Date_____________

REGISTRATION INFORMATION

Patient ____________________ **Cell Phone** ____________________ **Home Phone** ____________________

Responsible Party (if minor)____________________ **Relationship to patient** ____________________

Address____________________

City, State, Zip____________________ **Marital Status** ____________________

Sex ◻ M ◻ F **Age**________ **Birthdate**____________________ **Email**____________________

Social Security # ____________________ **How did you hear about us?**____________________

Emergency Contact ____________________ **Relationship**____________________ **Phone** ____________________

Referring Physician: ____________________ **Phone**____________________

Patient Employer / School ____________________

Occupation____________________ Employer / School Phone____________________

If your injury is related to a work injury or car accident please fill out the following information:

WORKER'S COMPENSATION OR MOTOR VEHICLE INSURANCE

Injury Type: ◻ **Work** ◻ **Auto**

Insurance Company ____________________ **Claim**____________________

Date of Injury: ___________ State Injury Occurred:_______ Adjuster: ____________________ Phone____________________

Claims Address: ____________________

PERSONAL HEALTH INSURANCE

Primary Insurance ____________________ **Phone** ____________________

Identification # ____________________ Group #____________________

Subscriber Name____________________ Relationship ____________________ DOB ____________________

Insurance Address____________________ City____________________ State _____ Zip ____________

SECONDARY INSURANCE____________________ **Phone** ____________________

Identification # ____________________ Group #____________________

Subscriber Name____________________ Relationship ____________________ DOB ____________________

Insurance Address____________________ City____________________ State _____ Zip ____________

I authorize the release of any information necessary to process my insurance claims. I assign and request payment directly to my medical provider(s). I further agree to all the financial policies of Advance Sports and Spine Therapy. I hereby authorize Advance Sports and Spine Therapy to administer and perform procedures deemed necessary or advisable in the treatment of this patient. In the event the above named patient requires immediate medical attention and is a minor unaccompanied by a legal gardian, or is unable to consent for medical care, I authorize and designate Advance Sports and Spine Therapy and the employees thereof the right to consent for medical care in case of an emergency.

Signature____________________ **Date** ____________________

Communication Release

I authorize Advance Sports and Spine Therapy to share my medical records and other information with the person(s) named below:

Name:________________________________ Relation:____________________

Name:________________________________ Relation:____________________

Name:________________________________ Relation:____________________

This authorization will remain in effect while I am under the care of Advance Sports and Spine Therapy. I understand that I can revoke this authorization at any time in writing.

____ I do not want Advance Sports and Spine Therapy to share my medical and/or account information with anyone but myself.

Print Patient Name:___________________________ Date of Birth:_______________

Signature:____________________________________ Date:______________________

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES
(To be retained by Medical Provider)

I understand that Advance Sports and Spine Therapy, LLC (referred to below as "the clinic" will use and disclose **health information** about me in the course of providing physical therapy care to me.

I understand that my **health information** may include information both created and received by the clinic, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand that the clinic is permitted to **use and disclose** my health information in order to:

- make decisions about and plan for my care and treatment;
- refer to, consult and coordinate with other health care providers in the course of my treatment;
- determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- perform various office, administrative and business functions that support the clinic's ability to provide me with appropriate care and arrange for payment.

I also understand that I have the right to receive a written **Notice of Privacy Practices** which describes how the clinic uses and discloses health information, the information practices followed by the clinic staff and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time and that I am entitled to receive a copy of any revised Notice of Privacy Practices upon request. I also understand that a copy or a summary of the most current version of the clinic's Notice of Privacy Practices in effect will be posted in waiting/reception area.

I understand that the Notice of Privacy Practices describes how I can exercise my right to ask that some or all of my health information not be used or disclosed, and I understand that the clinic is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and that I <u>have received</u> a copy of the Notice of Privacy Practices.

______________________________	______________________________
Print Patient Name	*Date of Birth*
______________________________	______________________________
Patient OR Patient Representative Signature	*Description of Representative's Authority*

____

Today's Date

Medical History Form

Name: ________________________________

Date: __________________

Occupation: ______________________

DOB/Age: _________________

Current work status:
□ working full-time □ working part-time
□ student □ retired □ homemaker
□ unemployed

Hand Dominance:
□ Right-handed □ Left-handed

Who referred you to Physical Therapy:
____

Social/Health Habits

Smoking:
- Do you smoke? □ Yes □ No
- Did you smoke in the past?
  □ Yes - year you quit ________ □ No

Exercise:
- Do you exercise beyond normal daily activities and chores?
  □ Yes □ No

Family History

Please indicate whether mother, father, brother/sister, aunt/uncle or grandmother/grandfather, and age of onset if known.

a. Heart disease: ____________________________
b. Hypertension: ____________________________
c. Stroke: ____________________________
d. Diabetes: ____________________________
e. Cancer: ____________________________
f. Psychological: ____________________________
g. Arthritis: ____________________________
h. Osteoporosis: ____________________________
i. Other: ____________________________

Medical/Surgical History

a. Please check if you ever had:

□ Arthritis □ Rheumatoid Arthritis
□ Broken bones □ Osteoporosis
□ Anemia □ Emphysema/Bronchitis
□ Blood disorders □ Circulation/vascular
□ Heart problems □ High Blood Pressure
□ Lung Problems □ Stroke
□ Diabetes □ Hypoglycemia
□ Head injury □ Multiple Sclerosis
□ Muscular Dystrophy □ Parkinson's Disease
□ Seizures/Epilepsy □ Allergies
□ Developmental Delay □ Thyroid Problems
□ Cancer □ Tuberculosis
□ Hepatitis _______ □ Kidney Problems
□ Repeated infections □ Ulcers
□ Stomach Problems □ Skin diseases
□ Depression □ Chemical Dependency
□ Other __________

b. Within the past year, have you had any of the following symptoms? (Check all that apply)

☐ Chest pain ☐ Heart palpitations
☐ Chronic cough ☐ Shortness of breath
☐ Dizziness ☐ Coordination issues
☐ Weakness in arms or legs
☐ Loss of balance ☐ Difficulty walking
☐ Joint pain or swelling ☐ Pain at night
☐ Difficulty sleeping ☐ Loss of appetite
☐ Nausea/vomiting ☐ Bowel problems
☐ Difficulty swallowing
☐ Weight loss/gain ☐ Urinary problems
☐ Fever/chills/sweats ☐ Headaches
☐ Migraines ☐ Hearing problems
☐ Vision problems

Other_________________________________
____

c. Have you ever had surgery? □Yes □No
If yes, please describe and include dates:

	Year
___________________________	_______
___________________________	_______
___________________________	_______
___________________________	_______

Medications

a. Do you take any prescription medications? □ Yes □ No

If yes, please list: ___________________

____

b. Do you take any non-prescription medications? (check all that apply)

□ Advil/Aleve □ Antacids
□ Ibuprofen □ Antihistamines
□ Aspirin □ Decongestants
□ Herbal supplements
□ Tylenol □ Other: ________

____
____

c. Have you taken any medications previously for the condition for which you are seeing the PT? □ Yes □ No

If yes, please list: _________________

____

Current Condition(s) or Chief Complaint

a. Describe the problem(s) for which you are seeking physical therapy? ______________

____
____
____

b. When did the problem(s) begin?

Month _____ Year _______________

c. What happened? ___________________

____
____

d. Have you ever had the problem(s) before?

□ Yes - What did you do for the problem?

____
____

- Did the problem get better? □ Yes □ No
- About how long did it last? ________

□ No, I've not had this problem before

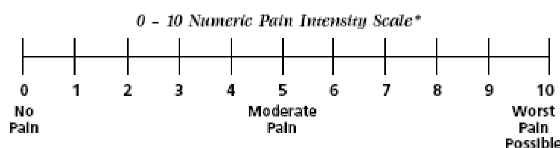
e. How are you taking care of the problem now? ______________________________

____

f. What are you goals with Physical Therapy? ___________________________

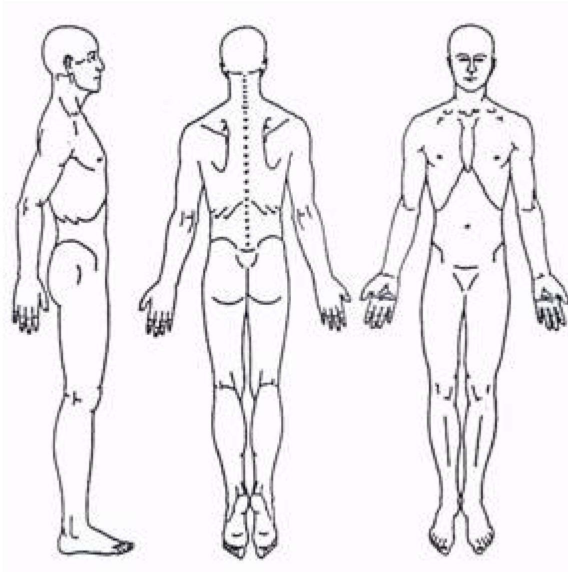
____
____

g. Please rate your current pain level on the scale below:



Body Diagram

On the diagram below please mark your area(s) of current symptoms. Please designate whether the symptoms are numbness, severe pain, moderate pain, or shooting by using the legend below



////////// Numbness
XXXX Severe Pain
■■■■■ Moderate Pain
→→→ Shooting Pain