Today's Date:_________________

Client Consultation/History Forms

Patient Name:_______________________________________ DOB: __________________________

Address: ____
Street City State Zip

Email:_____________________________________ Phone:______________________________________

Preferred Mode of Contact (Please Circle): Email/Text/Call

In case of emergency, whom may we contact? Name:_______________________ Phone:_____________

Who referred you? ____

Reasons for your visit today?

____

____

Who have you seen regarding this problem?

____

____

Current medications and reason:

____

____

History: Have you had or do you presently have any of the following? Please check the box if yes.

______ Recent operation	______ Shortness of breath at rest or with mild exertion
______ High / Low blood pressure	______ Chest pains, Heart attack or known heart disease
______ Fainting or dizziness	______ Palpitations or tachycardia (unusually strong or rapid beat)
______ Known heart murmur	______ Pain, discomfort in the chest, neck, jaw, arms, or other areas
______ Calf Cramping	______ Unusual fatigue or shortness of breath with usual activities
______ Diabetes	______ Other (please describe):

Present/Past History

Date of your last physical examination performed by a physician:________________________________

Do you currently exercise? Yes ______ No ______ (please explain)

____

Do you have injuries (bone or muscle disabilities) that may interfere with this assessment?

Yes ______No ______

If yes, briefly describe:

____

Do you smoke? Yes ______ No ______ If yes, how much per day? ______

There are no refunds for therapy/training services, packages or assessments. There is a 24 hour cancellation policy, if you neglect to call within 24 hours of your scheduled session you will be charged the session in full. If you cancel a scheduled session within the 24 hours, you must reschedule within 7 days to avoid losing the cancelled session. No exceptions.

Today's Date:_________________

PAIN & INJURY SOLUTIONS INC
linkage llc

Do you lose your balance because of dizziness or do you ever lose consciousness? Yes ____No ____

Do you have a bone or joint problem that could be made worse by a change in your physical activity?

Yes ___ No ____

Do you know of any other reason why you should not do physical activity? Yes ____ No ____

Pain Management

1. **What number best describes your pain level today? Please circle.** *(0 No Pain, 10 Disabling)*

   1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

2. **What number best describes, on average, how your pain interferes with your overall activity/work?** *Please circle. (0 No Pain, 10 Disabling)*

   1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

3. **What number describes, on average, how your pain interferes with your productivity? (i.e. Does your pain keep you from working?)** *Please circle. (0 No Pain, 10 Disabling)*

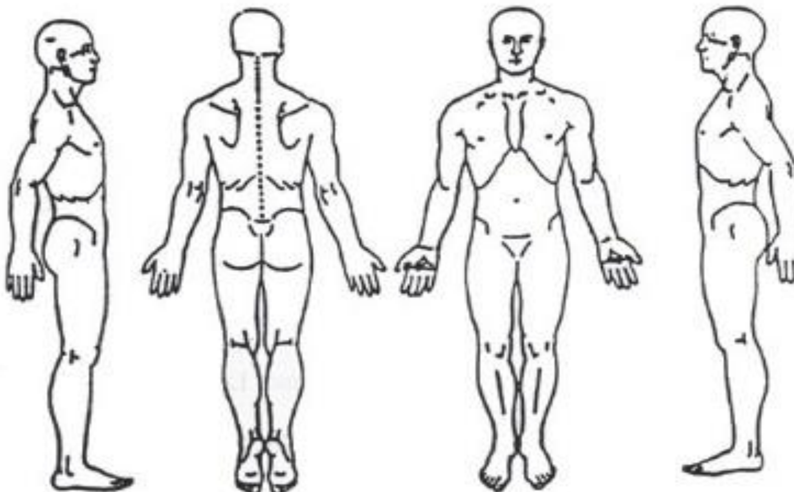
   1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

4. **How much sleep did you get last night?** ___hrs.
   a. **Did you dream?** Yes/No
   b. **Do you remember your dreams?** Yes/No
5. **How much water did you drink today?** ______oz.
6. **Do you drink soda?** Yes/No **How much?** ______oz. a day

Pain Diagram & Symptom Location

On the diagram below, please indicate where you are currently experiencing pain and/or other symptoms. Use the key beside the diagram to mark the type of symptoms you are experiencing.

KEY
===== **Numbness**
_ _ _ _ **Pins/Needles**
X X X X **Burning**
>>>>> **Aching**
/ / / / **Stabbing**
+ + + + **Other**



There are no refunds for therapy/training services, packages or assessments. There is a 24 hour cancellation policy, if you neglect to call within 24 hours of your scheduled session you will be charged the session in full. If you cancel a scheduled session within the 24 hours, you must reschedule within 7 days to avoid losing the cancelled session. No exceptions.

Today's Date:___________________

PAIN & INJURY SOLUTIONS INC
linkage llc

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING ___0___ + ______ + ______ + ______

=Total Score: ______

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

There are no refunds for therapy/training services, packages or assessments. There is a 24 hour cancellation policy, if you neglect to call within 24 hours of your scheduled session you will be charged the session in full. If you cancel a scheduled session within the 24 hours, you must reschedule within 7 days to avoid losing the cancelled session. No exceptions.

Today's Date:_________________

General Terms of Service:

There are no refunds for therapy/training services, packages or assessments. There is a 24 hour cancellation policy, if you neglect to call within 24 hours of your scheduled session you will be charged the session in full. If you cancel a scheduled session within the 24 hours you must reschedule within 7 days to avoid losing the cancelled session. No exceptions.

Liability Statement

By utilizing any document/program or service provided by "Linkage" or Pain & Injury Solutions Inc. or any of its agents you understand that the suggested information, exercises or stretches may involve strenuous physical activity including, but not limited to, muscle strength and endurance training, cardiovascular conditioning and training, and other various fitness activities. In doing so you affirm that you are in good physical condition and do not suffer from any known disability or condition which would prevent or limit my participation in this exercise program. You acknowledge that your enrollment and subsequent participation is purely voluntary and in no way mandated by "Linkage" or Pain & Injury Solutions Inc." "In consideration of your participation in this program you hereby release "Linkage" or Pain & Injury Solutions Inc. and its agents from any claims, demands, and causes of action as a result of your voluntary participation and enrollment." "You fully understand that you may injure yourself as a result of your enrollment and subsequent participation in this program and hereby release "Linkage" or Pain & Injury Solutions Inc. and its agents from any liability now or in the future for conditions that you may obtain. These conditions may include, but are not limited to, heart attacks, muscle strains, muscle pulls, muscle tears, broken bones, shin splints, heat prostration, injuries to knees, injuries to back, injuries to foot, or any other illness or soreness that I may incur, including death."

Waiver and Release of Liability

In agreeing to receive care provided by the residing care specialists (aka "Linkage", "Pain & Injury Solutions Inc.") and to use the facilities provided, I agree as follows:

I fully understand and acknowledge that (a) the activities in which I will engage as part of the treatment provided by the residing care specialists ("Linkage", "Pain & Injury Solutions Inc.") and their representatives, employees and the therapy activities and equipment I may use as a part of that treatment have inherent risks, dangers, and hazards and such exists in my use of any equipment and my participation in these activities; (b) my participation in such activities and/or use of such equipment may result in injury or illness including, but not limited to bodily injury, disease, strains, fractures, partial and/or total paralysis, death or other ailments that, could cause serious disability; (c) these risks and dangers may be caused by the negligence of the representatives or employees of "Linkage", Pain & Injury Solutions Inc., the negligence of the participants, the negligence of others, accidents, breaches of contract, or other causes. By my participation in these activities and for use of equipment, I hereby assume all risks and dangers and all responsibility for any losses and/or damages whether caused in whole or in part by the negligence or the conduct of the representatives or employees of The residing care specialists ("Linkage", "Pain & Injury Solutions Inc."), or by any other person.

I, on behalf of myself, my personal representatives and my heirs, hereby voluntarily agree to release, waive, discharge, hold harmless, defend, and indemnify The residing care specialists ("Linkage", "Pain & Injury Solutions Inc.") and their representatives, employees, and assigns from any and all claims, actions or losses for bodily injury, property damage, wrongful death, loss of services or otherwise which may arise out of my use of any equipment or participation in these activities. I specifically understand that I am releasing, discharging, and waiving any claims or actions that I may have presently or in the future for the negligent acts or other conduct by the representatives or employees of Linkage or Pain & Injury Solutions Inc.

I HAVE READ THE ABOVE TERMS, WAIVER AND RELEASE AND BY SIGNING IT AGREE. IT IS MY INTENTION TO EXEMPT AND RELIEVE "Linkage" or "Pain & Injury Solutions Inc." AND THEIR REPRESENTATIVES, EMPLOYEES FROM LIABILITY FOR PERSONAL INJURY, PROPERTY DAMAGE OR WRONGFUL DEATH CAUSED BY NEGLIGENCE OR ANY OTHER CAUSE.

Name (print) ____

Signature ____ Date _________________

There are no refunds for therapy/training services, packages or assessments. There is a 24 hour cancellation policy, if you neglect to call within 24 hours of your scheduled session you will be charged the session in full. If you cancel a scheduled session within the 24 hours, you must reschedule within 7 days to avoid losing the cancelled session. No exceptions.

Today's Date:_________________

Required to Have on File

CREDIT CARD AUTHORIZATION FORM

I, ______________________________ hereby authorize Pain & Injury Solutions Inc. to charge my credit card # ___________________________________ with the expiration date of ____/____/____ and security code number ____________ issued by(circle one card type)

By signing this form, I agree with all terms and conditions of the sale/order, as specified in the Pain & Injury Solutions Inc. Service Agreement, which I have made over the phone, by fax, or via the Internet. I also authorize Pain & Injury Solutions Inc. to charge recurring service fees not to exceed the amount of the fee for service or cost of product provided to this card, as well as any additional usage fees applicable, for the service subscription authorization period of 1 year from this date. Pain & Injury Solutions Inc. is also authorized to charge this card in the future for any additional services, or service upgrades, that I request on my account, during the service subscription authorization period. I understand that if I finish treatment or discontinue use of service, Pain & Injury Solutions Inc. will cease charging this credit card, and cancel all recurring billing.

Billing information of my credit card, if different from previously listed address:

Card Holder: ____

Street Address: ____City __________________ State _________ Zip/Postal Code ________________ Phone Number: ________________________

I understand that this information will be used for purposes of verification with the credit card issuer/processors to prevent fraudulent usage. This procedure is executed within strict rules established in United States Code, Title 18, Part I, Chapter 63. *Please note:* If your credit card expiration date changes, and/or if you are issued new credit card numbers, and/or if you wish to utilize a different credit card than presented on this form, and/or upon expiration of the service authorization period authorized by this form, you will need to complete and provide to Pain & Injury Solutions Inc. a new/revised Credit Card Authorization Form.

Printed Name: ____

Signature: ____ Date: _____/_____/_____

There are no refunds for therapy/training services, packages or assessments. There is a 24 hour cancellation policy, if you neglect to call within 24 hours of your scheduled session you will be charged the session in full. If you cancel a scheduled session within the 24 hours, you must reschedule within 7 days to avoid losing the cancelled session. No exceptions.