PHYSICAL THERAPY & SPORTS MEDICINE CENTERS

PT for life A PTSMC affiliate

Name: _____ **Primary Care Physician:**_____

Have you RECENTLY noted any of the following (check all that apply)?

- ❑ changes in appetite
- ❑ changes in bowel or bladder function
- ❑ difficulty maintaining balance while walking
- ❑ difficulty swallowing
- ❑ dizziness/lightheadedness
- ❑ fever/chills/sweats
- ❑ headaches
- ❑ nausea/vomiting
- ❑ pain at night
- ❑ shortness of breath
- ❑ weakness/fatigue
- ❑ weight loss/gain

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

- ❑ anemia
- ❑ asthma
- ❑ cancer (type)_____
- ❑ chemical dependency (i.e., alcoholism)
- ❑ depression
- ❑ diabetes Check One: ☐ Type 1 ☐ Type 2
- ❑ epilepsy
- ❑ heart disease
- ❑ high blood pressure
- ❑ kidney/liver problems
- ❑ lung problems
- ❑ multiple sclerosis
- ❑ osteoporosis
- ❑ pacemaker inserted
- ❑ Parkinson's disease
- ❑ rheumatoid arthritis
- ❑ stomach ulcers
- ❑ stroke
- ❑ thyroid problems
- ❑ other_____
- ❑ other_____

During the past month have you been feeling down, depressed or hopeless? ☐ **YES** ☐ **NO**
During the past month have you been bothered by having little interest or pleasure in doing things? ☐ **YES** ☐ **NO**
Is this something with which you would like help? ☐ **YES** ☐ **YES, but not today** ☐ **NO**

Do you smoke? ☐ **YES** ☐ **NO** _____ **pack/day**

Height:_____ **Weight:** _____

FOR WOMEN: Are you currently pregnant or think you might be pregnant? ☐ **YES** ☐ **NO**

Are you currently taking blood thinning or anticoagulant medications for any medical conditions? ☐ **YES** ☐ **NO**

ALLERGIES: _____
Are you latex sensitive? ☐ **YES** ☐ **NO**

Please list any surgeries or other conditions for which you have been hospitalized, including dates:
1. _____ 2._____ 3._____

For the injury you are seeing us for today:

Pain at LOWEST: Rate your lowest pain level IN THE PAST 3 DAYS.

0 1 2 3 4 5 6 7 8 9 10
No pain — Worst pain Imaginable

Pain Currently: Rate your level of pain now.

0 1 2 3 4 5 6 7 8 9 10
No pain — Worst pain Imaginable

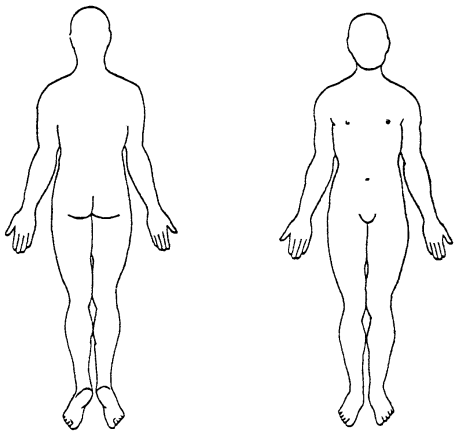
Pain at WORST: Rate your highest pain level IN THE PAST 3 DAYS.

0 1 2 3 4 5 6 7 8 9 10
No pain — Worst pain Imaginable

Body Chart:

Please mark the location of your pain and type of pain on the chart:

Key:
X sharp stabbing pain
O Dull achy pain
….Numb/Tingling
/// Throbbing
== Burning



What is your goal for therapy at this time?_____

Patient/Guardian/Responsible Party Signature:_____ **Date:**_____

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CONSENT FOR CARE & TREATMENT

I, the undersigned, do hereby agree and give my consent for ANB-PTSMA Holdings Inc, doing business as *Physical Therapy and Sports Medicine Centers* to furnish medical care and treatment to _____ that is considered necessary and proper in diagnosing or treating his/her physical and mental condition.

AUTHORIZATION BENEFIT ASSIGNMENT - FINANCIAL RESPONSIBILITY- RELEASE OF INFORMATION

I authorize *Physical Therapy and Sports Medicine Centers* to release to the insurance carrier any information needed for the payment of any claim. I authorize payment to *Physical Therapy and Sports Medicine Centers* from my insurance carrier or third party payer.

I agree to pay any applicable co-payments at the time of service and coinsurance and/or deductibles as agreed between *Physical Therapy and Sports Medicine Centers* and me. I understand that my insurance benefits may not cover all charges and that I am responsible for those charges not covered by my health insurance or third party payer. I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees.

The above may not apply for those patients that are considered Worker's Compensation. However, be advised if you claim Worker's Compensation benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you.

A photocopy of this authorization is to be considered as valid as the original.

By my signature, I authorize Physical Therapy and Sports Medicine Centers, to release all information necessary, including medical records, to secure payment.

Patient or Guardian/Responsible Party Signature: _____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

I have had full opportunity to read the *Physical Therapy and Sports Medicine Centers* Notice of Privacy Practices. I understand that by signing this consent, I am giving my consent to *Physical Therapy and Sports Medicine Centers* to use and disclose my protected health information to carry out treatment, payment activities and health care operations. I understand the terms of this notice may change with time and *Physical Therapy and Sports Medicine Centers* will always post the current notice at the clinic, on the website and have copies available for distribution.

Indicated below are individuals whom *Physical Therapy and Sports Medicine Centers* may speak to regarding my treatment. Please list names.

☐ spouse _____ ☐ father _____

☐ mother _____ ☐ other _____

Listed below are individual(s) whom I request restriction regarding my protected health information.

☐ Not Applicable

☐ _____

We may need to contact you. Do we have your permission to leave a confidential message at the phone numbers you provide us?

☐ Yes: Home Mobile Work Other: _____

☐ No

SIGNATURE for CONSENT

By my signature below I acknowledge that I have read, understand and agree to the terms and conditions contained in the *Consent For Use and Disclosure of Health Information.*

Patient (Age 18 or older) or Parent /Guardian_____

Date: _____

We recognize patients ages 16 & 17 as Mature Minors and would like their signature for Consent for Use and Disclosure of Health Information.

I acknowledge that I have read, understand and agree to the terms and conditions contained in the *Consent For Use and Disclosure of Health Information.*

Patient (Age 16 or 17) _____

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Patient Name: _____ Date: _____

Current List of Medications: Please list your current medications, the dosage, frequency and form.

☐ **See Attached List of Medications**

Medication & Dosage	**Frequency & Form** (pill, injection, spray, inhalant)

Rev 102018
Rev 102015
Rev 082011 WebPT Avon
Rev 01/2011
1/2009