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 __ Doctor

__ Internet __ Brochure

__ Insurance __ Other

Give details:

Referring Physician/Person's Name _____

City _____ State _____

Phone # _____

Signature _____ **Date** _____

ASTR ADVANCED SOFT TISSUE RELEASE®

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

26302 La Paz Rd. Suite 213, Mission Viejo, CA 92691 | **Tel:** (949) 236-6862 | **Fax:** (949) 315-4325
www.AdvancedSoftTissueRelease.com

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!

ASTR ADVANCED SOFT TISSUE RELEASE

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)

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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

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

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

_____
Print Patient's Name

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

_____
Print Representative Name and Relationship to Patient

A. Notifier:

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.** Physical Therapy below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.** Physical Therapy below.

D. Reliant Physical Therapy	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** Physical Therapy listed above.

  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.** Physical Therapy listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN**.** If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.** Physical Therapy listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed**.

☐ **OPTION 3.** I don't want the **D.** Physical Therapy listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

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: _____

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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 Alcohol	0 1 2 3 Fast Food
0 1 2 3 Fried foods	0 1 2 3 Smoke or chewing tobacco	0 1 2 3 Caffeinated beverages
0 1 2 3 Dairy products	0 1 2 3 Desserts, candy, refined sugar	0 1 2 3 Artificial sweeteners
0 1 2 3 Diet beverages	0 1 2 3 Baked goods/ refined flour	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	___ Chronic Fatigue / Fibromyalgia	___ Anxiety / depression
___ Bloating / Indigestion	___ Food Sensitivities/ Allergies	___ High Cholesterol
___ Nausea / Vomiting/ Diarrhea	___ Dry Skin/ Skin Problems	___ Diabetes
___ Acid Reflux/ Peptic Ulcer	___ Headache / Migraine	___ Frequent Flu/ Cold Sickness
___ Gastritis /Diverticulitis	___ Osteoporosis / Osteopenia	___ Arthritis Type _____
___ Crohn's Disease	___ Cancer	___ Hormonal Imbalance? _____
___ Ulcerative Colitis	___ Thyroid Problems	___ Autoimmune Disease? _____
___ Irritable Bowel Syndrome	___ High Blood Pressure	___ 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

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

Supplement	AM	Noon	PM

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