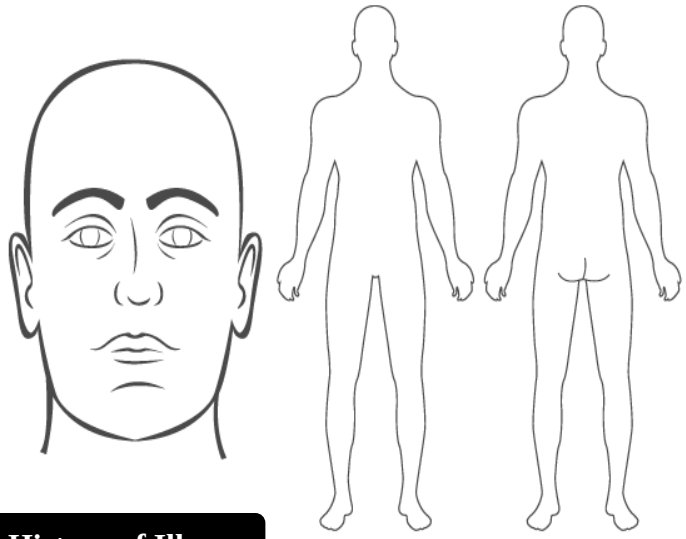
Front Back



Ache: MMM	**Tenderness**: Z Z Z
Burning: - - - -	**Pins & Needles:** • • •
Spasm: X X X	**Numbness:** 0 0 0
Radiating Pain: ↓ ↑	**Stabbing Pain:** / / /

Using the symbols above, please indicate the location & type of pain you are experiencing

History of Illness

Location of Pain or Symptoms:_____
Current Pain: No pain 1 2 3 4 5 6 7 8 9 10 Worst Pain
Min. Pain Level: No pain 1 2 3 4 5 6 7 8 9 10 Worst Pain
Max. Pain Level: No pain 1 2 3 4 5 6 7 8 9 10 Worst Pain

Is Pain/Symptoms:
O Constant O Improving O Not Changing O Intermittent
O Worsening

Pain is worst at: O AM O PM

Pain interferes with sleeping: O Yes O No O Sometimes

When & how did it start?
_____

What makes your pain/symptoms worse?
_____

What makes your pain/symptoms better?
_____

Does your condition interfere with any of the following:
O Mobility
O Carrying, moving, or handling Objects
O Changing or maintaining body position
O Self Care (Bathing, changing clothes, etc.)
Explain if other _____

I can <u>not</u> do the following daily activities of normal living:
1. _____ 3. _____
2. _____ 4. _____
5. _____ 6. _____

Have you had any of the following tests?
O XRAY O MRI O CT Scan O EMG/NCS

Where was the test done? _____

Surgeries/hospitalizations including dates (if known):
_____
_____
_____

Injuries with approx. dates (i.e., fractures, dislocations, sprains):
_____
_____
_____

Allergies (latex, nickel, etc.):
_____

Medications (over-the-counter, prescription, herbal, vitamin/mineral/dietary, nutritional supplements)

Name	Route of Administration	Dosage	Frequency taken

***I agree to notify clinical staff of any changes of dosage, frequency, or medicines as soon as possible _____ (Patient Initials)**

Patient Name (Printed): _____

Past Medical History

Have you EVER been diagnosed with the following?

YES	NO (check one)	
O	O	Diabetes
O	O	High blood pressure
O	O	Asthma
O	O	Heart Attack – Date/s _____
O	O	Other Heart Trouble (Type)_____
O	O	Stroke – Date/s _____
O	O	Emphysema
O	O	Osteoporosis
O	O	Arthritis
O	O	Seizures/Epilepsy
O	O	Fibromyalgia
O	O	Cancer – Type _____ Date/s _____
O	O	HIV/AIDS/Hepatitis/Other _____
O	O	Back Injury
O	O	Fracture – Type _____ Date/s _____
O	O	Respiratory Problems (explain)_____
O	O	Headaches
O	O	Muscular Dystrophy
O	O	Polio
O	O	TMJ Disorder
O	O	Stomach Ulcers
O	O	Chemical Dependency (alcoholism, legal/illegal drugs)
O	O	Thyroid Problems (hypo- or hyper-)
O	O	Multiple Sclerosis
O	O	Rheumatoid Arthritis
O	O	Depression, Anxiety, Bipolar Disorder, Schizophrenia
O	O	Kidney Disease (Type):_____
O	O	Blood Clots
O	O	Other _____

Do you live alone? O Yes O No

Are there steps in/around your home/work? O Yes O No
If yes, how many? _____
Does your home/work have ramp accessibility? O Yes O No

In a typical day, how many hours are you sitting?
_____

In a typical day, how many hours are you standing?
_____

Exercise:
O Sedentary (no exercise)
O Mild Exercise (climb stairs, walk 3 blocks, golf)
O Occasional Exercise (less than 4x/week for 30 min.)
O Regular vigorous exercise (4x/week for 30 min.)

Caffeine:
O Non-drinker
O Coffee: _____ cups/day
O Tea: _____ cups/day
O Soda: _____ cups/day

Alcoholic Beverages:
O Non-drinker
O _____ days per week (average)
O_____ drinks per sitting (average)

Tobacco:
O Non-user
O _____ years used
O Former Use (year quite: _____)

Type of Tobacco:
O Cigarettes: _____ per day
O Pipe: _____ per day
O Chew: _____ per day
O Cigar: _____ per day

Have you recently noticed any of the following?

YES	NO (check one)		YES	NO	
O	O	Fatigue or malaise	O	O	Difficulty swallowing
O	O	Unexplained weight loss/gain (circle one)	O	O	Skin rash
O	O	Fever/chills/sweats	O	O	Regular cough (how long _____)
O	O	Nausea/vomiting	O	O	Arm/leg swelling
O	O	Dizziness/lightheadedness	O	O	Heart racing in your chest
O	O	Tingling or numbness	O	O	Heartburn/indigestion
O	O	Weakness	O	O	Post-menopause
O	O	Change in cognitive abilities	O	O	Stress at home or work
O	O	Constipation/diarrhea (circle one)	O	O	Problems sleeping
O	O	Blood in the stools	O	O	Sexual difficulties
O	O	Urinary incontinence	O	O	Night sweats
O	O	Problems urinating (pain, starting, stopping, etc.)	O	O	Hearing problems
O	O	Blood in the urine	O	O	Joint/muscle swelling
O	O	Change in appetite	O	O	Easy bruising
O	O	Change in vision	O	O	Excessive bleeding
			O	O	Difficulty breathing

Patient Name (Printed): _____

Pre-Evaluation Form

In order to evaluate your condition fully, please be as accurate as possible. Thank you.

Name: _____ Age: _____ Gender: M F

Occupation: _____ Are you working? Y N

1	In your understanding, what do you think will make your problem better?		
2	How optimistic are you that you will get better? (circle one)	Not at all……Mildly optimistic……Fairly…… Very optimistic……Extremely	
3	What are some potential obstacles to you getting better?		
4	Over the next 30 days, how many hours per week will you commit to getting better?		
5	Known family medical history (cancer, diabetes, high blood pressure, etc.)?	Mother- Father- Siblings-	

Total:

I understand that my candidacy for a rehabilitation program will be dependent upon my ability and willingness to improve. I have answered the questions above honestly and accurately to the best of my ability. The doctor/therapist will determine whether or not I am a viable candidate for a rehabilitation program and my approval into their program is not guaranteed.

Patient Signature (or guardian): _____ Date: _____

Patient Express Registration

1. Patient Information *Complete Entire Form*

_____ _____ _____ ____/____/____
Last Name First Name Preferred Name Date of Birth

O Male O Female _____ _____ _____
Home Phone # Cell Phone # E-mail Address

_____ _____
Address, City, Zip Code Physician Name

_____ _____ _____
Emergency Contact or Parent Phone # Parent/ Guardian Signature if Minor

Marital Status: O Married O Single O Other Work Status: O Employed O Retired O Disabled O Student

Occupation? _____ Employer Name _____ Employer Phone _____

2. Medical Condition

Please mark those that apply to you

Within the past 12 months I have…
- o **Fallen** 2 or more times
- o **Fallen** 1 or more times with injury

O I am **currently** on **Home Health Care** (HHC)
- o HHC Agency:_____
- o HHC Start Date: _____

3. Appointment Reminders

Please choose one

O Email
O Phone Call
O None

4. Tell me more about……

Please mark those that apply to you

O 830 Cold Laser Session
O Golf Swing Analysis
O Custom Orthotics
O Sports Performance Enhancement
O Injury Prevention (Work or Sports)
O Weight-Loss Program
O Therapy Products

5. How did you hear about us?

Please mark those that apply to you

O Internet Search
O Newspaper
O Brochure
O Insurance
O Website
O T.V.
O Clinic Sign
O Friend/Family _____
O My Doctor/Dentist _____
O Other: _____

Informed Consent, Medical Release, and Policies Agreement

Medical Necessity
All treatments must be justified and medically necessary in order for us to treat and bill your insurance. Some of the factors that determine whether or not treatment is medically necessary are:

1) Does your condition interfere with the quality of your life?
2) Does your condition interfere with your ability to perform work or daily activities?
3) Are you motivated and able to participate in your treatment program and follow home and self-care instruction?
4) Is there potential for your condition to improve and/or resolve? If not, is there potential for your function or ability to perform daily activities to improve through modified movement, assistive devices, etc.?
5) Are there specific goals set that are measureable and track-able?

If the above criteria are not met, you are welcome to participate in our elective services (e.g., fitness & exercise training program, Weight Loss Program, Posture Program, etc.) which are payable out-of-pocket by cash, check or credit card.

Results
The purpose of physical therapy is to maximize your body's own healing potential through natural means and promote your ability to perform daily, work, and leisure and sports activities through increased strength, flexibility, agility, and movement strategies. It is not possible to predict the results or outcomes of treatment. Sometimes benefits are realized immediately and sometimes it's more gradual over time.

Informed Consent
By signing below, the patient gives the therapist permission to the evaluation and treatment. It is your right to accept or refuse any treatment offered. There are no guarantees made as to the results that may be obtained from our treatment(s). If you have any questions about your care, be sure to ask the therapist.

It is up to patient/caretaker to inform the therapist/staff about any health problems or allergies patient may have. Patient/caretaker must also tell the therapist/staff about drugs or medications being taken as well as any medical conditions and/or surgeries. Please discuss any questions or problems with the therapist before signing this statement of understanding and consent for care.

Medical Records Release
By signing below, I authorize and request the disclosure of all protected information for the purpose of review and evaluation to the Sports, Back and Pain Management Clinic. I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following:

> All medical records, meaning every page in my record, including but not limited to: office notes, phase sheets, history and physical, consultation notes, inpatient, outpatient and emergency room treatment, all clinical charts, reports, order sheets, progress notes, nurse's notes, social worker records, clinic records, treatment plans, admission records, discharge summaries, requests for and reports of consultations, documents, test results, and records received by other medical providers.

Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until two years from date of execution at which time this authorization expires.

_____ _____
Patient Signature/Date Patient's Representative Signature/Date

_____ _____
Front Desk Staff Signature/Date Relationship to Patient

Important Clinic Policies for a Successful Relationship

We strive to provide you the best personalized care available. To make this possible we adhere to a set of very important guidelines to ensure the highest quality of care for all patients. Please read them carefully, **initial all the boxes**, and indicate your agreement by signing the form at the bottom. ***We look forward to building a successful relationship with you that lasts a lifetime*!**

☐ **Late Policy "10 minutes"**
Being Late by more than 10 minutes will require you to either reschedule or wait for the next available opening. There are no guarantees since openings due to cancellations are unpredictable. We do not allow appointment overlap because this compromises the care of another patient.

☐ **24 – Hour Advance Notice Fee**
If you wish to change or cancel an appointment we require a minimum **24-hour advance notice**. Anything less will result in a $25 fee charged to your account. It cost money to make appointments available to you. Whether you attend or not we still accrue the expenses (for staff wages, rent, etc.). We don't charge you the actual cost for that appointment but rather a small fee. We do NOT make money with this charge; it is only to act as a deterrent from making last minute changes. Advance notice allows someone else (who needs it) to reserve it in place of you. Please be courteous and responsible. Thank you.

☐ **Copays are due upon arrival**
If you happen to forget your wallet or checkbook we will be able to see you without payment one time. However, if it occurs more than once, we will require a credit card number to be placed in your file for future occurrences.

☐ **No-Shows are Bad**
If you fail to show for an appointment without notice, all future appointments will be removed and a $25 fee assessed to your account. You may re-schedule appointments again on a "first come, first serve basis".

☐ **Cell phones must be turned OFF or silent.**
We realize emergencies may arise and thus you may need to carry your cell phone during your treatment session, however, please be courteous & set it to silent mode or turn it off during treatment. Thank you.

☐ **Children requiring supervision are NOT allowed to attend sessions with you.**
As our facility does not have child-care services, you may not bring children who require supervision with you to your appointment. If your child does not require supervision and is capable of waiting for you quietly, then you may bring them with you. If any disturbance is caused to other patients or staff members, you may be asked to terminate your session early and attend to your child.

☐ **HIPAA**
By initialing this box you confirm that you have received a copy of the Health Insurance Portability and Accounting Act (HIPAA).

I have read & agree to all of the above policies. Signature _____ Date_____