Denver Biofeedback Clinic, Inc.

Patient Registration

Name: _____

Street Address: _____ Apt #: _____ City: _____

State: _____ Zip code: _____ Social Security #: _____

Home phone #: ( ) _____ Work phone #: ( ) _____

Cell phone #: ( ) _____ Pager #: ( ) _____

Date of Birth: _____ Gender: Male _____ Female _____ Dominant Hand: R L

Marital Status (circle one): Married Single Divorced # of Children: _____ Ages: _____

Employment status (circle one): Full time Full time with restrictions Part time Student Not working

In case of emergency please notify: Name: _____

Address: _____ Phone: ( ) _____

Work injury: _____ Automobile accident: _____ Major Medical: _____ Are you the insured? _____

If no: Name of insured: _____ SS# of insured: _____

If Major Medical: Group #: _____ ID#: _____

Date of injury: _____ Insurance Claim #: _____

Insurance company covering this claim: _____

Insurance adjuster: _____ Phone #: ( ) _____

Insurance address: _____

Employer's name: _____ Phone: ( ) _____ Fax:( ) _____

Employer contact/supervisor: _____ Have you changed employers since your injury? _____

Name of referring physician: _____ Phone: ( ) _____ Fax: ( ) _____

Physician's address: Diagnosis: _____

Patient or Guardian signature required:
I authorize Denver Biofeedback Clinic, Inc. to perform evaluation and treatment of myself as needed. I authorize the release of any medical or other information necessary to my physicians and insurance company to process this claim. I furthermore authorize payment of medical benefits to Denver Biofeedback Clinic, Inc. I realize that I am fully responsible for any payments not covered by my insurance except where prohibited by law. "I hereby acknowledge that I have received a copy of the Provider's Notice of Privacy Rights."

Signed: _____ Date: _____

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Describe your work and your title or position: _____

If you have work restrictions, please describe them: _____

_____

Please describe how you were injured: _____

_____

Have you had any surgeries related to this injury? (date/description): _____

_____

Please date and describe any other major illnesses, accidents or surgeries that you have had: _____

_____

_____

List all medications and dosages that you are currently taking: _____

_____

Do you have a history of: Diabetes _____ Seizures _____ Thyroid dysfunction _____

Briefly describe activities that are limited due to your current condition: _____

_____

What are your goals and expectations for biofeedback and this training? _____

_____

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SYMPTOM CHECKLIST

Name:_____ Date: _____

____HEADACHES
____HIGH BLOOD PRESSURE
____RINGING IN EARS
____POUNDING HEART
____CONSTIPATION
____LOOSE BOWELS/DIARRHEA
____ULCER/INDIGESTION
____NAUSEA/VOMITING
____FAINTNESS/DIZZINESS
____ALLERGIES
____ARTHRITIS
____TIGHT KNOT IN STOMACH
____ITCHING/RASHES
____SWEATY PALMS
____SHORTNESS OF BREATH
____COLD HANDS/FEET
____FEELINGTENSE/NERVOUS

DIET:
____POOR APPETITE
____OVER-EATING
SKIP MEALS...HOW OFTEN_____
CAFFEINE...HOW OFTEN _____
SUGAR. ..HOW OFTEN _____

HOW OFTEN DO YOU:
USE ALCOHOL_____
USE RECREATIONAL
DRUGS_____
EXERCISE _____
SMOKE _____

PAIN SCALE: FROM O TO 10
0 = NO PAIN, 10 = SEVERE
JAW____ HEAD____ NECK____ ARM____
HIP____ SHOULDER____ LEG____
BACK____ HAND____ FEET____

STRESS SCALE: FROM O TO 10
WORK:____
HOME:____

____EASILY ANNOYED/IRRITATED
____DIFFICULTY CONCENTRATING
____OBSESSIVE THINKING
____ANGER
____DEPRESSION
____INCREASED WORRYING/FEARFUL
____THINKING IMPAIRED JUDGEMENT
____JOB DISSATISFACTION
____LOWERED SELF-ESTEEM
____ACCIDENT-PRONE
____TENDENCY FOR ERRORS

JAW PAIN:
____JAW TENSION
____POPPING/CLICKING PAIN
____AFTER EATING
____PAIN ON AWAKENING
____CLENCHING/GRINDING ....DAY/NIGHT
____TMJ SPLINT
____JAW LOCKS: OPEN____ CLOSED____

SLEEP:
NUMBER OF HOURS PER NIGHT _____
HOW LONG TO FALL ASLEEP _____
SLEEP POSITION: STOMACH____ BACK____ SIDE (RIGHT)____ (LEFT)____

IF YOU HAVE UNRESTFUL SLEEP, PLEASE ANSWER THE FOLLOWING QUESTIONS:
What time do you get ready to go to bed at night?_____ What time do you go to bed?_____
Do you read or watch TV or work in your bed or bedroom? _____
Do you wake up during the night?_____ How many times?_____
If you wake up, do you know why?_____ Explain_____
Are you able to fall back to sleep? _____ How long does it take to fall back to sleep?_____
Do you feel rested in the morning? _____
What time do you wake up in the morning?_____ What time do you get out of bed?_____
Do you fall back to sleep in the mornings? ____ Do you take naps during the day? _____
Do you drink coffee, caffeinated sodas, teas or eat chocolate? _____How often?_____
When is the latest you will have caffeine? _____
Do you drink alcohol in the evening? _____How often? _____

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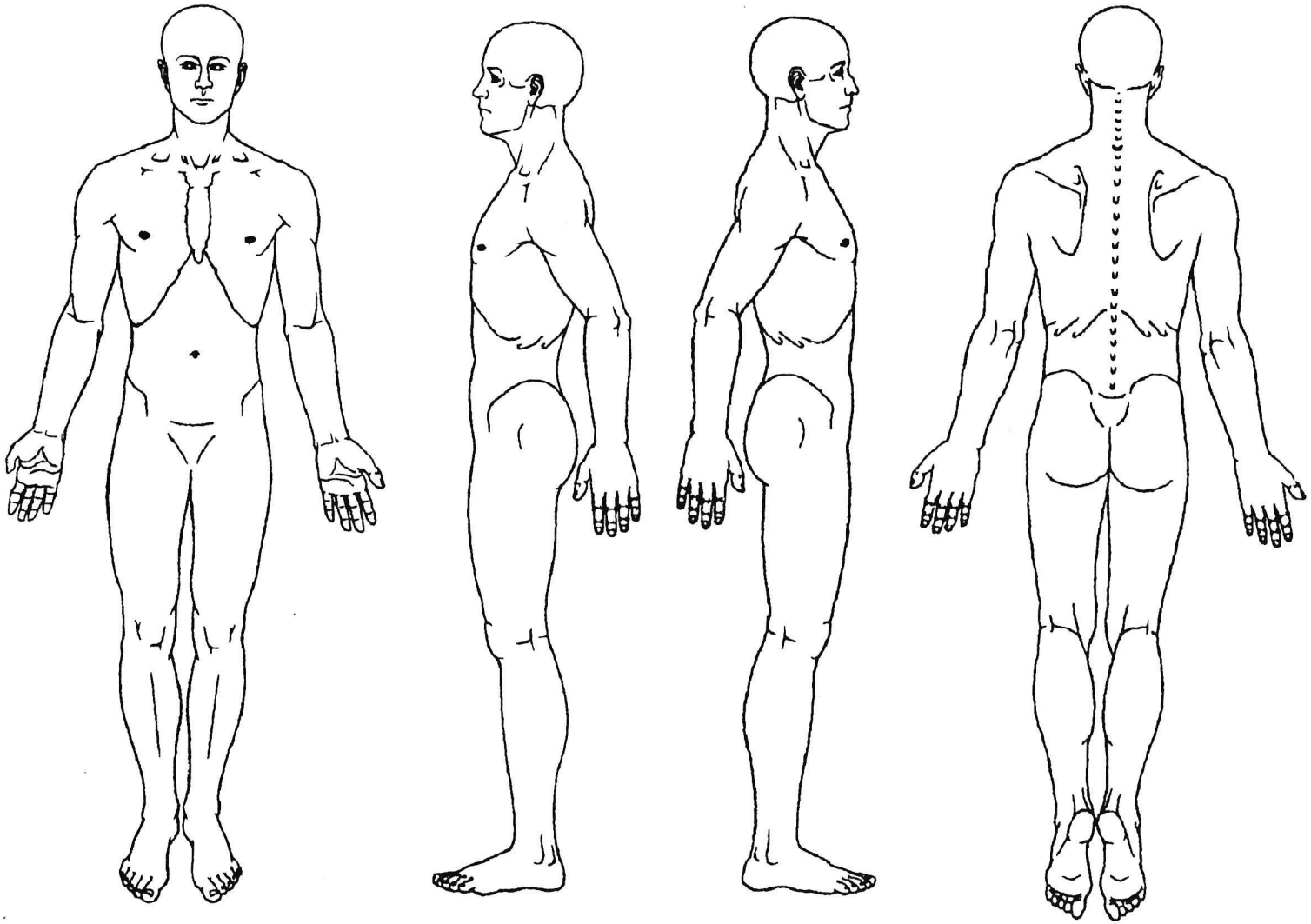
Pain Figure Drawing



Indicate the areas where you have experienced pain during the past week.

Use this key to indicate the type of pain that you are experiencing: Sharp = 1, Dull = 2, Shooting = 3, Discomfort = 4, Numbness = 5.

Denver Biofeedback Clinic, Inc.

Phone 720-855-6680 Fax 303-433-1899

RELEASE OF PROTECTED HEALTH INFORMATION AND VERBAL COMMUNICATIONS DISCLOSURE

I, _____, hereby authorize Denver Biofeedback Clinic, Inc. and its agents to release protected health information related to my evaluation and I or treatment to my insurance company and I or treating physician(s).
I also authorize the individuals, professionals, and companies named below to communicate with and I or release information to Denver Biofeedback Clinic, Inc.

This disclosure is for the purpose of _____Treatment, _____Payment, _____Operations,_____ the release of Psychotherapy Notes, or _____Other. If "the release of Psychotherapy Notes or Other" is checked, regardless of whether additional purposes are also checked, this form is a HIPAA compliant Authorization. As such, Denver Biofeedback Clinic, Inc. may not condition treatment, payment, enrollment in a health plan, or eligibility for health plan benefits on your signing this Authorization. Also, if this is an authorization, the practitioner must provide you a copy.

Insurance name: _____

Address: _____

Phone: _____ Fax: _____

Referring physician: _____

Address: _____

Phone: _____ Fax: _____

Attorney: _____

Phone: _____ Fax: _____

Other:(Physical Therapists, Psychologists, etc.)*** Please give a phone number for each name listed. _____

_____

THIS DISCLOSURE is intended to cover any and all medical records including but not limited to, those regarding drug and alcohol abuse, psychological or psychiatric disorders, muscle injuries or disorders, nerve injuries or disorders, bone or joint injuries and disorders, and brain injuries and disorders.

Denver Biofeedback Clinic, Inc. and its agents, as well as others named above, are AUTHORIZED to verbally communicate with my insurance company and physician(s) and each other concerning the information contained in the medial records and regarding my treatment and evaluation. It is not necessary that I be present during any such conversations. This authorization does not include anyone other than my biofeedback therapist or their agents, and those named above.

I certify that this request is made voluntarily and that the information given above is accurate to the best of my knowledge. This authorization will expire 1 year after the date of signature below. I may revoke this authorization with written notice, except to the extent that the practitioner or Denver Biofeedback Clinic, Inc. has taken action. You may treat a photocopy or fax of this signed authorization as a duly executed original for all purposes.

DATED this day of 20

Signature of Patient _____

Signature of Therapist _____

Denver Biofeedback Clinic, Inc,
499 West Belleview Avenue
Englewood, CO. 80110
720-855-6680 phone
303-433-1899 fax
mailto:denverbiofeedback@comcast.net
www.denverbiofeedback.com

Directions:

From the North:

Take 1-25 South to Santa Fe and Santa Fe South to Belleview. (Belleview is South of 285 or Hampden). Exit off of Santa Fe onto Belleview and you will go under the bridge and now face East on Belleview. Follow Belleview across Windermere and just before Broadway, you will see the building for Global Medicine on your left. Turn into the turning lane and turn left onto Delaware and then a quick left into the parking area.

From the South:

Take 1-25 North to the Belleview exit. Take Belleview West across University and Broadway. Just after Broadway you will see Delaware Street on your right. Turn right onto Delaware and then a quick left into the parking area for Global Medicine.