CONFIDENTIAL PATIENT INFORMATION

TODAY'S DATE _____

NAME:_____ _____**SS#**_____

DOB:_____ **AGE:** _____ **MARITAL STATUS: S M W D EMAIL**_____

ADDRESS:_____ **CITY:**_____**STATE**_____ **ZIP**_____

HOME PHONE: (**)**_____ **WORK PHONE: (** **)**_____**CELL PHONE: (** **)**_____

Emergency Contact Name & Phone _____

OCCUPATION: _____ **EMPLOYER NAME & ADDRESS** _____

_____

LIST PRESENT COMPLAINTS OR INJURIES _____

_____

_____

WHEN AND HOW DID YOUR CONDITION START ?_____

DID YOU SEE ANY OTHER DOCTORS FOR THIS CONDITION OR RECEIVE CARE AT A HOSPITAL? IF YES,

WHEN?_____ **WHERE?** _____

ARE YOUR COMPLAINTS DUE TO AN ACCIDENT? _____ **IF YES, TYPE? Auto / Work/ Other**

DATE OF ACCIDENT _____ **WHERE DID INJURY OCCUR?** _____

For Auto Accidents/Injuries-

What is the name of YOUR car insurance company? (*This information is necessary regardless of who is at fault*)

Claim # or Policy # _____

Do you have a police report? _____**Were you found at fault for accident?** _____

For Work Related Accidents/Injuries-

Who was injury reported to? _____

Have you lost any days of work as a result of your injury? If yes dates _____

Have you retained an attorney? If yes, name _____

Do we have permission to send records to your attorney? _____

Primary Care Physician _____ **Date of last exam**_____

INSURANCE INFORMATION

THIS PORTION MUST BE FILLED OUT IN ALL CASES:

Primary Health Insurance Co:_____(Please provide copy of card)

Insured: _____ ID#:_____

Secondary Health Insurance Co: _____(Please provide copy of card)

Insured: _____ID#:_____

Name of your automobile insurance company: (*CAR ACCIDENTS ONLY-REGARDLESS OF FAULT*)

_____

Policy or Claim# _____

Workers Compensation Insurance Carrier: _____

Claim #:_____ Claim Rep/Case Manager _____

I currently do NOT have health insurance _____ (Please Initial)

FINANCIAL RESPONSIBILITY STATEMENT

I understand and agree that insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that "Comprehensive Orthopedic and Sports Physical Therapy PC" will prepare necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to "Comprehensive Orthopedic and Sports Physical Therapy PC" will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment against the Doctor's recommendation, my account balances will be immediately due and payable.

Patient's Signature _____ SS#_____

Other Responsible Party _____

Relationship to Patient _____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Purpose of Consent

By Signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations. If you are involved in any legal action or third party suit, this will allow your attorney access to your records.

Notice of Privacy Practices You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent.

Right to Revoke

You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that the revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation and that we may decline to treat you or to continue treating you if you revoke this Consent.

I _____ , have had the full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

I have received a copy of the office's Notice of Privacy Practices.

Signature _____ Date _____

_____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name

Relationship to Patient

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations. I understand that revocation of my Consent will not affect any action you took in reliance of my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature_____ _____ Date_____

Major Complaint Information

What is your chief complaint? _____

When did this symptom(s) begin? _____

What makes it worse? _____

What makes it better? _____

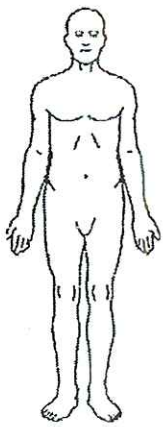
Is the pain worse in the AM or PM? _____ Does the pain radiate? _____

Have you seen another doctor for this? _____ Doctor's Name _____

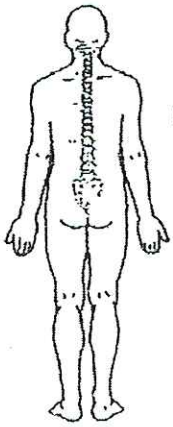
Date Consulted _____ Diagnosis _____

Using the symbols provided in the Pain Index box, mark the areas on the illustrations below where you are experiencing pain.

RIGHT

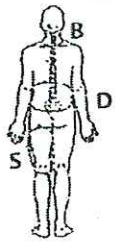


LEFT RIGHT



Pain Index

D	Dull Nagging Ache
B	Burning
S	Sharp / Stabbing
N	Numbness / Tingling



For example: The image to the left illustrates a burning pain in the neck, a dull ache in the lower back, and a sharp pain in the left thigh.

What is the pain interfering with that's most important in your life? _____

Check those activities below during which you experience difficulty or pain:

O Lying on back	O Getting in/out of car	O Pulling	O Sitting	O Standing for long periods
O Lying on side	O Dressing self	O Reaching	O Bending forward	O Sneezing
O Turning over in bed	O Sexual activity	O Kneeling	O Bending backward	O Coughing
O Lying flat on stomach	O Pushing	O Stooping	O Walking	O Other_____

Additional Complaints

Please check all additional complaints that you have at this time

O Loss of concentration	O Neck Stiffness	O Shortness of breath	O Cold hands	O Allergies (Please list)
O Eyes sensitive to light	O Neck motion restricted	O Irritability	O Cold Feet	_____
O Memory loss	O Upper back pain/stiffness	O Anxiety	O Jaw pain	_____
O Heavy feeling head	O Middle back pain/stiffness	O Depression	O Hypertension	_____
O Dizziness	O Lower back pain/stiffness	O Insomnia	O Diabetes	O Other (Please list)
O Ringing in ears	O Left/Right Shoulder pain	O Fatigue	O Convulsions	_____
O Loss of balance	O Left/Right Arm pain	O Excess perspiration	O Vision problems	_____
O Loss of smell	O Left/Right Leg pain	O Digestive Trouble	O Anemia	(Please specify location)
O Loss of taste	O Pins & Needles in Arms/Legs	O Nausea	O Heart Disease	O Swelling_____
O Pain behind eyes	O Sinus trouble	O Vomiting	O Arthritis	O Cuts_____
O Fainting	O Nervousness	O Diarrhea	O HIV (AIDS)	O Bruising_____
O Palpitation	O Chest pain	O Constipation		O Numbness_____

Do you have, or have you ever had, any diseases or medical problems not listed? O Yes O No If so, please list: _____

_____

Have you ever had O Motor vehicle injury O Sports injury O Work injury O Slip and fall injury

If yes, please explain: _____

Is there any additional information you would like the doctor to know about before beginning care? _____

_____

It is important that our office understands your complete medical history. Please list all medications including vitamins and herbal supplements that you are currently taking. Please include the reason you are taking the medication as well as the dosage.

Name of Medication	Condition	Dosage

I am currently not taking any medication. _____ (PLEASE INITIAL)

Signature _____

Date _____