# Sari Lewis, OTR/L, RCST®

14362 N. Frank Lloyd Wright Blvd. Unit 1105
Scottsdale, AZ 85260

## Confidential Patient Information
## Craniomandibular Face Sheet

### Please Print

Name: _____ Date of Birth: _____

Address: _____ Home Phone: _____

City/State/Zip: _____ Social Security #:_____

Employer: _____ Occupation: _____

Email: _____

Address: _____ Work Phone: _____

City/State/Zip: _____ Cell Phone: _____

Email address:_____@._____

Emergency Contact: _____ Relationship: _____

Phone Number(s) of your Emergency Contact: _____

Whom can we thank for referring you to Sari Lewis, OTR/L, RCST®? _____

### Insurance Information

****Please provide a photocopy of the front and back of your insurance card**

Name of Policy Holder: _____ Date of Birth: _____

Name of Insurance: _____

Address of Insurance Company: _____

Phone Number for Insurance Company: _____

Policy/Group Number: _____ ID #: _____

Name of Patient: _____ Relationship to Policy Holder: _____

Sari hands PLC

## Page 2 Name: _____

What is your major complaint? _____

_____

Are your symptoms: improving _____ getting worse _____ or variable _____

What activities aggravate your condition? (Please circle all that apply)

sitting standing walking bending lifting twisting coughing

Have you had these symptoms in the past? Yes No If yes, when? _____

Have you been treated by any other practitioner for any of the above symptoms? Yes No

If yes, what type of treatment did you receive? _____
Other pertinent information regarding your condition: _____

Mark the items below that you currently have or have ever had:

| | | |
|---|---|---|
| ___Dizziness/fainting | ___Tuberculosis | ___Nervousness |
| ___Backaches | ___Arthritis | ___Sinus trouble |
| ___Heart trouble/pacemaker | ___Headaches | ___Anemia |
| ___Diabetes | ___Numbness | ___Rheumatic fever |
| ___Asthma | ___Cancer | ___Vision problems |
| ___Migraines | ___Neck pain | ___Mid-back pain |
| ___Chest Pain | ___Shoulder pain | ___Arm or hand pain |
| ___Hip, Leg, or feet Pain | ___Digestive disorders | ___Orthodontics |
| ___High blood pressure | ___Dominance change | ___dentures ___braces ___plates |

Are you currently pregnant? Yes No How many times have you been pregnant? _____ No. of children_____

Are you……right handed……left handed……or ambidextrous? (Please circle one)

Has a physician treated you for any health condition in the last year? Yes No If yes, please describe: _____

_____

Who is your primary care physician? _____

When was your last physical exam? _____
List medications: (add sheet, if needed) _____
What surgeries have you had? (Please include dates) _____

---

My signature below certifies that the above information is true and correct. **If applicable,** I give my consent for the therapist to examine and treat my minor child. I also acknowledge that Sari Lewis, OTR/L, RCST®, bills insurance companies as a courtesy to me and that I am ultimately responsible for all charges not covered by my insurance. **If applicable,** I authorize the release of any information necessary to process my insurance claims. I also assign and request payment directly to Sari Lewis, OTR/L, RCST®.

_____ _____

**Patient or Guardian's Signature** **Date**