To schedule an appointment contact us at the following:
Jake Duhon: 337-789-4567 (Cell)
Alex Rozas: 337-580-6782 (Cell)

The Recovery Lounge & Sports Performance
Therapy Center – Jennings
2002 Johnson Street, Suite 100
Jennings, LA 70546

Participant Intake

PARTICIPANT INFORMATION:			
Last Name:	First Name:	MI:	
DOB:	Gender:	Email:	
Address:	City:	State:	Zip:
Home Ph:	Work Ph:		
Cell Ph:	Cell Ph. Carrier:		
EMERGENCY CONTACTS: (please list at least two)			
Name:	Phone:	Relationship to Participant:	
Name:	Phone:	Relationship to Participant:	
__ I agree to have text message reminders sent to me at the cell phone # above			
__ I agree to have email appt. reminders sent to me at the above email address.			
__ I agree to have clinic communications sent to me at the above email address (announcements, exercise programs, etc.)			
If you do not want phone messages to be left for you, please note that here:			
HOW DID YOU HEAR ABOUT US?			
__ Facebook __ Website __ Internet Search ___ School __ Friend/relative __ Athletic Trainer/Therapy Center			
ACKNOWLEDGMENTS/CONSENTS: Initial each line			
______ I hereby acknowledge that I have reviewed the Notice of Privacy Practices and have been offered a copy. This office utilizes a variety of measure to protect your identity and others.			
______ I agree to freely participate in evaluation, treatment, and re-evaluation as deemed necessary by the facility and/ or practitioner. I authorize the information I disclose throughout the course of treatment is accurate to the best of my knowledge. I agree to notify the said facility within 24hrs. should I experience any adverse reactions to treatment I received at this facility.			
______ I acknowledge, in the event that I should require medical care or treatment, I authorize The Therapy Center of Jefferson Davis Parish, Inc. to provide all emergency medical care necessary. In extreme circumstances, I agree to be transported to the nearest hospital. I further agree to assume all costs involved and agree to be financially responsible for any costs incurred as a result of such emergency medical care.			
______ I agree make payment on the date of service.			
Participant/Guardian Signature:		**Date:**	

OPTIONAL

PAST MEDICAL HISTORY:	
Have you been diagnosed or treated for: __ Arthritis/ RA __ Cancer __ Balance issues __ COPD __ Hepatitis __ cardiac conditions __ Diabetes __ Epilepsy __ headaches/migraines __ TB __ Hypertension __ Neurological conditions Do you have a pacemaker? Yes / No Other:	Prior Injuries: Prior surgeries & year performed:
MEDICATIONS:	
Name:	Taken for:
KNOWN ALLERGIES: (please specifically note for any latex allergies)	