thrivewellness

Inspiring & Cultivating, Healthy, Balanced Lifestyles...

CONFIDENTIAL PATIENT RECORD **DATE**

Please print legibly and fill out the form in its entirety.

Is your visit today a work-related injury or automobile accident? ***YES*** ☐ ***NO*** ☐

Name:

Address: Date of Birth: Age:

City: Email:

State: Phone #: (home)

Zip: (work)

Sex: MALE or FEMALE (mobile)

Preferred Contact Method: PHONE ☐ *or EMAIL* ☐

Emergency Contact (include phone #):

Relation to you:

Do you have insurance coverage for your treatment today? YES* ☐ NO ☐

**If yes, please make sure that you give your practitioner your insurance card so that we can verify your benefits*

What is your occupation?

What is your primary reason for today's visit?

Who is/are your practitioner(s) at Thrive?

How did you hear about us?

Would you like to be added to our monthly online newsletter? YES ☐ NO ☐

What are your health interests?

☐ Acupuncture ☐ Massage ☐ Personal Training

☐ Postural Therapy ☐ Nutrition ☐ Counseling

Are there any suggestions for the clinic that could make your experience more enjoyable?