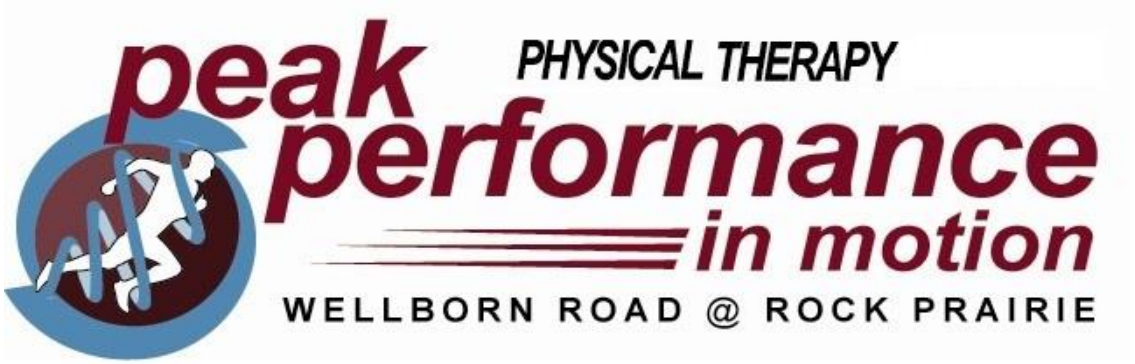

Last name_____ First name_____ Middle_____

Social Security_____ DOB_____ Sex: MALE FEMALE

Mailing Address_____ City_____ State_____ Zip_____

Permanent Address_____ City_____ State_____ Zip_____

Home number_____ Cell number_____ Primary Contact: HOME CELL WORK EMAIL

Employer (If a minor use Guardian's employer)_____ Work Number_____

Email address_____ Spouse Name_____ Contact Number_____

Nearest Relative (Not Living With You)_____ Relationship_____ Contact Number_____

Have you had any imaging done for this injury? YES NO If yes, what type? MRI CT Scan X-RAY OTHER_____

Where was this imaging done? _____ Referring Doctor_____

How did you hear about us? _____

Why are you coming to therapy? (Circle all that apply) PAIN INJURY ACCIDENT SURGERY OTHER_____

Date of injury, accident, surgery_____ When did pain begin?_____

Describe incident_____

Have you received any physical or speech therapy this year? YES NO If yes, where?_____ How many sessions?_____

Release of information: I understand that as part of my healthcare, Peak Performance in Motion originates and maintains medical records describing my health history, symptoms, examination, and test results, diagnosis, treatment and any plans for future care of treatment. I understand that this information serves as a means of communication among the many health care providers who contribute to my care, and as a means by which a payer can verify that services billed were actually provided. I hereby authorize Peak Performance in Motion and any of its employees to furnish to my insurance or third party payer any and all information necessary to process my claims. Initial_____

Assignment of Benefits: I assign and transfer all rights and benefits payable for healthcare rendered to Peak Performance in Motion. A photocopy of this assignment shall be considered as valid and effective as the original.. Initial_____

Consent of Treatment: I hereby consent to and authorize Peak Performance in Motion and its staff to administer any and all treatment as per my physician's orders. Initial_____

I have read and fully understand this document. I attest that the above said information in valid and true. I have signed this document freely and without coercion.

Patient Signature:_____ Date:_____