

SPINE & SPORTS MEDICINE

PATIENT INTAKE SHEET

1) Your Name: \_\_\_\_\_

2) Address: \_\_\_\_\_ Apt #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

3) Sex:  Male  Female    4) Status:  Single  Married  Other    5) If Student:  Full-Time  Part-Time

6) Social Security Number: \_\_\_\_\_ 7) Birth date: \_\_\_\_\_ Age: \_\_\_\_\_

8) How did you hear about us?  1—Referring Physician  2—Yellow Pages  3—Friend  4—Internet  5—Other

9) Employer Name: \_\_\_\_\_ 10) Phone #: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

11) Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

12) Emergency Contact Name: \_\_\_\_\_ 13) Relationship: \_\_\_\_\_

14) Phone #: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

15) If Applicable, Attorney Name: \_\_\_\_\_

16) Phone #: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ 17) Fax #: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

18) If patient is a minor, Guardian / Guarantor Name: \_\_\_\_\_

19) Relationship: \_\_\_\_\_ Phone #: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

20) If guardian's address is different than the patient, complete field below:

Address: \_\_\_\_\_ Apt #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

21) 1<sup>st</sup> Appointment Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

22) Status:  Active    23) Name of your Therapist: \_\_\_\_\_



Client Initial Self-Assessment Form

The following questions help us design an appropriate therapy plan so that you can get the most out of your PT. Please note that most insurance's cover Physical Therapy only if it is aimed at restoring lost function. In rehabilitation the term function is defined as "any physical activity or action required in the course of like, work, hobbies, or sports". Examples of function include, reaching up into a cupboard, sleeping, walking to the store and swimming.

Please describe the problem or problems you are coming to Physical Therapy for:

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List any activities or function that you are unable to do, or have difficulty with due to your problem:

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Please rate the current disability level of your injured body part from 0-10. Where zero would be totally normal, able to do all activities without difficulty and 10 would totally disabled, unable to do anything.

Rate only your injured body part.

Current functional level (rate from 0-best to 10-worst): \_\_\_\_\_

Please rate your pain levels, over the past 2 weeks, from 0-10. Where zero would be no pain or symptoms of any kind and ten would be the worst possible pain in you can imagine.

Current symptom level (rate from 0 to 10): \_\_\_\_\_

Symptom level of the worst you have had over the past 2 weeks: \_\_\_\_\_

What is the lowest level your symptoms have been in the past 2 weeks: \_\_\_\_\_

Average symptom level over the past 2 weeks: \_\_\_\_\_

What are you hoping to achieve in Physical Therapy?

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Patient Name: \_\_\_\_\_ Patient Signature: \_\_\_\_\_

\_\_\_\_\_ Date: \_\_\_\_\_



Patient Name \_\_\_\_\_ Date: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

1. Have you ever had any of the following?

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Allergies                     | <input type="checkbox"/> Fatigue             | <input type="checkbox"/> Metal Implants    |
| <input type="checkbox"/> Anxiety                       | <input type="checkbox"/> Frequent Infections | <input type="checkbox"/> Seizures          |
| <input type="checkbox"/> Arthritis                     | <input type="checkbox"/> Headaches           | <input type="checkbox"/> Drinking Disorder |
| <input type="checkbox"/> Asthma                        | <input type="checkbox"/> Kidney Problems     | <input type="checkbox"/> Hernia            |
| <input type="checkbox"/> Back Aches                    | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Weight Problems   |
| <input type="checkbox"/> Cancer                        | <input type="checkbox"/> Hypertension        | <input type="checkbox"/> Migraines         |
| <input type="checkbox"/> Colitis                       | <input type="checkbox"/> Skin Problems       | <input type="checkbox"/> Ulcers            |
| <input type="checkbox"/> Diabetes                      | <input type="checkbox"/> Hypoglycemia        | <input type="checkbox"/> Surgeries         |
| <input type="checkbox"/> Depression                    | <input type="checkbox"/> Insomnia            | <input type="checkbox"/> Other             |
| <input type="checkbox"/> Tumor                         | <input type="checkbox"/> Irritability        |  |
| <input type="checkbox"/> Bladder Problems/Incontinence | <input type="checkbox"/> Pregnancy           |  |
| <input type="checkbox"/> Weight Fluctuation            | <input type="checkbox"/> Heart Attack        |  |

2. Surgeries- Please Indicate any surgeries, including date

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

**Spine and Sports Medicine Institute, Inc.**

**WORKERS COMP. INSURANCE**

**General Information, Release of Information, and Policy Overview**

Welcome to our clinic! Our goal is to exceed your expectations of quality patient care and that your treatment will be productive and timely. We are always open to your suggestions for improving our services and encourage you to provide us with your comments. If you enjoy your treatment at SSMI, we hope that you will let your physician know.

We would like to make you aware of several important policies at our clinic, which serve to provide you with a professional, positive, and efficient experience. Please take the time to read this information in its entirety, sign below indicating your agreement, and return this sheet to the receptionist.

**Fees for Our Services To be paid by the Workers Compensation Insurance Carriers.** Fees for our services will be paid by your employer’s workers compensation insurance company. We are required to obtain pre-authorization from the insurance company in order to collect payment for our services. As such, you agree to assist us, if necessary, in obtaining such authorizations and collection for services to the extent you are able. During the course of your treatment, further authorizations may be required, and it is possible that your treatment may be suspended until we can obtain the proper approvals.

**Cancellations and “No Shows”.** In order to make progress with your treatment, it is imperative that you attend ALL of your scheduled visits to the clinic. If you are unable to keep a scheduled appointment we require 24 hours advance notice. Your consideration allows other patients to be seen by our therapists. If you do not provide us 24 hour advance notice we will send a progress note to your physician, your case manager, and/or your insurance adjuster indicating your non-compliance with treatment. Subsequent cancellations or “no shows” will result in your discharge from the clinic.

**Returned checks.** If your check is returned to us from the bank, your account will be assessed a \$25 processing fee. In the event SSMI does not receive payment, we serve the right to pursue the California “Bad Check Law” Civil Code B719.

**Assignment of Insurance Benefits.** By signing below, you hereby authorized your insurance carrier or attorney to pay directly to Spine & Sports Medicine Institute, Inc. any benefits allowable for professional services rendered to you.

**Consent to Treatment.** Your therapist will inform you of the treatment prescribed by your physician. Your therapy is provided by SSMI solely at the direction of your physician, and as such SSMI is not liable for any act or omission related to such therapy. You acknowledge that no guarantee or assurance has, or can be made by SSMI as to the expected results of such therapy. By signing below, you consent to have SSMI provide therapy as prescribed by your physician. You may revoke this consent at any time.

**Information Privacy.** As part of the HIPPA regulations we have implemented strict information privacy rules to protect your private information. The SSMI Privacy Policy Statement (attached) explains how we may use your private health information, as well as your rights regarding the use of this information. You may obtain a copy of the SSMI Privacy Policy Statement at any time from the Front Reception Desk. By signing below, you acknowledge that you have received this Statement. You authorize Spine & Sports Medicine Institute, Inc. to release any information it may have concerning your account and treatment, including medical and psychological records, to your insurance carrier(s) and their agents, doctor(s) or attorn(ies), or to any agent of SSMI for purposes related to your care, or for collecting payment for our services. You agree that SSMI may accept photocopies and/or facsimile copies of information requests as valid and legal requests.

I have read the information above. I understand and agree to the policies on this sheet. I have received a copy of this “General Information, Release of Information, and Policy Overview” sheet.

Patient’s Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian’s Signature (for minors): \_\_\_\_\_ Date: \_\_\_\_\_



**CONTRACT OF COMMITMENT FOR  
THE WORKERS COMPENSATION PATIENT**

As a new patient with Spine & Sports Medicine we would like to welcome you to our Clinic. Our primary responsibility is to help you reach a level of physical ability that is acceptable to both you and your employer, so you can return to your occupation quickly and safely. For you to have a positive and successful rehabilitation as a Workers Compensation patient, your responsibilities have been outlined as follows:

- You are responsible for attending all authorized and prescribed treatment sessions as scheduled.
- We require a 24 hour notice for canceling an appointment (illness or an extreme emergency constitutes a cancellation). If you fail to contact the clinic we will notify your Worker's Comp Carrier/Adjuster, Nurse Case Manager and your referring Physician.
- If you No-Show or are consistently late for appointments your Worker's Comp Carrier/Adjuster, Nurse Case Manager and your referring Physician will be notified.

Please read and sign the following statement.

I am expected to participate and attend physical therapy sessions as scheduled. I understand if I am late or fail to give appropriate cancellation notice, I will hinder my rehabilitation. I have read the above agreement and agree to comply.

\_\_\_\_\_  
Worker/Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Worker/Patient Printed Name

\_\_\_\_\_  
Witness