice.** Anything less will result in a **$50 fee** charged to your account. It costs us money to make appointments available to you. Whether you attend or not we still accrue the expenses (for staff wages, rent, etc.). We don't charge you the actual cost for that appointment but rather a mere **$50 fee.** We do NOT make money with this charge; it's only to act as a deterrent from making last minute changes. Advance notice allows someone else (who needs it) time to reserve it in place of you. Please be courteous and responsible.

☐ **No-shows are bad**

If you fail to show for an appointment without notice all future appointments will be removed and a **$50 fee** assessed to your account. You may re-schedule appointments again on a "first come, first serve basis".

☐ **Copays are due upon arrival**

If you happen to forget your wallet or checkbook we may still be able to see you if you pay over the phone immediately after your appointment or make arrangements to pay at the beginning of your next scheduled appointment.

☐ **Cell phones must be shut OFF or silent**

We realize emergencies may arise and therefore allow you to carry your cell phone during your session, how- ever, please be courteous and set to silent mode or turn off. Thank you.

☐ **Children requiring supervision are NOT allowed to attend sessions with you**

Unless your facility offers child care services, you may not bring children who require supervision with you to your appointment. If your child does not require supervision and is capable of waiting for you quietly then you may bring them. If any disturbance is caused to other patients or staff members you may be asked to terminate your session early and attend to your child.

☐ **Patient Balances/ Late Fee**

If payment is not received within 30 days of the statement, a **$35 late fee** each month will be applied to your balance until full payment is received.

☐ **Bounced Checks**

If we receive a returned check from our bank for a payment you made, you will be charged for the original amount of the check plus a **$25 bank fee**. Payment of the total charged amount will be due within 30 days.

☐ **Important Notice from the Federal Government:**

**"It is unlawful to routinely avoid paying your copay, deductible or coinsurance payments** . . . even if your doctor allows it. Unless you complete a "Financial Hardship" form and qualify for financial assistance under Federal Standards, you may NOT routinely evade paying your responsibility portions for medical care as outlined in your insurance plan even if your doctor allows it. You both may be charged for breaking the law. This includes services deemed as "professional courtesy" and "TWIP's - Take what insurance pays". Failure to comply places you in violation of the following laws: Federal False Claims Act, Federal Anti-Kickback Statute, Federal Insurance Fraud Laws, State Insurance Fraud Laws. Failure to comply may result in civil money penal- ties (CMP) in accordance with the new provision section 1128 A(a)(5) of the Health Insurance Portability and Accountability Act of 1996 [section 231(h) of HIPAA]. Exceptional cases do apply. Please see contact info for more information. Office of Inspector General, Department of Health and Human Services. Contact by phone: 202 619-1343, by fax: 202 260-8512, by email: paffairs@oig.hhs.gov, by mail: Office of Inspector General, Office of Public Affairs, Department of Health and Human Services, Room 5541 Cohen Building, 333 Independence Avenue, S.W., Washington, D.C. 20201, Joel Schaer, Office of Counsel to the Inspector General, 202 619-0089."

**We look forward to building a successful relationship with you that lasts a lifetime!**

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## Direct Physical Therapy Treatment Services

You are receiving direct physical therapy treatment services from an individual who is a physical therapist licensed by the Physical Therapy Board of California.

Under California law, you may continue to receive direct physical therapy treatment services for a period of up to **45 calendar days or 12 visits**, whichever occurs first, after which time a physical therapist may continue providing you with physical therapy treatment services only after receiving, from a person holding a physician and surgeon's certificate issued by the Medical Board of California or by the Osteopathic Medical Board of California, or from a person holding a certificate to practice podiatric medicine from the California Board of Podiatric Medicine and acting within his or her scope of practice, a dated signature on the physical therapist's plan of care indicating approval of the physical therapist's plan of care and that an in-person patient examination and evaluation was conducted by the physician and surgeon or podiatrist.

**AB1000**

7) States that the provisions of this bill shall not be construed to require health care service plan, insurer, workers' compensation insurance plan, employer, or state program to provide coverage for direct access to treatment by a PT.

**I am responsible for all charges whether paid by insurance or not.**

___________________________________ (Participant Signature)

___________________________________ (Parent/Guardian Signature)

___________________________________ (Date)

# Informed Consent and Policies Agreement

**Medical Necessity**
All treatments must be justified and medically necessary in order for us to treat and bill your insurance. Some of the factors that determine whether or not treatment is medically necessary are:

1) Does your condition interfere with the quality of your life?
2) Does your condition interfere with your ability to perform work or daily activities?
3) Are you motivated and able to participate in your treatment program and follow home and self-care instruction?
4) Is there potential for your condition to improve and/or resolve? If not, is there potential for your function or ability to perform daily activities to improve through modified movement, assistive devices, etc.?
5) Are there specific goals set that are measurable and track-able?

If the above criteria are not met, you are welcome to participate in our elective services such as 830laser, massage, whole Body Maintain Program, fitness/exercise training, Posture Program, etc. payable out-of-pocket by cash, check or credit card.

**Cancel/No-show/Late**
Please refer to the Express Registration Form.

**Authorization for Release of Records**
**Assignment of Benefits** (for insurance patients)
Please refer to the Assignment of Benefits form.

**Results**
The purpose of physical/occupational therapy is to maximize your body's own healing potential through natural means and promote your ability to perform daily, work, and leisure and sports activities through increased strength, flexibility, agility, and movement strategies. It is not possible to predict the results or outcomes of treatment. Sometimes benefits are realized immediately and sometimes it's more gradual over time.

**Insurance Patients**
It is your responsibility to know your benefit and insurance coverage for physical therapy services, including any maximums or exclusions. **You are responsible for all charges whether paid by insurance or not.** Any balances that exceed 30 days may incur fees and collection costs.

**Medicare Patients**
If you do NOT have supplemental insurance, you will be responsible for the twenty percent (20%) co-insurance portion not paid by Medicare as well as any deductible amounts not yet met. It is your responsibility to keep track of therapy cost totals for the purpose of not exceeding the Therapy Cap (unless your diagnosis is exempt from the Cap).

**Minors and Parents**
If patient is a minor (under 18 years of age), the parent or legal guardian is responsible for all charges and decisions made by the minor. We do not assume any liability for the minor while on premises or not, and it is the responsibility of the parent or guardian to supervise the minor before, during and after treatments.

**Informed Consent**
By signing below, you give the therapist permission to perform the evaluation and treatment. You have the right to accept or refuse any treatment offered. There are no guarantees made as to the results that may be obtained from our treatment(s). The therapist may have to work on your coccyx (tale bone)/ pelvic/gluteus/hip area, in order to obtain an accurate assessment. You will be informed of this before treatment begins and will have an opportunity to refuse treatment at that time. We will do our best to provide a treatment/exercise program that causes the least amount of pain to you. It is your responsibility to tell the therapist when you feel pain. If you have any questions about your care, be sure to ask the therapist.

It is up to you(patient)/caretaker to inform the therapist/ staff about any health problems or allergies you may have. You, the patient or the caretaker must also tell the therapist/staff about drugs or medications being taken as well as any medical conditions and/or surgeries.
Please discuss any questions or problems with the therapist before signing this statement of understanding and consent for care.

**Patient Declaration**
The therapist has explained to me the type of treatments ideal for my condition and the benefits of therapy, along with the risk of NOT receiving treatment. I have been given an opportunity to ask questions, and all my questions have been answered to my satisfaction. I confirm that I have read and fully understand this consent and policies form.

I have read and understand the foregoing explanation of rehabilitation/therapy care given to me. I hereby give my consent for the therapist to render treatments to me.

________________________________________
Patient Signature/Date

________________________________________
Patient's Representative Signature/Date

________________________________________
Relationship to Patient

________________________________________
Witness Signature/Date

Advanced Soft Tissue Release Institute
Reliant Physical Therapy

# Statement of Privacy Notice

*Effective December 1, 2012*

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations.

We may disclose your health information to your insurance provider for the purpose of payment or health care operations.

We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

We may disclose your health information in the course of any administrative or judicial proceeding.

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

We may disclose your health information to coroners or medical examiners.

We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

We may disclose your health information for military, national security, prisoner and government benefits purposes.

We may leave a message on an automated answering device or person answering the phone for the purposes of scheduling appointments. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment."

We may contact you or send your bill by phone, mail, or email. "It is our practice to participate in charitable and marketing events to raise awareness, food donations, gifts, money, etc. During these times, we may send you a letter, post card, invitation or call your home to invite you to participate in the charitable activity.

In the event that we are sold or merged with another organization, your health information/record will become the property of the new owner.

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that we are not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.
- You have a right to request that we amend your protected health information. Please be advised, however, that we are not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by us.
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

We reserve the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, we are required by law to comply with this Notice.

We are required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact us by calling this office at **(949) 236-6862**. If our Privacy Officer is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

Complaints about your Privacy rights, or how we have handled your health information should be directed to our Privacy Officer by calling this office at **(949) 236-6862**. If our Privacy Officer is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide the company above with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice

________________________________________
Print Patient's Name Date

________________________________________
Patient's Signature Date

________________________________________
Authorized Facility Signature Date

## Assignment of Benefits to Reliant Physical Therapy

Patient Name:________________________________ DOB: ________________________

Insured Name:_______________________________ Insured DOB: __________________

Your relationship to the Insured: ☐ Parent ☐ Spouse ☐ Other:_______________

I hereby instruct and direct the insurance company above to pay by check made out and mailed to:

**Reliant Physical Therapy**
26302 La Paz Rd, Suite 213
Mission Viejo, CA 92691
**(949) 236-6862**

If my/this current policy prohibits direct payment to doctor, I hereby also instruct and direct you to make out the check to me and **mail it to the above address** for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered.

**This is a direct assignment of my rights and benefits under this policy.**

This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

- A photocopy of this Assignment shall be considered as effective and valid as the original.
- I authorize the release of any medical or other information pertinent to my case to any insurance company, adjuster, or attorney involved in this case for the purpose of processing claims and securing payment of benefits.
- I authorize the use of this signature on all insurance submissions.
- I authorize Reliant Physical Therapy to deposit checks made in my name.
- I authorize Reliant Physical Therapy to initiate a complaint to the Insurance Commissioner for any reason on my behalf.
- It is the patient's responsibility to be aware of his/her insurance policy's visit limit and keep track of his/her physical therapy visits.
- The benefit and/or authorization information we obtain from your insurance company does not guarantee payment or verify eligibility. Payment of benefits are subject to all terms, conditions, limitations, and exclusions of the member's contract at the time of service.
- **I understand that I am financially responsible for all charges whether or not paid by insurance.**

__________________________________
Dated

__________________________________ ______________________________
Signature of Policyholder Witness

# Patient -Physical Therapy Arbitration Agreement

Article 1: **Agreement to Arbitrate**: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review or arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided on a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrated:** I understand and agree that this arbitration agreement binds me and anyone else who may have a claim arising out of or related to all treatment or services provided by the physical therapist, including any spouse or heirs of the patient and any children, whether born or unborn at the time of the occurrence giving rise to any claim. This includes, but is not limited to, all claims for monetary damages exceeding the jurisdictional limit of the small claims court, including, without limitation, suits for loss of consortium, wrongful death, emotional distress or punitive damages. I further understand and agree that if I sign this agreement on behalf of some other person for whom I have responsibility, then, in addition to myself, such person(s) will also be bound, along with anyone else who may have a claim arising out of the treatment or services rendered to that person. I also understand and agree that this agreement relates to claims against the physical therapist and any consenting substitute physical therapist, as well as the physical therapist's partners, associates, association, corporation or partnership, and the employees, agents, and estates of any of them. I also hereby consent to the intervention or joinder in the arbitration proceeding of all parties relevant to a full and complete settlement of any dispute arbitrated under this Agreement, as set forth in the CMA/CHA Medical Arbitration Rules.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must communicate in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, nit supplant, any other applicable statutory or common law.

Either party shall have the absolute right ti arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.
The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.
The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Section 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrations a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05, however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: **General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in once proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Retroactive Effect:** If patient intends this agreement to cover services rendered before the date it is Effective as of the date of first medical services.

Article 6: **Acknowledgement.** By signing this agreement, I acknowledge that I have discussed to my satisfaction any questions I may have regarding the arbitration agreement with a staff member of Reliant Physical Therapy, APC.

If any provision if this arbitration agreement is held invalid of unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.
I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.
**NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL.**
**SEE ARTICLE 1 OF THIS CONTRACT**

__________________________________________
Print Patient's Name

__________________________________________
Facility Representative's Signature (Date)
Reliant Physical Therapy, APC

__________________________________________
Patient's or Patient Representative's Signature (Date)

__________________________________________
Print Representative Name and Relationship to Patient

ASTR | ADVANCED SOFT TISSUE RELEASE®

## Consent To Participate In Research Study

I ____________________________________ Agree to participate in a research study conducted by Advanced Soft Tissue Release Institute and its affiliates. My participation in this study is voluntary. I have read the information below and have asked questions regarding anything I do not understand and have decided to participate in the study/research. I further authorize the said parties to use my medical information in their literature.

My participation in this research study will help others have a better understanding of the effects of Advanced Soft Tissue Release on patients. Advanced Soft Tissue Release Institute will not use my name, address or phone number in this study/research.

Date: ________________________________

Print Name: ___________________________

Signature: ___________________________

ASTR | ADVANCED SOFT TISSUE RELEASE

**Name:**___________________________

**Circle the number that applies**

0 = Do not eat or use 1= eat or use 2 to 3 times per month 2= eat or use weekly 3 = eat or use daily

0 1 2 3 Sodas
0 1 2 3 Fried foods
0 1 2 3 Dairy products
0 1 2 3 Diet beverages
0 1 2 3 Alcohol
0 1 2 3 Smoke or chewing tobacco
0 1 2 3 Desserts, candy, refined sugar
0 1 2 3 Baked goods/ refined flour
0 1 2 3 Fast Food
0 1 2 3 Caffeinated beverages
0 1 2 3 Artificial sweeteners
0 1 2 3 Soy products

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Are you currently experiencing or have you experienced any of the following problems:

___ Heartburn /Constipation
___ Bloating / Indigestion
___ Nausea / Vomiting/ Diarrhea
___ Acid Reflux/ Peptic Ulcer
___ Gastritis /Diverticulitis
___ Crohn's Disease
___ Ulcerative Colitis
___ Irritable Bowel Syndrome
___ Chronic Fatigue / Fibromyalgia
___ Food Sensitivities/ Allergies
___ Dry Skin/ Skin Problems
___ Headache / Migraine
___ Osteoporosis / Osteopenia
___ Cancer
___ Thyroid Problems
___ High Blood Pressure
___ Anxiety / depression
___ High Cholesterol
___ Diabetes
___ Frequent Flu/ Cold Sickness
___ Arthritis Type ________________
___ Hormonal Imbalance? ____________________
___ Autoimmune Disease? ____________________
___ Others _________________

---

Provide an example of what your typical Breakfast, Lunch, Dinner and Snack consists of

Breakfast ____________________ Lunch ____________________ Dinner ____________________ Snack _______________

Breakfast ____________________ Lunch ____________________ Dinner ____________________ Snack _______________

- How many times do you have **bowel** movement? per day _______ per week _______
- How many servings of **fruits** and **vegetables** do you eat? per day ________

## Do you feel/ have:

___ Fatigue/ tired daily
___ Fatigue / tired by the end of the day
___ Low energy by the end of the day
___ Crave sweets in afternoon or evening
___ Crave coffee in afternoon or evening
___ Bad breath
___ White/ yellow coated tongue
___ Gas / bloating
___ Body oder
___ Dark spots on skin
___ Acne/ rosacea / itchy
___ Overheated / excessive sweating
___ Fluid retention / congested sinuses
___ Increased waist size
___ Chemical sensitivity (alcohol, fragrances, etc)
___ Foggy memory or drowsy in the morning
___ Body aches
___ Difficulty handling stress
___ Higher energy in the evenings
___ Moodiness / Irritability
___ Crave sweet or salty foods
___ Low libido
___ Difficulty getting up each morning, even after a long sleep
___ Frequent urination
___ Difficulty memorizing things
___ Memory is not very sharp
___ Frequent thirst
___ Sleepy in afternoon
___ Gaining/ Losing weight
___ Difficulty falling or staying asleep

**Name:**_________________________

Are you currently taking or have you been taken any of the following **medications** in the last year

___ Antibiotics / Antifungals

___ Antacids /laxatives

___ Stool softener

___ Anti-anxiety / antidepressants

___ Anticonvulsants

___ Aspirin/ Ibuprofen

___ Tylenol / acetaminophen

___ Cortisone/ steroids

___ Diuretics

___ Heart medications

___ Cholesterol medications

___ Diabetic medications/ insulin

___ Estrogen / progesterone/ testosterone

___ Recreational drugs

___ High blood pressure medications

___ Thyroid medication

___ Beta blockers

___ Sleeping pills/ relaxants

___ Asthma inhalers

___ Birth control pills

___ Chemotherapy / radiation

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**Practitioner complete this section**

| | **Date** | | | | | |
|---|---|---|---|---|---|---|
| **Nails** | Lunula 8/10 | | | | | |
| | Color | | | | | |
| | Lines | | | | | |
| | Shape | | | | | |
| | Texture | | | | | |
| | Capillary Refill | | | | | |
| **Mouth** | Tonsils | | | | | |
| | Tongue Color | | | | | |
| | Breath | | | | | |
| | Gum | | | | | |
| | Lips | | | | | |
| **Skin** | Dry | | | | | |
| | Acne | | | | | |
| | Petechiae | | | | | |
| | Acanthosis Nigerians | | | | | |
| | Lesion healing | | | | | |
| **Hair** | Loss | | | | | |
| | Growth | | | | | |

ASTR ADVANCED SOFT TISSUE RELEASE®

| Medication | AM | Noon | PM |
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| Supplement | AM | Noon | PM |
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26302 La Paz Rd. Suite 213, Mission Viejo, CA 92691 | **Tel:** (949) 236-6862
www.AdvancedSoftTissueRelease.com