

**PATIENT INFORMATION SHEET
ORTHOSPORTS**

Name: _____ Date Of Birth: _____

Please circle one: Dr./ Mr. / Mrs. / Ms. What would you prefer to be called: _____

Social Security Number: _____

Street Address: _____ E-mail Address: _____

City: _____, New York Zip code: _____

Telephone: (home) _____ (work): _____

If a minor, Parent or Guardian's name and address (include zip code:)

Working Status: Yes / No Date of disability: _____

Employer: _____ Occupation: _____

Address: _____, New York Zip _____

Referring Physician: _____ Address: _____

Next appointment date with the referring physician: _____

Family Physician: _____

In case of an emergency, provide a name and telephone number we should contact: _____

INSURANCE INFORMATION

Name of Insurance Company: _____

Policy Holder's Name: _____ Relationship of patient: _____

Certificate or ID# _____ Group _____

Secondary Insurance – Name of Insurance Company: _____

Policy Holder's Name: _____ Relationship of patient _____

Certificate or ID# _____ Group Number: _____

IS THIS WORKER'S COMPENSATION OR NO FAULT YES/NO

(If yes, you must provide Orthosports PT with the name/address of the insurance carrier)

Worker's Comp. Board or No Fault Number: _____ Carrier Case Number: _____

Policy Number: _____ Claim Number: _____

Date of injury: _____

How injury occurred: _____

INSURANCE CARRIER: _____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____

Telephone Number: _____ Case Handler: _____

If you are working with an Attorney, Please complete:

Attorney's Name: _____ Phone Number: _____

I hereby certify that this is, to the best of my knowledge, complete and accurate. I understand that I am financially responsible to Orthosports for all services rendered at this time. It is the policy of this office to accept only assignment from the following Insurance Companies:

No-Fault, Worker's Compensation, Community Blue, GHI, Blue Cross/Blue Shield, Univera, Independent Health, and Medicare, less any contractual agreements for deductibles and co-payments. Any reimbursements for these services are the patient's responsibility.

Also, I hereby authorize release of information pertaining to my medical condition and treatments to my Insurance Company, Social Services, Administration or Medicare Program. I authorize my insurance company to pay Orthosports Physical Therapy directly for claims submitted by them. Furthermore, if my insurance denies payment and I receive a settlement, I agree to a lien on any proceeds I may receive from said settlement to pay for my balance.

We would appreciate 24 hours in advance notice if you wish to cancel an appointment. There is an additional charge for any check returned to Orthosports from the bank.

Signature: _____ Date: _____

General Health

(circle one)

- 1. Are you taking prescription or over – the – counter medications? Yes No
If yes, please list: _____

- 2. Have you had any illness within the last 3 weeks (e.g., colds, influenza, bladder or kidney infection)? Yes No

- 3. Have you noticed any lumps or thickening of skin or muscle anywhere on your body? Yes No

- 4. Do you have any sores that have not healed or any changes in size, shape, or color of a wart or mole? Yes No

- 5. Have you had any unexplained weight gain or loss in the last month? Yes No

- 6. Do you smoke or chew tobacco? Yes No
If yes, how many packs a day?____ For how many months or years?_____

- 7. How much alcohol do you drink in the course of a week? _____

- 8. Do you use recreational drugs (marijuana, cocaine, crack, amphetamines, etc.)? Yes No
If yes, what, how much, how often?_____

- 9. How much caffeine do you consume daily (including soft drinks, coffee, tea, or chocolate)?_____

- 10. Are you on any special diet prescribed by a physician? Yes No

- 11. Do you have a pacemaker, transplanted organ, joint replacement, or metal implants? Yes No

- 12. Are you or is there a possibility you could be pregnant? Yes No

Medial Testing

- 1. Have you had any x-rays, sonograms, computed tomography (CT), scans, or magnetic resonance imaging (MIR) done recently? Yes No
If yes, when _____
Where? _____
Results? _____

2. Have you had any laboratory work done recently (urinalysis or blood test)? Yes No
If yes, when? _____
Where? _____
Results (if known)? _____

3. Please list any operations that you have ever had and the date (s):
Operation: _____ Date: _____

4. Have you ever received physical therapy before?
When? _____
Where? _____
Why? _____

Present Condition

Where is your pain? _____

Is this a recurrent injury? Yes No When did it start? _____

Chief complaint/injury: _____

Degree of pain (circle one) 0 1 2 3 4 5 6 7 8 9

Type of pain: Dull Sharp Constant Intermittent Localized Radiating

Work Environment

Occupation: _____

Does your job involve: () prolonged sitting (e.g., desk, computer, or driving)
 () prolonged standing (e.g., equipment operator, or sales clerk)
 () prolonged walking (e.g., mill workers, or delivery service)
 () use of larger or small equipment (e.g., telephone, forklift, typewriter, drill press, or cash register)
 () lifting, bending, twisting, climbing, or turning
 () exposure to chemicals, pesticides, toxins, or gases
 () other: please describe _____

Do you use any special supports: () back cushion or neck cushion
 () back brace or corset
 () other kind of brace or support for any body part

Past Medical History

Have you or any immediate family member ever been told you have:

	Check One		Do not complete – for therapist		
	Yes	No	Relation to Client	Date of Onset	Current Status
Cancer					
Diabetes					
Hypoglycemia					
Hypertension or high blood pressure					
Heart Disease					
Angina or chest pain					
Shortness of breathe					
Stroke					
Kidney disease/stones					
Urinary tract infection					
Allergies					
Asthma, hay fever					
Rheumatic/scarlet fever					
Hepatitis/ jaundice					
Cirrhosis/liver disease					
Polio					
Chronic bronchitis					
Pneumonia					
Emphysema					
Migraine headaches					
Anemia					
Ulcers/stomach problems					
Depression					
Chemical dependency (alcohol/drugs)					
Arthritis/gout					
Hemophilia/slow healing					
Guillain-Barre Syndrome					
Epilepsy					
Thyroid problems					
Multiple sclerosis					
Tuberculosis					
Fibromyalgia/myofascial pain syndrome					
Other					

History of falls:

- I have had no falls
- I have just started to lose my balance/fall
- I fall occasionally
- I fall frequently (more than two times during the past 6 months)
- Certain factors make me cautious (e.g., curbs, ice, stairs, getting in and out of the tub)

For the physical therapist

Vital Signs

Resting pulse rate: _____ Oral temperature: _____

Blood pressure: 1st reading _____ 2nd _____

Position: _____ Extremity: _____