Greenwich Wellness

11 Maple Avenue
Greenwich, CT 06830
203-637-1111

Date:

Patient Number:

Whom may we thank for referring you to Greenwich Wellness? ____________________

Name: ______________________________ Male: ___Female: ___ Date of Birth:_______

Address: ______________________________City:________________Zipcode:______________

Preferred Phone: ____________________ Secondary Phone: ____________________

Email:______________________________

Relationship Status: ________________ Partner's Name________________ *Children:* ____________

What type of exercise do you perform on a daily basis? ___None ___ Moderate ___Heavy

What do your daily work habits include? (e.g. sitting, standing, light labor, heavy labor, computer work)

____

Do you smoke? ___Yes ___No How much liquor to you consume on a weekly basis?______________

How much coffee or caffeinated beverages do you consume on a daily basis?________________

(For Women) Are you pregnant? ___Yes ___No

Please list all medications you are currently taking: ______________________________

Allergies: ____

Are you currently experiencing any symptoms? ___Yes ___No

If Yes, please explain:

____

____

Where specifically is the problem(s) located? ______________________________________

Type of Pain: ___Sharp ___Dull ___Throbbing ___Numbness ___Burning ___Aching ___Shooting
___Tingling ___Cramps ___Stiffness ___Swelling ___Other:________________

Rate the severity of your pain on a scale from 1(least pain) to 10(severe pain) ___

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Have you suffered from:

___ Dizziness ___ Diabetes

___ Heart Trouble ___ Headaches

___ Arthritis ___ Neuritis

___ Asthma ___ Neck Pain

___ Nervousness ___ Backaches

___ Digestive Disorders

___ Sinus Trouble

Have you ever been in a car accident? ___Yes ___No

If Yes, please explain any injuries from the accident:

____

____

____

List any surgeries you have had:

____

____

____

____

What supplements are you currently taking and/or considering?

____

____

Do you feel energized or tired more frequently? If more tired, how do you manage your energy levels?

____

____

What additional health goals do you have?

____

____

DOCTOR'S NOTES ONLY

Financial Responsibility

I am responsible for all charges incurred, for all treatments rendered for all dates of service here forward.

Initial Visit	$199.00
Adjustment	$105.00
Massage Therapy	$50.00
Acupuncture	$120.00
Erchonia Laser	$40.00
IASTM	$120.00
Nutritional Consultation	$160.00
Supplements (non-refundable)	Prices Vary

I understand my financial responsibility at Greenwich Wellness and will adhere to their policies.

Signature:____ Date:__________

GREENWICH WELLNESS
Dr. Adam Massoud
11 Maple Ave.
Greenwich CT 06830

Tele: (203) 637-1111
Fax: (203) 637-5956

Patient Name:________________________________ Date:______________

Cancellation/ Missed Appointment Policy

Your appointment time has been set aside for you. The time is unavailable to other patients. Therefore, we require at least 24 hours advanced notice if you need to cancel your appointment. For all missed or cancelled appointment with less than 24 hours' notice, you will be charged a $50 cancellation fee. Appointment reminder calls are a courtesy. Should you not receive a reminder telephone call; it is still your responsibility to remember your appointment.

I have read and understand the cancellation/missed appointment a policy

____

(Patient Signature)

If Patient is a minor, please provide parent or guardian's information

Name ________________________ Relationship ________________________

Parent or Guardian signature ____