

Name: _____ Primary Care Physician: _____

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

- | | | |
|---|--|--|
| <input type="checkbox"/> changes in appetite | <input type="checkbox"/> dizziness/lightheadedness | <input type="checkbox"/> pain at night |
| <input type="checkbox"/> changes in bowel or bladder function | <input type="checkbox"/> fever/chills/sweats | <input type="checkbox"/> shortness of breath |
| <input type="checkbox"/> difficulty maintaining balance while walking | <input type="checkbox"/> headaches | <input type="checkbox"/> weakness/fatigue |
| <input type="checkbox"/> difficulty swallowing | <input type="checkbox"/> nausea/vomiting | <input type="checkbox"/> weight loss/gain |

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

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

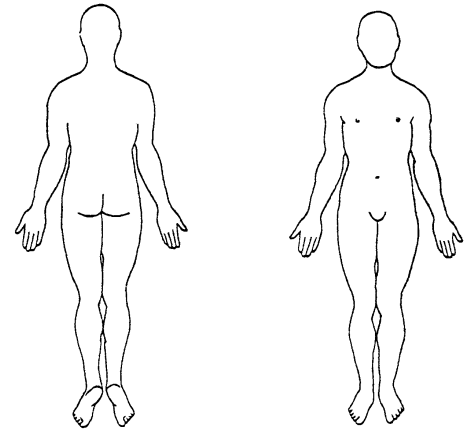
Pain at WORST: Rate your highest pain level IN THE PAST 3 DAYS.

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: _____



CONSENT FOR CARE & TREATMENT

I agree and give my consent for ANB-PTSMA Holdings Inc, doing business as **Physical Therapy and Sports Medicine Centers (PTSMC)**, to provide medical care and treatment that is considered necessary and proper in diagnosing or treating my physical condition.

RELEASE OF INFORMATION - FINANCIAL RESPONSIBILITY

I authorize Physical Therapy and Sports Medicine Centers, to release all information necessary, including medical records, to secure payment. I authorize **PTSMC** to release to the insurance carrier any information needed for the payment of any claim. I authorize payment to **PTSMC** 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 agree to inform PTSMC immediately if my insurance benefits change, including a change in carrier or benefits. I understand that I am responsible for balances as a result of my failure to inform PTSMC of a change in benefits. 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.

I acknowledge that there will be an additional \$45.00 fee for any checks returned to **PTSMC** for insufficient funds. I further acknowledge that there will be a 15% charge added to any delinquent balance that is my responsibility and requires the services of an outside collection agency.

I understand that the above may not apply if I am covered by Worker's Compensation insurance. I understand that if my Worker's Compensation claim and Worker's Compensation benefits are subsequently denied I may be held responsible for the total amount of charges for services rendered to me.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

I have had full opportunity to read the **PTSMC** Notice of Privacy Practices. I understand that by signing this consent, I am giving my consent to **PTSMC** 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 **PTSMC** will always post the current notice at the clinic, on the website and have copies available for distribution.

Indicate below who **PTSMC** may speak to regarding your treatment. Please list name and phone number.

Name _____
Phone # _____

Do we have your permission to leave a confidential message at the phone number you provide us?

Yes - Phone # _____
 No

SIGNATURE for CONSENT

By my signature below I acknowledge that I have read, understand, and agree to the terms and conditions contained in this consent form including:

- Consent for Care and Treatment
- Consent to Release of Information and Financial Responsibility
- Consent for Use and Disclosure of Health Information
- Consent that I have received an electronic copy of the Notice of Privacy Practices*

Patient (Age 18 or older) or Parent /Guardian _____

Date: _____

*If you wish to receive a paper copy of the Notice of Privacy Practices please request one from the front desk staff.



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)
