Katie Gavin, MSPT, LMT
Boulder Higher Health
Phone: 720-772-8167
Fax: 713-913-0946

Date: ____/____/____

File #: _____

Client Information

Personal Information

Patient Name: _____ Preferred Name: _____

Birthdate: _____/_____/_____ Age: _____ Male: ☐ Female: ☐ Other: ☐

Address: _____ City: _____ State: _____ Zip: _____

Daytime Phone: _____ Evening Phone: _____

Email: _____ Referred By: _____

Emergency Information

Name: _____ Relation: _____

Phone: _____

Medical Doctor: _____ Phone: _____

Employment Information

Employer: _____ Occupation: _____

Reason For Visit

The reason for this visit is a result of: ☐ Work ☐ Sports ☐ Auto ☐ Trauma ☐ Chronic ☐ Surgery

Explain what happened: _____

_____

_____

Please describe the pain & it's location: _____

_____

_____

_____

When did condition begin: ____/____/____ Is it getting worse? ☐ Yes ☐ No ☐ Constant ☐ Comes and Goes

Does it interfere with Work Sleep Daily Routine Explain: _____

Have you had this or similar conditions in the past? ☐ Yes ☐ No Date: ____/____/____

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Client Information Continued

Health History

Please list any current medications here: _____

_____

Do you have or ever had any of the following conditions? (Please check all that apply.)

- ☐ Heart Attack
- ☐ Hepatitis
- ☐ Cellulitis
- ☐ Heart Surgery/Pacemaker
- ☐ Diabetes
- ☐ Artificial Bones/Joints
- ☐ Auto-immune disease
- ☐ Fractures
- ☐ Severe/FrequentHeadaches
- ☐ Sinus Problems
- ☐ HIV+/AIDS
- ☐ Cancer
- ☐ Fainting/Seizures/Epilepsy
- ☐ Difficulty Breathing / Asthma
- ☐ Arthritis
- ☐ Vertigo
- ☐ Alcohol/Drug Abuse
- ☐ Miscarriage
- ☐ Lower Back Pain
- ☐ Lyme disease
- ☐ Chemotherapy
- ☐ Stroke/TIA
- ☐ Anxiety / Depression
- ☐ Congenital Heart Defect
- ☐ DVT/Blood Clots
- ☐ High/Low Blood Pressure
- ☐ Traumatic Brain Injury or Concussion
- ☐ OSteoporosis/Osteopenia

Please list any other serious medical conditions you have or ever had: _____

_____

Allergies: _____

_____

Previous surgeries with dates: _____

Any past serious accidents with dates: _____

Are you pregnant? ☐ Yes ☐ No How Long? _____ Nursing? ☐ Yes ☐ No

I, (your name) _____, give my therapist, Katie Gavin, 'consent to treat' in regards to my treatment goals.

I, (your name) _____, give my consent for my therapist, Katie Gavin, to communicate about my personal medical information or discuss my injury and status with the provided insurance adjuster, doctor and/or referring provider (chiropractor, PT or acupuncturist) if applicable. Otherwise, privacy and HIPPA guidelines will be strictly adhered to.

We realize that emergencies and other scheduling conflicts arise and are sometimes unavoidable. However, advance notice allows me to fulfill my other client's scheduling needs and keeps my business operating at is most efficient level.
A 24-hour notice is required to change or cancel an appointment. If you miss an appointment without notifying us you will be charged the cost of the session. If you cancel late, you will be charged the full amount of your session as a cancellation fee that Weather, covid safety and emergencies are exceptions. I understand and agree.

I have read, understand and agree to abide by the above policy.

Signature: _____ Date: _____

☐ Adult ☐ Patient ☐ Parent or Guardian