Back Benders

Chiropractic Massage Pilates
Energetic Medicine

WELCOME, BACK BENDER!

DR. BEATRIZ H-TUPTA. - THE HOLISTIC HEALER

We are thrilled to serve your back bending needs and help you stay healthy...naturally! (Heck, we've been doing this since the 90s!) Caring for your body is our main mission, which is why we offer an integrated, whole-body approach to health, combining chiropractic care, massage therapy, Pilates...and even energy healing and meditation!

Please take a few minutes to fill out this form, and PLEASE print clearly! But first of all...

WHO MAY WE THANK FOR REFERRING YOU TO US?:_____

NAME:_____

ADDRESS:_____

CITY:_____ STATE:_____ ZIP CODE:_____

DATE OF BIRTH:_____/____/_____ GENDER (circle one) : MALE/ FEMALE/ TRANS/BINARY

HEIGHT:_____ WEIGHT:_____

MARITAL STATUS: [__] SINGLE [__] MARRIED [__] DIVORCED [__] DOMESTIC PARTNER [__] WIDOWED

PRIMARY PHONE NUMBER: (_____) _____-_____

SECONDARY PHONE NUMBER:(_____) _____-_____

EMAIL ADDY:_____@_____

EMPLOYMENT STATUS *(Check all that apply)*:

[__] FULL TIME [__] PART-TIME [__] SELF-EMPLOYED [__] UNEMPLOYED [__] STUDENT [__] PART-TIME STUDENT

EMPLOYER NAME: _____

PROFESSIONAL TITLE:_____

EMPLOYER ADDRESS:_____

EMPLOYER PHONE NUMBER(_____)_____-_____

EMERGENCY INFO

EMERGENCY CONTACT NAME:_____

RELATIONSHIP TO YOU:_____ PHONE NUMBER: (_____) _____-_____

GETTIN' DOWN TO IT

Main reason for your visit:

[__] EMERGENCY [__] NEW INJURY [__]OLD INJURY [__] CHRONIC PAIN [__] WELLNESS VISIT

Have you ever been seen by a chiropractor? [___] YES [___] NO

If "YES" please let us know when and what for:

_____

Have you had a professional massage before? [___] YES [___] NO

If "YES" please let us know when and what for:

_____

Have you ever taken Pilates before? [___] YES [___] NO

If "YES" please let us know when and for how long you practiced Pilates for:

_____

Is your visit related to an injury? [___] YES [___] NO

If "YES" please let us know where:

[__] WORK [__] SPORTS [__] WORKOUT [__] ROUTINE/ HOUSEWORK/ GARDENING [___]AUTO ACCIDENT

Patient Name _____ Date _____

When did the pain and/or injury occur?_____

Please explain to us what happened:

_____

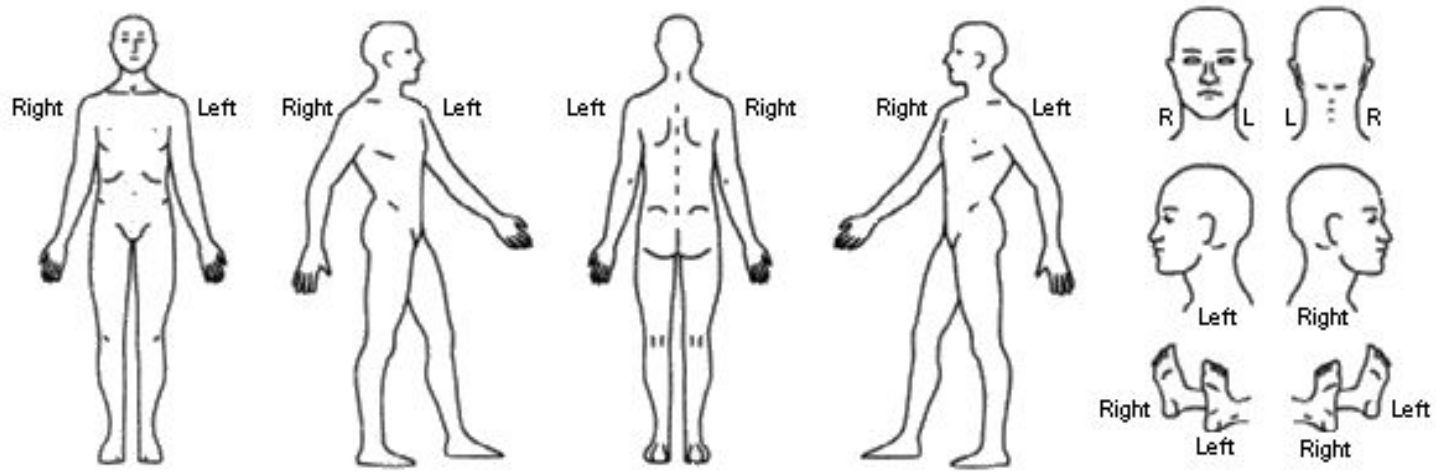
_____

_____

_____

_____

Using the body diagram to circle all affected areas.



Are you currently in pain? [__] YES [__] NO

If "YES" please rate your pain:

General Discomfort 1___2___3___4___5___6___7___8___9___10 ____ *Very Severe*

Is your condition getting worse? [___]YES [___] NO [___] THE SAME [___] COMES AND GOES

Is your condition interfering with one or all of the following: [___] WORK [___] SLEEP [___] DAILY ROUTINE

If so, please give us some more detail:_____

_____

_____

Has anything like this happened in the past? [___] YES [___] NO

If "YES" please explain: _____

Patient Name _____ Date _____

Are you taking any medication? [___] YES [___] NO

(Example: Nerve Pills, Medical Marijuana, Pain Killers, Aspirin , Muscle Relaxers, Blood Thinners, Tranquilizers, Insulin, HRT, Fertility, etc.)

Page:

If "YES," which ones do you take: _____

And, how often do you take them: _____

*PLEASE NOTE THAT ANY KIND OF ASPIRIN/ ASPIRIN BASED PILLS MAY CAUSE BRUISING*_____*(PATIENT INITIALS)*

Have you had any surgeries recent or otherwise? [___] YES [___] NO

If "YES," please describe:_____

Do you take any kind of supplements or vitamins? [___] YES [___] NO

If "YES" which ones:_____

Do you use any essential oils/holistic healing elements (i.e.magnesium baths, warming oils) [___] YES [___] NO

If “YES,” which ones: _____

Do you smoke? [___] YES [___] NO

If "YES" How many/day:_____ times a week?_____

Do you drink? [___] YES [___] NO

If "YES" how many/day:_____ times a week?_____

Do you have allergies? [__]YES [__]NO

If “YES,” please list: _____

Do you have any skin conditions? [__]YES [__]NO

If “YES,” please list: _____

Do you have any infectious condition? YES[__] NO [__]

If "YES" which ones:_____

Do you have frequent headaches? YES[__] NO [__]

If "YES," please explain:_____

Patient Name _____ Date _____

For the Ladies:

Are you on birth control? [___]YES [___] NO Are you nursing? [___] YES [___] NO

Are you pregnant? [__]YES [__] NO If "YES"...CONGRATS! How far along are you?_____

If pregnant, we will need a medical release from your doctor in order for you to do Pilates

If you've had kids, did you have them via C- Section or natural birth? _____

Please check which medical conditions or procedures you have or have had in the past, so we know how to best help you!

[__] Migraines
[__] Arthritis
[__] Lower Back Problems/ Surgery
[__] TMJ Pain
[__] Disc Problems/ Disc Replacement
[__] Hip Problems/ Hip Replacement
[__] Coronary Heart Disease
[__] Osteoporosis/Osteopenia
[__] Knee Issues/Knee Replacement
[__] Stroke
[__] Chronic Fatigue
[__] Tendonitis
[__] Thyroid Disease
[__] MS
[__] Asthma
[__] Neck Pain
[__] Sinus Problems
[__] Artificial Bones/Joints/Implants
[__] Cancer (please describe:_____)
[__] Impingement Syndrome
[__] Numbness (on left side/ right side of the body/ face)
[__] Hernia
[__] Diabetes (Circle: Type I or Type II)
[__] Emphysema
[__] Dizziness
[__] Bursitis
[__] Hypertension
[__] Fibromyalgia
[__] High Cholesterol
[__] Scoliosis (Type of Curve: _____)

IT'S ALL IN THE FAMILY

Check off which conditions your family's experienced, so we can create the best preventative plan for you! (No need to go back eons. Father and Mother's medical history will do just fine.)

PATERNAL:

[__] HEART MURMUR
[__] MIGRAINES
[__] BACK PAIN
[__] NECK PAIN
[__] INSOMNIA
[__] CANCER (Please describe: _____)
[__] SINUS PROBLEMS
[__] ARTHRITIS
[__] DIABETES (Circle one: Type I or Type II)

MATERNAL

[__] HEART MURMUR
[__] MIGRAINES
[__] BACK PAIN
[__] NECK PAIN
[__] INSOMNIA
[__] CANCER (Please describe:_____)
[__] SINUS PROBLEMS
[__] ARTHRITIS
[__] DIABETES (Circle one: Type I or Type II)

Patient Name _____ Date _____

WE GOT YOU COVERED…AND SO DOES YOUR INSURANCE CO.

***Please allow us to make a copy of your insurance card and I.D. for our records. Gracias!*

INSURANCE NAME:_____

NAME OF POLICYHOLDER:_____ (SELF/PARENT/ SPOUSE)

SUBSCRIBER ID#_____ GROUP#_____ SS#_____-_____-_____

PATIENT NAME:_____

PLEASE SIGN HERE:_____

(PATIENT SIGNATURE)

DATE:_____

LET'S GET PHYSICAL…PHYSICAL!

In order to participate in our kick-abs Pilates program, we need a bit of your exercise history. This also is needed so our massage therapists can know what kinks to work on, given your physical history.

If I have any heart issues, chest pain, bone or joint problem that can be made worse by a change in physical activity, am currently, or in the future, on blood pressure or heart condition medication, am pregnant, or know of any other reason why I should not engage in physical activity, I understand and agree that I must consult my physician before engaging in physical activity, discuss what type of activity is suitable for my current condition, and obtain a medical release for any physical activity at Back Benders, including, but not limited to Pilates. _____

Patient's Initials

Is there any other condition that we need to be aware of to safely engage you in exercise? [__]YES [__]NO

If "YES," please explain_____

Do you currently work out on a regular basis? [__]YES [__]NO

If "YES," please explain your workout regimen_____

_____

_____

_____

Has any exercise program had a positive or negative effect on your body? [__]YES [__]NO

If "YES," please explain_____

_____

Patient Name _____ Date _____

What are your fitness goals? *(Please check all that apply)*

[__] Back Pain Reduction [__] Gain Core Strength [__] Stress Reduction
[__] Increase Flexibility [__] Gain Energy [__] Injury Recovery
[__] Weight Loss [__] Gain Muscle Tone [__] Improve Posture

Which recreational activities do you currently partake in? *(Please check all that apply)*

[__] Yoga [__] Group Exercise [__] Pilates
[__] Martial Arts/Boxing [__] Zumba [__] Golf
[__] Tennis [__] Basketball [__] Cycling/Spinning
[__] Skiing/Snowboarding [__] Dance [__] Swimming
[__] Volleyball [__] Running [__] Chasing after my young kids
[__] Other: _____

BACK BENDERS WAIVER

(CAUTION: Some fancy-shmancy legal jargon is included, so please read carefully)

I, _____, through the purchase of chiropractic, massage, and/or Pilates training sessions, have agreed to voluntarily participate in an exercise and health program, including, but not limited to, chiropractic, massage, strength training, flexibility development, Pilates, and aerobic exercise under the guidance of Back Benders' instructors and therapists. I hereby stipulate and agree that I am physically and mentally sound and currently have no physical conditions that would be aggravated by my involvement in an exercise and/or health maintenance program, and/or have obtained and provided verification from a licensed physician that I am able to undertake a general fitness-training and/or Pilates program. I am aware that Back Benders' instructors and therapists are here to serve me by sharing knowledge of Pilates and health.

I understand and am aware that physical-fitness activities, including the use of equipment and the practice of chiropractic, are potentially hazardous activities. I am aware that participating in these types of activities, even when completed properly can be dangerous. I agree to follow the verbal instructions issued by the instructors and therapists. I am aware that potential risks associated with these types of activities, include but are not limited to: death, fainting, disorders in heartbeat, serious neck and spinal injuries that may result in complete or partial paralysis or brain damage, serious injury to virtually all bones, joints, ligaments, muscles, tendons, and other aspects of the musculoskeletal system, and serious injury or impairment to other aspects of my body, general health, and well-being.

I understand that I must judge my own capabilities with respect to practicing Pilates, or the any chiropractic adjustments and/or massages at Back Benders.

I understand that I am responsible for my own medical insurance and will maintain that insurance throughout my entire period of participation with Back Benders. I will assume any additional expenses incurred that go beyond my health coverage. I will notify Back Benders of any significant injury that requires medical attention (such as emergency care, hospitalization, etc.), or any general changes in my physical and mental health.

Patient Name _____ Date _____

Although Back Benders will take precautions to ensure my safety, I expressly assume and accept sole responsibility for my safety and for any and all injuries that may occur. In consideration of the acceptance of this entry, for myself and for my executors, administrators, and assigns, waive and release any and all claims again Back Benders and any of their staffs, officers, officials, volunteers, sponsors, agents, representatives, successors, or assigns and agree to hold them harmless from any claims or losses, including but not limited to claims for negligence for any injuries or expenses that I may incur while exercising or while traveling to and from training sessions. These exculpatory clauses are intended to apply to any and all activities occurring during the time for which I have contracted with Back Benders.

Back Benders will provide the equipment to be used in connection with the workouts, including but not limited to Pilates reformer, Pilates Cadillac, Pilates EXO chair, and/or any balls, therabands and small weights, and similar items. I represent and warrant any and all equipment I provide for training sessions is for personal use only. Back Benders has not inspected my equipment and has no knowledge of its condition. I understand that I take sole responsibility for my equipment. I acknowledge that although Back Benders takes precautions to maintain the equipment, any equipment may malfunction and/or cause potential injuries. I take sole responsibility to inspect any and all of my equipment or Back Benders' equipment prior to use.

I understand that from time to time during private or semi-private Pilates instruction or chiropractic visits physical adjustments to my form may be necessary by using physical touch. If I do not wish to receive physical adjustments, I will so inform my Back Benders' instructors and therapists immediately at each visit. I also acknowledge that if I do not wish to receive physical adjustments it is my responsibility to inform Back Benders' instructors and therapists when an adjustment has gone as far as I desire at that time.

By signing below I confirm that I understand that massage therapy given at Back Benders is for the purpose of stress reduction, relief from muscular tension or spasm or for increasing circulation and is **NOT** of sexual nature. I understand the massage therapist prescribes neither medical treatment nor pharmaceuticals nor performs spinal manipulations. It has been made very clear that massage therapy is not a substitute for conditions.

I have stated all my known medical conditions and take it upon myself to keep the chiropractors, Pilates instructors, and massage therapists updated on any changes to my physical health.

I represent and warrant I am signing this agreement freely and willfully and not under fraud or duress.

HAVING READ THE ABOVE TERMS AND INTENDING TO BE LEGALLY BOUND HEREBY UNDERSTANDING THIS DOCUMENT TO BE A COMPLETE WAIVER AND DISCLAIMER IN FAVOR OF BACK BENDERS, I HEREBY AFFIX MY SIGNATURE HERETO.

_____

Your Name (please print clearly)

_____

Your Signature

_____

Date

Patient Name _____ Date _____

IF UNDER THE AGE OF 18 PLEASE HAVE PARENT/ GUARDIAN FILL OUT THIS PORTION:

I_____BEING PARENT OR LEGAL GUARDIAN OF_____ AUTHORIZE DR. BEATRIZ H- TUPTA AND HER STAFF TO ADMINISTER CHIROPRACTIC, MASSAGE, AND PILATES AS DEEMED SAFE AND NECESSARY, AND CONSENT TO THE ABOVE CONDITIONS.

PATIENT NAME:_____DATE:_____

BACK BENDERS POLICIES

Please initial each of the policies listed below, so we start our relationship with mutual respect and understanding.

STUDIO + SAFETY

_____ I agree to notify Back Benders if there is a change in my health or medical condition before my next appointment.

_____ I agree to not use the Pilates machines unattended and that I will wear clean socks while on the Pilates equipment.

INSURANCE POLICY

_____ I understand that I am responsible for my own medical insurance, and will maintain that insurance throughout my entire period of participation with Back Benders. I agree to notify Back Benders should my medical insurance coverage and/or company change, before my next appointment.

_____ I understand that Back Benders is contracted with most PPO insurances, and that Back Benders will submit visits to see what my insurance covers. I understand that this is not a guarantee of payment from my insurance company and that if my insurance company does not cover my visits, I will be personally responsible for payment. I understand that Back Benders strongly recommends that I ask my insurance company what coverage I have for chiropractic care (such as deductible, co-pays, preauthorization, amount of visits allowed) and that, as a courtesy, Back Benders will follow up with my insurance company.

TARDY + CANCELLATION POLICIES

_____ I understand Back Benders enforces a 24 hour cancellation policy for all appointments & if I do not cancel my scheduled appointment or class 24 hours in advance I will be charged in full. I understand that the charge may be deducted from my existing package, and/or I will have to pay the full price of the missed session within six weeks and/or at the time of my next lesson, session, or visit.

_____ I understand and agree that the session begins at the time of my appointment, not at the time of my arrival.

PACKAGES + PAYMENT POLICIES

_____ I agree to pay in full for services rendered at the time of my visit and/or pre-pay for a package of visits, unless other arrangements have been made with the office manager and/or doctor.

_____ I understand that all packages are non refundable and non transferable.

Patient Name _____ Date _____

_____ I understand that if a check I write is returned, then I will be charged the full amount for the session which the check was written for, and be charged for the Returned Item Fee as well, which I will need to pay the time of my next session. And, I understand that if a check is returned, I will only be able to pay with cash or card from thereon out.

_____ I understand, that unless stated otherwise, all packages expire within 6 months of purchase.

_____ I understand that I must pay by cash or check for all Healthy Happy Hour sessions.

I have carefully read, fully understand and agree to the above.

Date _____ Signature _____

Patient Name _____ Date _____