Sport and Spine
Physical Therapy and Wellness Center

New Patient Verification:

First Name: _____Middle Initial: ____Last Name: _____

Sex: _____ Age: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home / Mobile#: ( ) _____-_____

Email: _____

Marital Status:

Single_____ Married _____ Divorced _____ Widowed _____ Domestic Partner _____

Employer's Name: _____ Occupation: _____

Emergency contact: _____ Phone # ( ) _____-_____

How did you hear about us? (Check one box)

- ☐ *Family / Friend: _____*
- ☐ *Facebook*
- ☐ *Instagram*
- ☐ *Other: _____*

Patient's signature: _____

Date signed: _____

Physical Therapy Patient History

Name_____ Date of Birth _____

Are you currently off work because of this problem? ☐ Yes ☐ No ☐ Light duty

When and how did your problems begin? _____

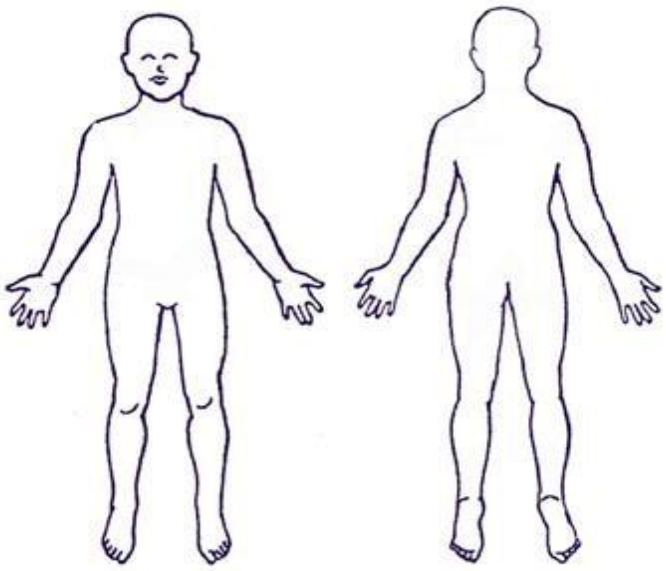
Have you seen an MD, PA, NP or DC about this specific condition? ☐ Yes ☐ No If so, please write the name, phone number and date or month of the visit:

_____

Rate your pain: No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

Draw your pain: **(Indicate on the diagram)**

Describe your pain:
☐ Ache ☐ Sharp ☐ Stabbing ☐ Pins & Needles
☐Shooting Pain ☐ Burning
☐ Numbness/Tingling
☐ Other_____



Is your pain constant? ☐ Yes ☐ No
Fluctuates with activity. ☐ Yes ☐ No
Wakes you up at night. ☐ Yes ☐ No

What makes your symptoms worse?
☐ Sitting ☐ Standing ☐ Walking
☐Lifting ☐ Bending ☐ Lying down
☐ Squatting ☐ Stress ☐
Other_____

Are you ever totally pain free? ☐ Yes ☐ No

What makes your symptoms better? ☐ Sitting ☐ Standing ☐ Walking ☐ Lifting
☐ Bending ☐ Lying down ☐ Other_____

What time of day are your symptoms worst? _____ Best? _____

Do you feel you are: ☐ Getting better ☐ Getting worse ☐ Staying the same?

Have you had diagnostic studies for your current condition? **(X-ray, MRI, CT scan...)** ☐ Yes ☐ No

Any history of blood clots ☐ Yes ☐ No Any pacemaker / implantable device ☐ Yes ☐ No

Any surgeries? ☐ Yes ☐ No If yes, please explain: _____

Any medical problems? ☐ Yes ☐ No If yes, please explain: _____

What are your goals in physical therapy? _____

Thanks for taking the time to fill out this form as completely as possible! It will save us on treatment time during your first visit and will help in assessing your condition and guiding your treatment plan.

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified on your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time, and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____

Name: _____ Date: _____