

# THE RENKENS CENTER

3811 Bedford Ave. Suite 104  
Nashville, TN 37215  
(615) 915-3188

## About You

Full Name: \_\_\_\_\_ Today's Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number You Prefer: \_\_\_\_\_

Email Address: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Whom can I thank for referring you here? \_\_\_\_\_

Would you like to receive The Renkens Center Newsletter once / month via email:  Yes  No

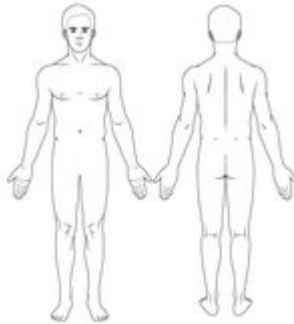
## For What Reason Are You Here?

Pain Complaint  Performance Enhancement

*We are only as strong as our weakest link.*

If you checked 'Pain Complaint' above, please answer the following:

Place a mark on the diagrams below where you feel pain / discomfort.



Rate Your Pain 1 – 10 (10 is the worst pain you can imagine): \_\_\_\_\_

How frequent is the condition?  Constant  Intermittent  Worse in morning  Worse in evening

Is there a specific movement / activity you can do to further provoke your pain?  Yes  No, pain is constant.

Is there anything you can do to relieve the pain?  Yes  No

---

Who or what other therapies have you tried before coming to see me?

List here: \_\_\_\_\_

None

Were X-rays or other imaging exams performed for your complaint?  Yes  No

Please list all surgical procedures and scars you have had:

\_\_\_\_\_

Do you wear orthotics?  Yes  No

#### Your Habits

	Heavy	Moderate	Light	None
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Soft Drinks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Smoke / Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stress Level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How many days a week do you exercise?  5-7 days  3-4 days  1-2 days  I do not exercise

How many meals do you eat per day?  5+  3-4  1-2

On average, how many hours of sleep do you get each night?  9+  7-8  5-6  Less than 5

Rate your level of overall health on a scale of 1 – 10 (10 is as healthy as you can imagine yourself being): \_\_\_\_\_

#### Treatment

Are you interested in  TEMPORARY RELIEF or  PERMANENT SOLUTIONS to your problem(s)?

Are you healthier than you were 5 years ago?  Yes  No

If not, what has contributed to the decline of your health?

\_\_\_\_\_

Will you be healthier 5 years from now than you are today?  Yes  No

If yes, what action steps will you take to make it happen?

\_\_\_\_\_

Would you like to hear how we can help you attain your goals?  Yes  No

\_\_\_\_\_

INFORMED CONSENT TO PATIENT CARE

I understand that the above information and the statements made on this form are accurate to the best of my knowledge and I understand it is my responsibility to inform this office of any changes in medical status.

I hereby request and consent to the performance of adjustments / manipulations and other procedures, including Active Release Techniques®, Muscle Activation Techniques, Kinesio Taping, and low-level laser therapy by Dr. Josh Renkens. I understand that results are not guaranteed.

I further understand and am informed that, as in all health care there are some very slight risks to treatment. I do not expect Dr. Renkens to be able to anticipate and explain all risks and complications. I wish to rely on Dr. Renkens to exercise judgment during the course of the procedure which he feels at the time, based on the facts, is in my best interest.

Please note we do not accept insurance. Payment will be accepted at the completion of each visit. We are more than willing to provide receipt and appropriate documentation upon your request for you to submit independently to your insurance company.

I have read the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the procedures to be taken. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I may seek treatment from Dr. Renkens.

\_\_\_\_\_

Patient's Printed Name

\_\_\_\_\_

Signature

\_\_\_\_\_

Date

\_\_\_\_\_

Parent / Guardian Signature if Minor

\_\_\_\_\_

Date