OPTIMAL SPORTS PHYSICAL THERAPY

Name:_____ **DOB:**_____ **Date:**_____
Primary Care Physician:_____

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

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

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

- ❑cancer: type_____ Active OR Remission
- ❑heart disease
- ❑high blood pressure
- ❑blood clot/ emboli
- ❑pacemaker inserted
- ❑osteoporosis
- ❑numbness/ tingling
- ❑rheumatoid arthritis
- ❑stroke
- ❑depression
- ❑anemia
- ❑lung problems
- ❑thyroid problems
- ❑other
- ❑diabetes (type 1/ type 2)
- ❑multiple sclerosis
- ❑kidney/liver problems
- ❑stomach ulcers
- ❑epilepsy
- ❑Parkinson's disease
- ❑weight loss/gain
- ❑shortness of breath
- ❑headaches
- ❑Alzheimer's
- ❑cardiovascular disease
- ❑cauda equina syndrome
- ❑current infection
- ❑fibromyalgia
- ❑fracture
- ❑Huntington's
- ❑immunosuppresion
- ❑lupus
- ❑muscular dystrophy
- ❑obesity
- ❑osteoarthritis
- ❑traumatic brain injury
- ❑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**

Do you smoke? YES NO _____pack/day

Height:_____ **Weight:**_____

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

Please list current medications:_____
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 diagnostic tests performed for this condition (x-ray, MRI, etc):_____
Please list all medical providers you have seen for this condition:_____

Please list any surgeries or other conditions for which you have been hospitalized, including dates:

Reviewed by:_____

1._____ 2._____ 3._____

For the injury you are seeing us for today:

Pain at LOWEST: Rate you lowest pain level in 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 at this time.

_____

0 1 2 3 4 5 6 7 8 9 10

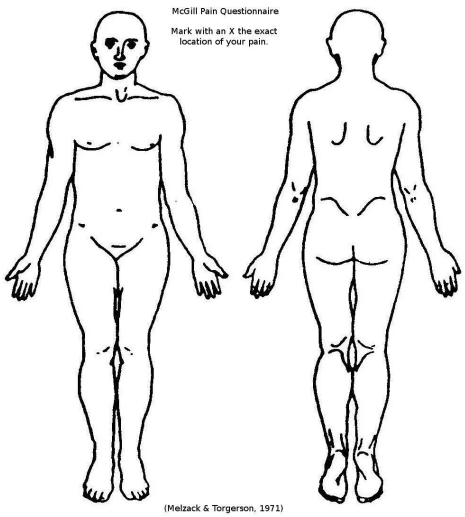
No pain Worst pain Imaginable

Pain at WORST: Rate your highest pain level in past 3 days.

_____

0 1 2 3 4 5 6 7 8 9 10

No pain Worst pain Imaginable



Things that help to EASE symptoms:_____

Things that make symptoms WORSE: _____

List 1 (one) important activity you are unable or have difficulty performing as a result of your pain/symptoms. (ex. Stairs, reaching overhead) _____

Have you had previous PT for this condition? YES NO

What is your goal for therapy at this time?_____

HIPAA Compliance Patient Consent

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

Reviewed 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 at 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 the 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.

Patient Signature:_____ **Date:**_____

Reviewed by:_____