Date seen: _____ By: _____ Consult with: _____

Wellness Manager: _____ Plan: _____ Purchased: _____

Client Information

Preferred Name: _____

Legal Name: _____

Age: _____ Date of Birth: _____

Address: _____

City: _____ Zip: _____

Email: _____

Cell #: _____ Service Provider: _____

Home #: _____ Work #: _____

Best way to contact me would be: ☐ Cell ☐ Home ☐ Work

Opt out of text message reminder: ☐ Yes ☐ No

Occupation/Employer: _____

Emergency Contact: _____

Relationship: _____ Phone #: _____

Get a $5 credit for each of the following:

☐ Google Review
☐ Yelp Review
☐ Link to our website
☐ Tag or follow on Instagram
☐ Like or check-in on Facebook
☐ Review on Mindbody App

How did you hear about us?

☐ Google ☐ Facebook ☐ Yelp ☐ Newspaper ☐ Flyer

☐ Other: _____

☐ Family/Friend. Name: _____

Refer a friend for a free consultation

Name: _____ Phone/Email: _____

Name: _____ Phone/Email: _____

Fitness Goals

☐ Weight Loss/Gain
☐ Improve Diet
☐ Increase Flexibility
☐ Increase Strength
☐ Decrease Body Fat
☐ Improve Cardiovascular Health
☐ Decrease Pain
☐ Increase Range of Motion

☐ Other: _____

Exercise History

What have you done in the past?

☐ Weights ☐ Cardio
☐ Yoga ☐ Kettle bell
☐ CrossFit ☐ Pilates
☐ Plyometrics ☐ Functional training
☐ Other _____

Currently doing? _____

How many days per week? ☐ 0-1 ☐ 2-3 ☐ 2-4 ☐ 3-5 ☐ 6-7

Have you worked with a personal trainer before? ☐ Yes ☐ No

What services are you interested in?

☐ Massage therapy ☐ Personal Training ☐ Chiropractic
☐ Acupuncture ☐ Physical Therapy ☐ Nutrition Counseling
☐ Weight Loss Program ☐ Prolotherapy ☐ Osteopathy
☐ Semi-Private Training ☐ Facial Rejuvenation ☐ Oxygen Therapy

Orthopedic Limitations

	Neck	Back	Hip	Knee	Ankle	Shoulder	Wrist
Recent injury	☐R ☐L	☐R ☐L	☐R ☐L	☐R ☐L	☐R ☐L	☐R ☐L	☐R ☐L
Weak, not chronic	☐R ☐L	☐R ☐L	☐R ☐L	☐R ☐L	☐R ☐L	☐R ☐L	☐R ☐L
Chronic, not severely limiting	☐R ☐L	☐R ☐L	☐R ☐L	☐R ☐L	☐R ☐L	☐R ☐L	☐R ☐L
Chronic, severely limiting	☐R ☐L	☐R ☐L	☐R ☐L	☐R ☐L	☐R ☐L	☐R ☐L	☐R ☐L

Please describe the foods you eat in a typical day:

Time: _____ Breakfast: _____

Time: _____ Snack: _____

Time: _____ Lunch: _____

Time: _____ Snack: _____

Time: _____ Dinner: _____

Surgeries/Hospitalization

What surgeries, operations, traumas, fractures, car accidents, etc. have you had in the past 5 years, 10 years, 15 years +? _____

Medication

Please list any medication you are taking, or have taken in the past, and for how long. State the reason for taking it.

Consent and Liability Waiver Release Form

I, _____
(parent or guardian if client is under 18) on behalf of

_____
(minor or child under 18)
hereby affirm that I am entering a course of instruction in physical fitness and manual therapy, and the basic safety rules for services connected herewith.

I understand and agree that neither the class nor instructors, practicers, owners, operators, agents, including but not limited to MedXcare H. P. (M.H.P.) and/or Santa Cruz CORE Fitness + Rehab (SCCFR), may be held liable in any way for any occurrence in connection with my physical fitness and performance, conditions and limitations which may result in injury, death, or damages to me or my family, heirs or assignees. I further acknowledge and forever release M.H.P. and/or SCCFR in connection directly or indirectly with my physical fitness, training and manual therapy as a result of M.H.P. and/or SCCFR's own negligence, which may result in injury, death or damages to me or my family, heirs or assignees.

In consideration of being allowed to enroll in this service, I hereby personally assume all risks connected with the services, and I further release the instructors, practitioners, program, agents and operators, including but not limited to the persons mentioned, for any injury or damage which may be incurred by me while I enrolled in the fitness or performance service or manual therapy, including all risks connected therewith, whether foreseen or unforeseen; and further claim by me, or my family, estate, heirs, or assignees, arising out of my enrollment and participation in these services.

I further state that I am of lawful age and legally competent to sign the aforementioned release; that I understand that the terms herein are contractual and not merely recital; and that I have signed this document as my own free act.

I have fully informed myself of the contents of the aforementioned and release by reading it before I sign it, that I have been advised to submit, at my own expense and time, to a medical examination to ensure myself, and assume my own responsibility of any wellness program, and am physically fit as tested by a medical examination. I also understand that the owner reserves the right of membership. IN WITNESS WHEREOF, I have executed the aforementioned, agree to hold M.H.P. and/or SCCFR harmless and understand there are NO REFUNDS.

Client's Signature:_____

Date: _____

Authorized Signature:_____
(if client is under 18)

Date: _____

We Take Most Insurances

Includes, but isn't limited to; "Anthem Blue Cross PPO, Blue Shield PPO, Aetna PPO, Cigna PPO, United Health Care PPO, Personal Injury cases and Auto Accident Cases, Workman's Compensation cases.

We do not take any HMOs, such as KAISER, ASH (American Special Health), Blue Shield HMO, Blue Cross HMO, Aetna HMO etc. We also do not take any government funded insurance programs, such as medicare, supplemental medicare, medi-cal, medicaid, or 3rd party.

Insurance Company:

_____

ID#:

_____

Group #:

_____

Primary Holder:

_____

Relation:

_____

I certify that I, and/or my dependant(s), have insurance coverage with

_____

and assign directly to:

☐ MedXcare H.P./SCCFR ☐ Other:_____
☐ Dr. Walton, D.C.
☐ Debra Mayah, LAc.

all insurance benefits, if any, otherwise payable to me for service rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will last as long as I continue care at M.H.P. and/or SCCFR.

Signature of Client, Parent or Guardian:

X _____ Date _____

☐ Client ☐ Mother ☐ Father ☐ Guardian

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

Disclosure of Your Health Care Information

Treatment: We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations. (Example) "It is our policy to provide a substitute health care provider, authorizing M.H.P. and/or SCCFR, to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider's absence due to vacation, sickness, or other emergency situation." Every effort will be made to protect your privacy. If you are at all uncomfortable, please inform any of our staff.

Stress Level

Rate your current stress level on a scale from 1-10 (10 being most stressed). Please note that stress can come in various forms such as being overworked, relationships, health concerns, tiresome family or work responsibilities, excessive fear, worry, anxiety, insomnia, road rage, etc.

Overall Stress: _____

Main Reason for Stress: _____

If your stress level is over 5, what steps are you currently taking to reduce your stress? _____

_____

_____

Energy Level

On a scale of 1-10 (10 being highest) what is your energy level during the following times:

AM: _____ Afternoon: _____

Evening: _____ Late PM: _____

After meals: _____ Overall: _____

Daily Habits/Activities

For each item listed below, specify if you consume them and how often (i.e. 2 cups/day):

Coffee/Tea: _____ Soda: _____

Alcohol: _____

Water: _____

Fast Food: _____

Tobacco: _____

How many hours do you sit per day? _____

Vitamins/Minerals: ☐ Multi ☐ Vitamin D ☐ Omega-3

Sleep Quality

How is your sleep? (check all that apply)

☐ Restful ☐ Restless
☐ Hard to get sleep ☐ Wake up often
☐ Nightmares ☐ On back
☐ On side ☐ On stomach

What time do you usually go to sleep? _____

Hours of sleep/night? _____

Family History

	Maternal Grandpa	Maternal Grandma	Paternal Grandpa	Paternal Grandma	Mother	Father	Brother	Sister	Onset	Outcome
Allergies	☐	☐	☐	☐	☐	☐	☐	☐		
Arthritis (type)	☐	☐	☐	☐	☐	☐	☐	☐		
Asthma	☐	☐	☐	☐	☐	☐	☐	☐		
Cancer (type)	☐	☐	☐	☐	☐	☐	☐	☐		
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐		
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐		
Mental Disease	☐	☐	☐	☐	☐	☐	☐	☐		
Thyroid Imbalance	☐	☐	☐	☐	☐	☐	☐	☐		

Other _____

Review of Systems

	< Now	< Ever
GENERAL		
Weight loss	☐	☐
Weight gain	☐	☐
HEAD		
Headache	☐	☐
Dizziness	☐	☐
Head trauma	☐	☐
Fainting	☐	☐
Blacking out	☐	☐
EYES		
Change in vision	☐	☐
Cataracts	☐	☐
Light sensitivity	☐	☐
Flashes in vision	☐	☐
Spots in vision	☐	☐
EARS		
Hearing difficulty	☐	☐
Earaches	☐	☐
Discharge	☐	☐
Ringing	☐	☐
NOSE		
Nosebleeds	☐	☐
Sinus problems	☐	☐

	< Now	< Ever
MOUTH		
Bleeding gums	☐	☐
Cold sores	☐	☐
Dentures	☐	☐
Sore throat	☐	☐
Jaw pain	☐	☐
Changes in taste	☐	☐
Hoarseness	☐	☐
SKIN		
Rash	☐	☐
Bruising	☐	☐
Brittle nails	☐	☐
Changes in moles	☐	☐
Itching	☐	☐
LUNGS		
Difficulty breathing	☐	☐
Asthma	☐	☐
Pneumonia	☐	☐
Wheezing	☐	☐
Persistent cough	☐	☐
Coughing phlegm	☐	☐
Coughing blood	☐	☐
Tuberculosis	☐	☐

	< Now	< Ever
VASCULAR		
Chest pain	☐	☐
Palpitations	☐	☐
Ankle swelling	☐	☐
Cold feet/hands	☐	☐
Leg cramps	☐	☐
Calf pain	☐	☐
Varicose veins	☐	☐
Low blood pressure	☐	☐
High blood pressure	☐	☐
G-I SYSTEM		
Gas	☐	☐
Heartburn	☐	☐
Indigestion	☐	☐
Ulcers	☐	☐
Vomiting/Nausea	☐	☐
Abdominal pain	☐	☐
Diarrhea	☐	☐
Constipation	☐	☐
Blood in stool	☐	☐
Hemorrhoids	☐	☐
Gallbladder disease	☐	☐
Liver disease	☐	☐

	< Now	< Ever
G-U SYSTEM		
Difficulty urinating	☐	☐
Pain urinating	☐	☐
Blood in urine	☐	☐
Incontinence	☐	☐
Foul odor of urine	☐	☐
Increased urination	☐	☐
Decreased urination	☐	☐
Urinary infection	☐	☐
Genital infection	☐	☐
NEUROLOGICAL		
Seizure/epilepsy	☐	☐
Stroke	☐	☐
Tingling sensation	☐	☐
Numbness	☐	☐
Weakness	☐	☐
Difficulty walking	☐	☐
Poor coordination	☐	☐
MUSCLE/BONE		
Joint pain	☐	☐
Arthritis	☐	☐
Bone pain	☐	☐
Fracture	☐	☐

CONDITIONS		
Pregnant	☐	☐
Diabetes	☐	☐
Thyroid condition	☐	☐
Heart condition	☐	☐
Rheumatic arthritis	☐	☐
Rheumatic fever	☐	☐
Glaucoma	☐	☐
Alcoholism	☐	☐
Cancer/tumor	☐	☐
Polio	☐	☐
Parkinson's	☐	☐
Multiple Sclerosis	☐	☐
Gout	☐	☐
Anemia	☐	☐
Osteoporosis	☐	☐
Osteoarthritis	☐	☐
High cholesterol	☐	☐
TIA's		
Pacemaker	☐	☐
Stroke	☐	☐
Allergies	☐	☐

Our answering machine is not a closed system. When messages are retrieved, there is a chance your message could be overheard. Again, every effort is made to take messages off the machine with your privacy considered. Staff monitors our filing area at all times, as it is separate from the treatment rooms.

Worker's Compensation: We may disclose health information, as necessary, to comply with State Worker's Compensation Laws.

Emergencies: We may disclose health information to notify, or assist in notifying, a family member, or another person responsible for your care about your medical condition or in the event of emergency or of your death.

Public Health: As required by law, we may disclose health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting diseases or infectious exposure.

Judicial and Administrative Proceedings: We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement: We may disclose your health information to law enforcement officials for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Persons: We may disclose your health information to coroners or medical examiners.

Research: We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

Public Safety: It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious or imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies: We may disclose health information for military national security, prisoner and government benefit purposes.

Marketing: We may contact you for marketing purposes as described below:

1) As a courtesy to our patients, it is our policy to call your home on the evening prior to your scheduled appointment to remind you of your appointment time. If you are not at home, we will leave a reminder message on your answering machine or with the person answering the phone. No personal health information will be disclosed during this reporting or message other than the date and time of your scheduled appointment.
2) As a service to our patients, it is our policy to occasionally send a health newsletter or a flyer regarding upcoming health classes offered on our premises. It is not our policy to disclose any personal health information about your condition for the purpose of these marketing mailings.
3) It's our practice to participate in charitable events to raise awareness, food donations, gifts, money, etc. During these times we may send you a letter, postcard, invitation, or call your home to invite you to participate in charitable activities. We will provide you with the information about the type of activity, the date and times, and request your participation in such events.
4) Occasionally we will send birthday or holiday greetings or health reminders to our patients. It is not our policy to disclose any personal health information about your condition in these mailings.
5) You grant M.H.P. and/or SCCFR permission to use your likeness in a photograph, video, or other digital media ("photo") in any and all of its publications, including web-based publications, without payment or other consideration. You understand and agree that all photos will become the property of M.H.P. and/or SCCFR and will not be returned. You hereby irrevocably authorize M.H.P. and/or SCCFR, to edit, alter, copy, exhibit, publish, or distribute these photos for any lawful purpose.

Change of Ownership: In the event that M.H.P. and/or SCCFR, is sold or merged with another organization, your health information/record will become the property of the new owner.

Your Health Information Rights

1) You have the right to request restriction on certain uses and disclosures of your health information. However, that M.H.P. and/or SCCFR,is not required to agree to the restrictions you requested.
2) You have the right to inspect and comply health information.
3) You have the right to request that M.H.P. and/or SCCFR, amend your protected health information. Please be advised, however, that M.H.P. and/or SCCFR, is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you cannot disagree with the denial.
4) You have the right to receive an accounting of disclosure of your protected health information made by M.H.P. and/or SCCFR.
5) You have the right to a paper copy of this notice of privacy practices at any time, upon request.

Changes to this Notice of Privacy Practices
M.H.P. and/or SCCFR, reserves the right to amend the Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, M.H.P. and/or SCCFR, is required by law to comply with this Notice.
M.H.P. and/or SCCFR, is required by law to maintain in the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact us,by calling this office at 831-425-9500. You may make an appointment or a personal conference in person or by telephone within 2 working days.

I have read the Privacy Notice and understand my rights contained in the notice. By way of my signature, I provide M.H.P. and/or SCCFR with my authorization and consent to use and disclose my protected health care information for the purpose of treatment, payment and health care operations as described in the Privacy Notice.

Client's Name (print)

Client's Signature Date

Authorized Facility Signature Date

Santa Cruz CORE Fitness + Rehab
Office Policies

Appointments

We would like to take this opportunity to thank you for being prompt for your appointments. Please arrive 5 minutes prior to your scheduled appointment time to ensure the full length of service. Out of courtesy to our staff and to allow time for other clients to schedule, we require 48 hours notice for appointment cancellations or reschedules.

Missed Appointments/Late Cancellations

If an appointment is cancelled with less than 48 hours notice prior to the appointment, or if you do not arrive for your appointment (no-show), your credit card on file will be charged the amount for the full session. If you have a pre-paid service on your account (i.e., a package item or membership) the session will be deducted from your account. If you are using a voucher or gift certificate it will be marked as used.
We pay our practitioners for their time, so when appointments are late, cancelled, or missed, we respectfully ask for your cooperation with this policy.

Prompt Payment

Payment is expected at the time of service. To reserve an appointment a credit card or redeemable gift certificate/ voucher number will be taken at the time of booking to reserve the space. ***We do not offer any refunds. All sales are final.*** There is a $35 fee on all returned checks and $25 fee on declined autopay transactions.

Insurance Policy

if you are using your insurance for any of the services at core if you are unable to make it to half or more of your appointment you will need to pay in full for the appointment as we will not be able to bill insurance for the shortened appointment.

Discounted Services

Coupons and discounts can only be applied to full service rates/prices. Monthly massage, contracted service rates, insurance copays and sessions billed to insurance cannot be further discounted in conjunction with any published coupons or specials.

Appointment Histories

Clients are responsible to maintain any receipts or documentation for their visit histories. We maintain medical records as per the law, but providing of appointment histories and billing of insurance is not guaranteed by Santa Cruz CORE Fitness + Rehab, LLC (if the medical providers are not in network with your insurance company). Clients are advised that providing reports of appointment histories will cost $35 and take a minimum of 2 weeks from the time of the request.

I have read and agree to Santa Cruz CORE's office policies and payment agreements.

Patient Signature: _____

Date: _____