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

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

When and how did your problem start? _____

Have you previously consulted a physician or healthcare provider regarding this condition?
☐ Yes → ***You must provide at least ONE doctor's full name and phone number.***
(Do not write "many," "multiple doctors," or only the facility name.)

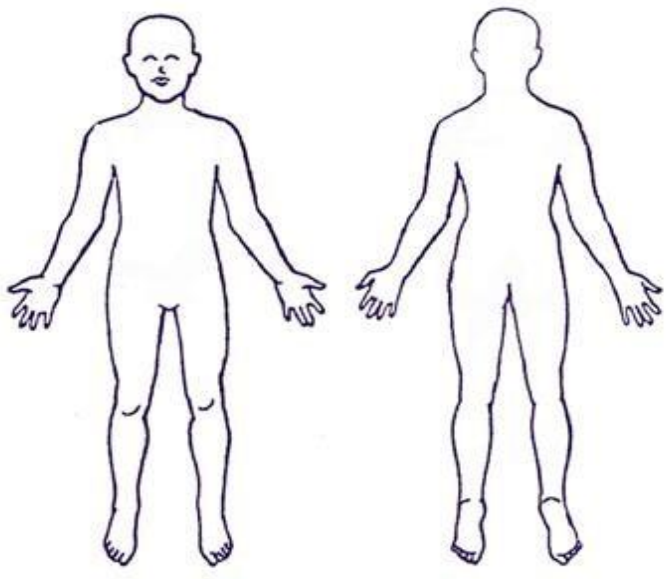
Doctor's Name: _____

Phone Number: _____

☐ No

Pain Level (circle one): No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

Draw where you feel pain: (use diagram)



Type of pain:
☐ Aching ☐ Sharp ☐ Stabbing ☐ Burning
☐ Shooting ☐ Pins & needles ☐ Numbness/Tingling
☐ Other: _____

Is your pain: Constant? ☐ Yes ☐ No
Worse with activity? ☐ Yes ☐ No
Waking you at night? ☐ Yes ☐ No

What makes pain worse?
☐ Sitting ☐ Standing ☐ Walking ☐ Lifting
☐ Bending ☐ Lying down ☐ Stress
☐ Other: _____

Are you ever pain free? ☐ Yes ☐ No

What makes pain better? ☐ Sitting ☐ Standing ☐ Walking ☐ Lying down ☐ Other: _____
Symptoms are worse: _____ best: _____ (AM or PM)
Overall, are you: ☐ Getting better ☐ Getting worse ☐ Staying the same
Have you had imaging tests? (X-ray, MRI, CT, etc.) ☐ Yes ☐ No
History of blood clots? ☐ Yes ☐ No Pacemaker or implanted device? ☐ Yes ☐ No
Previous surgeries? ☐ Yes ☐ No If yes: _____
Medical problems? ☐ Yes ☐ No If yes: _____
Goals for 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 Privacy Acknowledgment & Communication Consent

I acknowledge that I have received or have been given access to the practice's Notice of Privacy Practices, which explains how my protected health information (PHI) may be used and disclosed in accordance with HIPAA.

A copy of the Notice of Privacy Practices is available at the front desk.

I understand that my PHI may be used for treatment, payment, and healthcare operations as permitted by law.

I understand that I may revoke this consent in writing at any time, except to the extent that action has already been taken.

Communication Preferences:

May we contact you to confirm appointments or provide information related to your care?

☐ Phone ☐ Text ☐ Email ☐ No contact

May we leave a voicemail or message on your phone?

☐ Yes ☐ No

May we discuss your medical information with family members or other individuals?

☐ Yes ☐ No

If yes, please list names: _____

Patient Name: _____

Signature: _____

Date: _____