Dunamis Accelerated Recovery and Performance
Patient Intake Form

ALL FIELDS MUST BE COMPLETED OR THIS FORM IS INVALID
NOTE: ALL INFORMATION IS KEPT STRICTLY CONFIDENTIAL

PATIENT HISTORY AND PRESCRIPTION REQUEST

Today's Date:_____

Patient name: _____

E-mail address: _____

Home address: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Work: _____

Cell phone: _____

Sex: Male/ Female Date of Birth: _____ Marital status: _____

Student status: _____ Employment status: _____

Emergency contact: _____ Phone: _____

CONTRAINDICATIONS FOR ARP

Please circle all present symptoms related to your current condition:

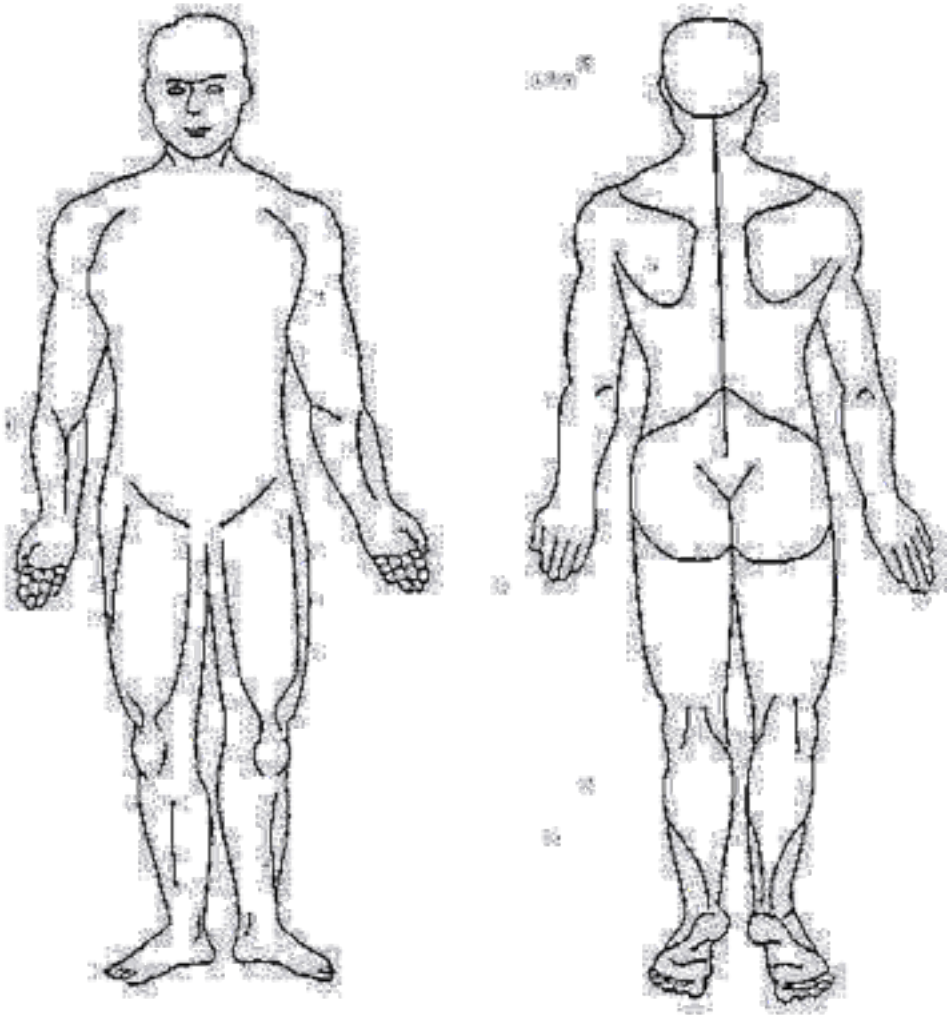
Are you pregnant or breastfeeding? : Yes No

Do you have a pacemaker? : Yes No

Do you have cancer? : Yes No

Do you have a history of blood clots? : Yes No

TO HELP MEET YOUR NEEDS, PLEASE INDICATE WITH AN 'X' YOUR PRIMARY AREA OF DISCOMFORT AND CIRCLE ANY OTHER AREAS OF DISCOMFORT ON THE FOLLOWING DIAGRAM:



When did your symptom/complaint begin?

_____

Describe your current symptom complaint:

_____

_____

_____

What was the cause of your symptom?

_____

How have your symptoms progressed?

_____

What other treatments have you done? (Circle all that apply)

Massage medication physical therapy

Rest/Ice/compression surgery chiropractic

Other:_____

What activity or movement bothers you the most?

_____

What activity or movement lessens your symptoms?

_____

What does your pain feel like? (Circle) burning stabbing aching numbing pins & needles

Rate the intensity of your pain: 1 2 3 4 5 6 7 8 9 10

Have you been seen by another doctor for your current condition?

Doctor's Name: _____ Phone_____

Result of visit

_____

_____

TRUTHFUL REPRESENTATION:

UPON SELECTING THE FOLLOWING BOX STATING "ALL INFORMATION IS TRUE" I HEREBY STATE THAT ALL THE INFORMATION I HAVE PROVIDED IS TRUE, CORRECT AND COMPLETE. IF MORE INFORMATION ABOUT MY CONDITION BECOMES KNOWN, I WILL TELL THE DOCTOR WHEN POSSIBLE SO THAT IT CAN BE ADDED TO MY RECORD:

_____ ALL INFORMATION IS TRUE. (Please initial)

RELEASE OF LIABILITY:

IN CONJUNCTION WITH MY TREATMENT WITH THE ARP AT DUNAMIS ACCELERATED RECOVERY AND PERFORMANCE AND AS PART OF THE CONSIDERATION FOR MY TREATMENT, I, MY HEIRS, EXECUTORS, SPOUSE, SUCCESSORS, ASSIGNS, OFFSPRING AGENTS, AND REPRESENTATIVES EXPRESSLY RELEASE, HOLD HARMLESS, AND INDEMNIFY DUNAMIS ACCELERATED RECOVERY AND PERFORMANCE, CHRIS KNOTT, INC., ITS OWNERS, AGENTS, EMPLOYEES, REPRESENTATIVES, ASSIGNEES, LICENSEES, AND INVITEES, FORM ALL LIABILITY FOR ANY TREATMENTS GIVEN.

AFTER YOU HAVE ANSWERED ALL OF THE QUESTIONS ABOVE, PLEASE SIGN BELOW.

Signature _____ Date _____