SPORT & SPINE PHYSICAL THERAPY PATIENT DATA SHEET						
First:	MI:	Last:				
Date of Birth:	Age:	Gender: Male Female				
Physical Address:		Mailing Address:				
-						
Phone Numbers: OK T	o Call Best Tir	ne To Call				
Home:	]					
Work:	 ]					
Cell:						
May we send you text message above? Yes No	es for your appo	ointment reminders to the number(s) listed				
	es for Marketinເ	g Materials, including Patient review requests t				
the number(s) listed above?	Yes No					
By marking "Yes" above, you of unauthorized access to you		t text messages may NOT be secure, with a risk				
May we send you emails relating to your care with us? Yes No By providing your email address below, you understand that email communications may NOT be secure, with a risk of unauthorized access to your information.  Email:						
Preferred language:		Interpreter required? Yes				
Date of Injury:	Refer	rring Physician:				
Injury Area:		Nork Accident: Auto Work N/A				
State Where Accident Occured	<b>!</b> :					
Are you currently receiving or h (including any therapy, nursing						
Are you currently receiving or the last 60 days?	nave you receive	ed other therapy services in Yes No				
Marital Status:						
Married Single	Divorced	Widowed Separated Unknown				
Student Status:						
Full-Time Part-Time	None					

EMPLOYMENT STATUS						
Employment Status: Active Military Full-Time None	Part-Time Retired Self Employed					
Employer:	Occupation:					
Address:						
Phone:						
Employer: C	Occupation:					
Address:						
Phone:						
INSURANCE INFORMATION						
Primary Insurance:						
Policy Holder's Name:	Holder's Birth Date:					
Policy or Certificate #:	Group #:					
Policy Holder's Employer:						
Secondary Insurance:						
Policy Holder's Name:	Holder's Birth Date:					
Policy or Certificate #:	Group #:					
Policy Holder's Employer:						

MR #: Page: 3/4 Patient Name: How did you hear about us? **Physician** Hospital Marketing Ad - Print **Employer Cross Referral** Friend - Word of Mouth Case Manager ■ Marketing Ad - Billboard Former Patient Marketing Ad - Direct Mail - Email Attorney Adjustor Self School **Screens - Open Houses** Marketing Ad - Other \_\_\_\_ Specify if other: Note: Please provide us with the most updated information below. **EMERGENCY AND OTHER CONTACTS** Name Phone Work Cell Fax Туре DISCLOSURE OF MEDICAL RECORDS I authorize the following individuals to have access to my medical and billing records: Relationship Name Relationship Name

Signature of Patient

Date

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## PATIENT INTAKE AND CONSENT FORM

A/C Type Office # A/C# Internal Use Only: Name CONSENT TO TREATMENT I consent to rehabilitation and related services at: SPORT & SPINE PHYSICAL THERAPY In doing so, I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touch and/or direct contact of a sensitive nature. Initials: TREATMENT OF MINORS I, as a parent/guardian of a minor receiving treatment hereunder, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so. Initials: LIABILITY I know and agree that SPORT & SPINE PHYSICAL THERAPY is not responsible for loss or damage to personal valuables. Initials: **WAIVER AND RELEASE** I hereby release, discharge and acquit: SPORT & SPINE PHYSICAL THERAPY its agents, representatives, affiliates, employees, or assigns, of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency and or medical services including but not limited to ambulance service, Emergency Medical Technician, physician urgent care or services. Initials: **AUTHORIZATION OF PAYMENT** I hereby assign all benefits directly to: SPORT & SPINE PHYSICAL THERAPY I also authorize release of any medical records to other healthcare providers as necessary to facilitate my treatment and to other third parties as necessary to process medical claims and otherwise permitted or required in the Notice Of Privacy Practices. Initials: FINANCIAL POLICY I understand fully that, in the event my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment. To assist in establishing your account, please: - Supply all necessary information for accurate billing of your claim, including your insurance card, driver's license, employer information, and demographic information. - Satisfy all insurance co-payments, co-insurance, deductibles, and non-covered services on the day services are rendered. - Provide your insurance company and us with any additional information requested to complete the processing of claims filed on your behalf. Initials: NOTICE OF PRIVACY/PATIENT BILL OF RIGHTS I acknowledge receipt of Notice of Privacy Practices. Initials: I acknowledge receipt of the Statement of Patient Rights. Initials: I certify that all of the information provided herein is true and correct. Patient/Guardian Witness Signature Signature **Date** 

## **Medical History Form**

Patient Name:		Today's Date:			
Referring Physician:		Date of Birth: Age:		Age:	
Primary Care Physician:		Date of Injury or Onset:			
Date of Next Physician Appointment:					
Reason for Therapy:		l			
Course of Indiana on Operate Assistant	Ata D. Marile D. Otha	If Other relea	aa avulain.		
Cause of Injury or Onset: Accident Auto Work Other: If Other, please explain:					
Have you been hospitalized for the present condition?   Yes   No If Yes, date:					
Did you have surgery for this condition If Yes, surgery type:	? 🗌 Yes 🗌 No	If Yes, date:			
Are you currently receiving any other call f Yes, please describe:	are for the condition r	nentioned above?	□Yes □No		
Have you ever received therapy in the p	past for the condition	mentioned above? [	_Yes	es, date:	
Describe previous treatment:					
Previous Treatment: ☐Successful ☐Un	successful				
Have you fallen in the last year?  Yes  No If Yes, how many times? If Yes, were you injured?  Yes  No Do you worry about falling?  Yes  No Do you worry about falling?  Yes  No					
What are your personal goals/outcome	s you hope to achieve	from therapy?			
Describe your general health:   Excel	lent ☐ Good ☐ Fair	☐ Poor <b>Do yo</b>	ou smoke or use	tobacco?	
DO YOU CURRENTLY HAVE OR HAVE A HISTORY OF ANY OF THE FOLLOWING CONDITIONS? (check all that apply)					
☐ Allergies ☐ Latex ☐ Other	☐ Dizziness		☐ Kidney Problems		
☐ Anemia	☐ Epilepsy or Seizure Disorder		☐ Metal Implants		
☐ Anxiety or Panic Disorders	☐ Fainting		☐ MRSA		
☐ Arthritis ☐ OA ☐ RA	☐ Fatigue or Weak	☐ Fatigue or Weakness		☐ Multiple Sclerosis	
☐ Asthma	☐ Fever or Chills	☐ Fever or Chills		☐ Nausea / Vomiting	
☐ Use of Blood Thinners	☐ Fractures		☐ Osteoporosis		
☐ Bowel or Bladder Disorder	☐ Headaches		☐ Pacemaker		
☐ Bleeding Disorder	☐ Head Injury or Concussion		☐ Parkinson's Disease		
☐ Cancer	☐ Hearing Impairment		☐ Peripheral Vascular Disease		
☐ Chronic Cough	☐ Heart Disease or Heart Attack		☐ Respiratory or Breathing Problems		
☐ COPD	☐ Hepatitis ☐ A ☐ B ☐ C		☐ Ringing in Ears		
☐ Congestive Heart Failure	Hernia		☐ Sexual Dysfunction		
☐ Currently Pregnant	☐ Blood Pressure ☐ High ☐ Low		☐ Skin Abnormalities		
☐ Deep Vein Thrombosis (DVT)	☐ HIV or AIDS		☐ Stroke or TIA		
☐ Depression	☐ Hypoglycemia		☐ Thyroid Problems		
☐ Diabetes ☐ Type I ☐ Type II	☐ Hypersensitivity	y to Hot or Cold		sis	
List any other medical problems and explain:					

## **Medical History Form**

Medication List							
Name of Medication	Dosage	Frequency					
☐ Check Box if Medication List provided separately.							
1.			☐ Injection ☐ Oral ☐ Topical ☐ Other				
2.			☐ Injection ☐ Oral ☐ Topical ☐ Other				
3.			☐ Injection ☐ Oral ☐ Topical ☐ Other				
4.			☐ Injection ☐ Oral ☐ Topical ☐ Other				
5.			☐ Injection ☐ Oral ☐ Topical ☐ Other				
6.			☐ Injection ☐ Oral ☐ Topical ☐ Other				
7.			☐ Injection ☐ Oral ☐ Topical ☐ Other				
8.			☐ Injection ☐ Oral ☐ Topical ☐ Other				
9.			☐ Injection ☐ Oral ☐ Topical ☐ Other				
10.			☐ Injection ☐ Oral ☐ Topical ☐ Other				
11.			☐ Injection ☐ Oral ☐ Topical ☐ Other				
12.			☐ Injection ☐ Oral ☐ Topical ☐ Other				
Over the Counter Medications (check all that apply):       ☐ Aspirin/Ibuprofen       ☐ Antacids       ☐ Sleeping Aids       ☐ Cold Medicine:         ☐ Cough Medicine       ☐ Allergy Relief       ☐ Laxative       ☐ Diet Pills       ☐ Vitamins/Herbal Supplements       ☐ Other:							
Pain Scale Rate the severity of your pain by circling a box on the following scale.  No Pain  Worst Pain  1 2 3 4 5 6 7 8 9 10  On the Body Diagram mark where you are experiencing symptoms, right now. Use the letters below to indicate the type and location.  KEY:  A = Aching B = Burning N = Numbness P = Tingling S = Stabbing O = Other							
Signature of Patient:		DOB:					
Printed Name of Patient:		Date:					