P5 PERFORMANCE

Date: _____

Thank you for choosing P5 Performance. Please completely fill out the information requested. We may ask you to look over this information from time-to-time to insure accuracy

Patient Name:	Date of Birth:
Address:	Sex: ___Male ___Female
City, State, Zip:	Marital Status: M S D W
Social Security Number:	Employer:
Home or Mobile Phone Number:	Work Phone Number:
Emergency Contact:	Emergency Contact Phone Number:
Insurance company name and policy number- Primary (see Insurance Card): Ins. Name: _____ Policy Holder: _____ Policy Number: _____ Group Number: _____	Insurance company name and policy number- Secondary (see Insurance Card): Ins. Name: _____ Policy Holder: _____ Policy Number: _____ Group Number: _____
Primary Care Physician (if applicable):	
Are you covered under the policy of a spouse, partner, parent, or legal guardian?	

Name of Insured:	Social Security Number:
Date of Birth:	Address:
Home or Mobile Phone Number:	Work Phone Number:
Employer:	Sex: ___Male ___Female Marital Status: M S D W
Referring Physician:	Referring Physician Phone Number:

Signature: _____ Date: _____

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8861 Coleman Boulevard Frisco, Texas 75034

P5 PERFORMANCE

Consent to Treat

I authorize the Physicians of P5 Performance to provide me with reasonable and proper medical care according to today's standards. I acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as to the outcome of any procedure and/or treatments.

_____ _____

Patient/Responsible Party Signature

_____ _____

Witness Date

DISCLOSURE

Patient contact Information:

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

Emergency Contact Name(s): _____

Relationship: _____ Phone: _____

Do you give consent for P5 Performance staff and/or your physician to discuss your medical condition with this person(s) if needed?

YES NO

Printed Name: _____

Signature: _____ Date: _____

COBRA PATIENTS

COBRA patients must provide documentation of active coverage on a month-to-month basic provided by employer.

I _____ am currently on a COBRA plan through my employer and am aware that I am responsible for verification of coverage. In the event that I am unable to provide the necessary documentation and my coverage is not valid, I understand that I am personally responsible for all charges incurred at the time services are rendered.

Signature: _____ Date:_____

Patient History

Where are you currently having symptoms? _____

What treatment have you already received for this conditions: _ Medication _ Surgery _ Physical _ Chiropractic _ None _ Other Please Specify: _____

Family History:

Father	__ Diabetes	__ Heart	__Kidney	__Cancer	__ Other _____
Mother	__ Diabetes	__ Heart	__Kidney	__Cancer	__ Other _____
Brother(s)	__ Diabetes	__ Heart	__Kidney	__Cancer	__ Other _____
Sister(s)	__ Diabetes	__ Heart	__Kidney	__Cancer	__ Other _____

Social History:

EXERCISE	WORK HISTORY	HABITS
__ None	__ Sitting __ Light Labor	__ Smoking Packs/Day_____
__ Moderate	__ Heavy Labor __ Standing	__ Alcohol Drinks/Week_____
__ Daily	__ Currently Working? Yes/ No	__Coffee/Caffeine Drinks Cups/Day_____
__ Heavy	Date you last worked: _____	__ High Stress Level Reason _____

Date and description of **ANY** surgeries: _____

_____

Current Medication (by name, both over-the-counter and prescribed)	Allergies	Vitamins/Herbs/Mineral
_____	_____	_____
_____	_____	_____

Past Medical History: Please circle EACH condition that you have now or have previously suffered from.

AIDS/HIV Diabetes Hepatitis Lung Disease Rheumatoid Arthritis
Allergies/ Asthma Epilepsy High Blood Pressure Osteoarthritis Fibromyalgia
Sexually Transmitted Disease Angina/ Chest Pain Kidney Disease Osteoporosis
Stroke Cancer Heart Disease Liver Disease Pacemaker Thyroid Ulcer
Are you allergic to latex? YES/ NO Do you take blood thinners? YES/ NO
Do you have weakness in your arms and/or legs? YES/ NO

REVIEW OF SYSTEMS: Please circle EACH that applies to you.

Neurologic: Loss of consciousness, paralysis, tremors, gait disturbances, headaches, dizziness, falling, stroke
Cardiovascular: shortness of breath, palpitation, chest pain on exertion, resting chest pain, heart murmur
Musculoskeletal: backache, neck ache, fractures, leg pain with walking, swelling of joints, masses/lumps
Gastrointestinal: heartburn, ulcer, jaundice, hepatitis, blood in stool, nausea, vomiting, IBS, Colitis
Respiratory: chronic cough, wheezing, asthma, pain with breathing, flu, pneumonia, difficulty sleeping flat
Genitourinary: urinary freq urgency, inability to urinate, dribbling increased amount urine, bladder infection
Head & Neck: blurred/double vision, loss of hearing and/or smell, sinus infection, diff swallowing, lump in neck
Psych: anxiety, depression, suicidal ideation, binge eating, Bulimia, Anorexia, Bipolar, Schizophrenia

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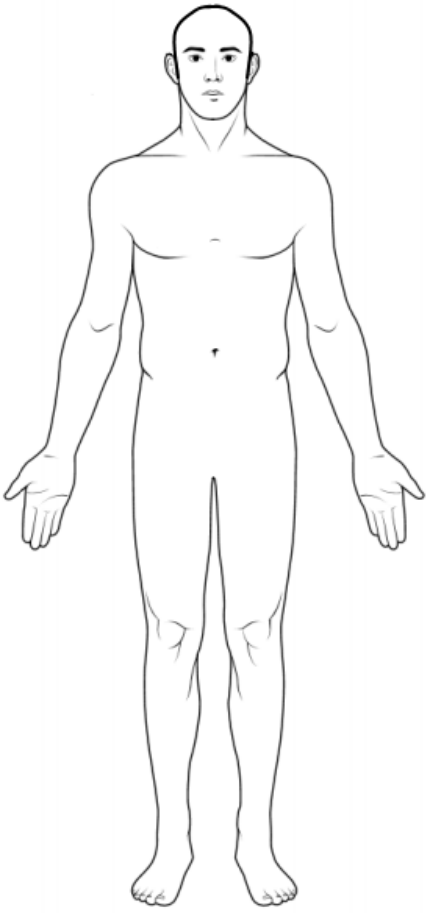
Dermatological: bruising, rashes, itching, skin cancer, abnormal moles, breast mass, burns
General: Recent illness, fever, chills, night sweats, weight loss/gain, abnormal bleeding

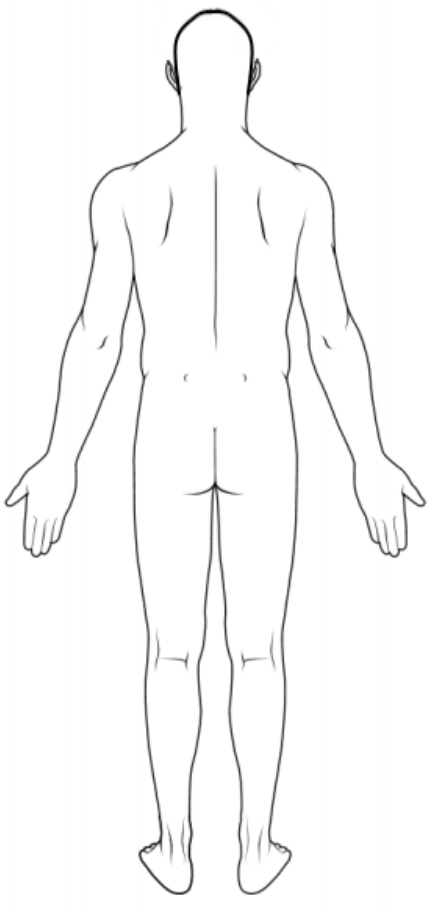
Pain Drawing

Where is your pain **NOW**?
Mark the areas on your body where you feel the described sensations. Use the symbol. Mark the areas of radiation. Include all affected areas.
Ache ^^^ Numbness ooo Pins and Needles === Stabbing /// Burning xxx



Where is the pain?
_____
When did the pain start?
_____
What makes it feel better?
_____
What makes it feel worse?
_____
Time of Day _____

For Provider only	
+/ -	Dejarine's Triad
+/ -	Saddle Paresthesia
+/ -	B/B
+/ -	Progressive motor weakness UE/LE



PLEASE MARK ON THE LINE: How bad is your pain on a scale from 0 to 10?
0 _____10

P5 PERFORMANCE

Assignment of Benefits

Financial Responsibility: All professional services rendered are charged to the patient and are due at the time of service unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments

_____Patient Initials

Assignment of Benefits: I hereby assign all medical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s) including Medicare, private insurance and nay other health/medical plan to issue payments check(s) directly to P5 Performance for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any, I understand that I am responsible for any amounts not covered by insurance. In the event that I receive insurance payment, I realize that I will be billed personally until balance is paid.

_____Patient Initials

Authorization to Release Information: I hereby authorize P5 Performance to release any information necessary to insurance carriers regarding my or my dependent's illness and treatments; to process insurance claims generated in the course of examination or treatment and to allow a photocopy of my signature to be used to process insurance claims for the period of life-time. This order will remain in effect until revoked by me in writing.

_____Patient Initials

No Show/Cancellation Fee: I hereby understand and authorize P5 Performance to collect a $25.00 fee for all missed/no show appointments without a 24 hour prior notification.

_____Patient Initials

_____ _____

Signature of Patient (or Parent if patient is a minor- under 18) Date

_____ _____

Witness (Authorized signature of P5 Performance employee) Date

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P5 PERFORMANCE

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____
Previous Name: _____ Social Security #: _____
I request and authorize_____ to release healthcare information to the patient named about to:

Name: **P5 Performance**
Address: **8861 Coleman Boulevard**
City: **Frisco** State: **Texas** Zip Code: **75034**

This request and authorization applies to:
□ Healthcare information relating to the following treatment, condition, or dates: _____
_____
□ All healthcare information
□ Other: _____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lyphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

□ Yes □ No I authorize the release to my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

□ Yes □ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPRES NINETY DAYS AFTER IT IS SIGNED.

Health Questionnaire: To Be Completed for *Female* Patients

Name: _____ **Date:** _____

Symptom (please check mark)	Never	Mild	Moderate	Severe
Depressive mood				
Fatigue				
Memory Loss				
Mental confusion				
Decreased sex drive/libido				
Sleep problems				
Mood changes/Irritability				
Tension				
Migraine/severe headaches				
Difficult to climax sexually				
Bloating				
Weight gain				
Breast tenderness				
Vaginal dryness				
Hot flashes				
Night sweats				
Dry and Wrinkled Skin				
Hair is Falling Out				
Cold all the time				
Swelling all over the body				
Joint pain				

Family History

	NO	YES
Heart Disease		
Diabetes		
Osteoporosis		
Alzheimer's Disease		
Breast Cancer		

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Health Questionnaire: To Be Completed for *Male* Patients

Name: _____ **Date:** _____

Symptom *(please check mark)*	Never	Mild	Moderate	Severe
Decline in general well being				
Fatigue				
Joint pain/muscle ache				
Excessive sweating				
Sleep problems				
Increased need for sleep				
Irritability				
Nervousness				
Anxiety				
Depressed mood				
Exhaustion/lacking vitality				
Declining Mental Ability/Focus/Concentration				
Feeling you have passed your peak				
Feeling burned out/hit rock bottom				
Decreased muscle strength				
Weight Gain/Belly Fat/Inability to Lose Weight				
Breast Development				
Shrinking Testicles				
Rapid Hair Loss				
Decrease in beard growth				
New Migraine Headaches				
Decreased desire/libido				
Decreased morning erections				
Decreased ability to perform sexually				
Infrequent or Absent Ejaculations				
No Results from E.D. Medications				

Family History

	NO	YES
Heart Disease		
Diabetes		
Osteoporosis		
Alzheimer's Disease		

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