ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____ (printed name of patient or personal representative) acknowledge that I have received a copy of the Notice of Privacy Practices of **G2 Sports and Physical Therapy** for (check one) _____ me _____ specify name of individual [please print clearly] and agree to the liability limitations explained therein: _____ .

_____ _____

Signature of Patient or Personal Representative **Date**

_____ _____

Print Name **Relationship to patient (not self)**

CONSENT TO TREAT

The patient authorizes the Physical, Occupational, and/or Speech Therapist to examine and treat the condition as he/she deems appropriate through the use of physical/occupational, and/or speech therapy measures, and the patient gives authorization for these procedures to be performed.

The patient has the right to informed participation in decisions involving his/her health care. This shall be based on clear, concise explanation of his/her condition and of all proposed treatment procedures. All possible risks and/or side effects as well as the probability of success with such procedures shall be disclosed to the patient by his/her attending Physical, Occupational, and/or Speech Therapist. The patient will not hold the Physical, Occupational, and/or Speech Therapist responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

The patient has the right to know who is responsible for authorizing and performing any and all treatment procedures.
The patient shall not be subjected to any procedure without his/her voluntary, competent, and understanding consent or the consent of his legally authorized representative. Where medically significant alternatives for care or treatment exist, the patient shall be so informed.

The patient shall be advised if G2 Sports and Physical Therapy proposes to engage in or perform human experimentation, for the purpose of research, affecting his/her care. The patient has the right to refuse to participate in such research projects.

I have read (or have had read to me) the above information and understand the content.

_____ _____

Patient (or Guardian) Signature **Date**

_____ _____

Witness Signature **Date**

G2 Sports Physical and Physical Therapy Late Cancellation/Missed Appointment Policy

Missed appointments and those cancelled less than **24** hours in advance impact our ability to provide healthcare to you and others that are in need of our care. We provide reminder calls and/or emails prior to your appointment but this does not excuse you from any missed appointments. You are ultimately responsible for any and all of the appointments that you have scheduled with us.

Any appointments that are either cancelled less than **24** hours in advance or are missed will result in a ***$125*** fee that will be charged directly to your account. ***A pattern of missed appointments may also result in our no longer being able to provide you further care at our facility.***

I, the undersigned, have been informed about the Cancelation/Missed Appointment Policy here at G2 Sports and Physical Therapy. I understand that a pattern of missed appointments not cancelled at least **24** hours in advance may result in my termination of care at this clinic and will also be subjective to a **$125** "Late Cancelation/Missed Appointment" fee for each occurrence that I am responsible for.

_____ _____

Patient (or Guardian) Signature Date

SPORTS + PHYSICAL THERAPY

Intake Information Form

How did you find out about our facility?

☐ MD ☐ Friend ☐ Previous Patient ☐ Insurance Carrier ☐ Other:_____

Patient Information

Last First M.

Address

City State Zip

Home Phone Cell Phone

Sex M ☐ F ☐

Work Phone

Employer

Date of Birth Age

Spouse's Name Work Phone

Responsible Party/Billing

Last First M.

Address

City State Zip

Home Phone Cell Phone

Sex M ☐ F ☐

Work Phone

Employer

Date of Birth Age

Spouse's Name Work Phone

Email Address:_____

Y / N ***Please send me information on your upcoming events and Specialty Services***

Referring Physician Phone # Primary Care Physician Phone #

Patient/Guardian Signature:_____ Date_____

I hereby Authorize G2 Sports and Physical Therapy Access to my Medical Records for the Above Physician/'s

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Are current symptoms related to: ☐ Auto Accident; If so, has the accident been reported? ☐ Yes ☐ No State of Accident _____

☐ Work Injury; If so, is there a case manager involved? ☐ Yes ☐ No Date of Accident: _____

Case Manager Name: _____ Phone # _____ Fax # _____

Employer Contact/Title**:** _____ Phone # _____ Fax # _____

Current Work Status: ☐ Full Duty ☐ Limited Duty ☐ Not Working

Diagnosis (es):_____ Date of last MD Appt:_____Date of Next MD Appt:_____

Date of Onset/Injury: _____Rx Date_____ Surgery: ☐ Yes ☐ No Date of Surgery:_____

Have you had physical therapy, occupational therapy, speech therapy, chiro care, etc. this benefit year? ☐Yes If so, where_____ ☐ No

G2 SPORTS + PHYSICAL THERAPY

INITIAL EVALUATION SUBJECTIVE HISTORY WORKSHEET (Page 1)

Patient Name: _____ **Date of Birth:** _____ **Date of Eval:** _____

SUBJECTIVE

Age: _____ **When did your symptoms start?** _____

Hand Dominance: ☐ Right ☐ Left **Date of next Doctor's appointment:** _____

Describe the current problem that brought you here: _____

_____

Are your symptoms: ☐ Improving ☐ Getting Worse ☐ Staying the Same

Have you had any testing? ☐ X-rays ☐ MRI ☐ EMG/ Nerve Conduction Test ☐ CT Scan

☐ Other **Results:** _____

Have you ever had these symptoms before? ☐ Yes ☐ No **Description:** _____

Have you ever had treatment before for these symptoms? ☐ Yes ☐ No **If Yes, please describe:**

☐ **Medication:** **Beneficial?** ☐ Yes ☐ No **Explain:** _____

☐ **Injection:** **Beneficial?** ☐ Yes ☐ No **Explain:** _____

☐ **Physical Therapy:** **Beneficial?** ☐ Yes ☐ No **Explain:** _____

☐ **Massage/Chiropractic:** **Beneficial?** ☐ Yes ☐ No **Explain:** _____

Did you have surgery? ☐ Yes ☐ No **Date of Surgery:** _____

If yes, what procedure did you have done? _____

THERAPIST COMMENTS:

CURRENT COMPLAINTS

If you have pain, what is your pain level?

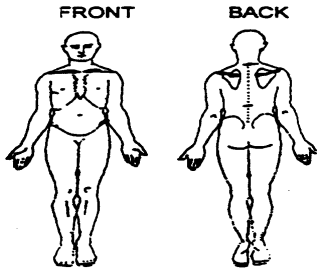
(0 = No Pain, 10 = Extreme Pain – Circle)

AT WORST: 0 1 2 3 4 5 6 7 8 9 10

AT BEST: 0 1 2 3 4 5 6 7 8 9 10

CURRENTLY: 0 1 2 3 4 5 6 7 8 9 10

Mark the location of your pain with an "X":



Are your symptoms: ☐ Constant ☐ Come and Go ☐ Ache ☐ Deep ☐ Superficial ☐ Dull ☐ Sharp ☐ Shooting ☐ Burning ☐ Numbness/Tingling ☐ Other: _____

Day Pattern:

Does your pain seem to be WORSE at a certain time of day? ☐ Yes ☐ No

If Yes, ☐ Morning ☐ Night ☐ Other: _____

Does your pain progress as the day goes along? ☐ Yes ☐ No

If Yes, please explain: _____

Do you have difficulty falling asleep? ☐ Yes ☐ No

If Yes, please explain: _____

Do you wake due to pain? ☐ Yes ☐ No **If Yes, # of times per night:** _____

THERAPIST COMMENTS:

FUNCTIONAL ABILITIES AND RESTRICTIONS

What activities are difficult to perform due to your condition? ☐ Squatting ☐ Sitting ☐ Standing ☐ Walking ☐ Lifting ☐ Dressing/Grooming ☐ Driving ☐ Stairs ☐ Reaching ☐ Work Tasks ☐ Gripping/Pinching ☐ Kneeling ☐ Position Changes ☐ Other: _____

_____

What household duties are you having difficulty performing? ☐ Cooking ☐ Cleaning ☐ Vacuuming ☐ Laundry ☐ Yard Work ☐ Grocery Shopping ☐ Other: _____

_____

What activities make your pain WORSE? _____

What activities make your pain BETTER? _____

What were you doing prior to this injury that you are unable to do currently? _____

_____

Do you use an assistive device? ☐ None ☐ Cane ☐ Walker ☐ Wheelchair ☐ Other: _____

Hobbies/ Interests/ Exercise: _____

_____

THERAPIST COMMENTS:

G2 SPORTS + PHYSICAL THERAPY

INITIAL EVALUATION SUBJECTIVE HISTORY WORKSHEET (Page 2)

Patient Name: _____ **Date of Birth:** _____ **Date of Eval:** _____

Occupation: _____ **Presently Working:** ☐ Yes ☐ No

If Yes, ☐ Full Duty ☐ Limited Duty: **Restrictions:** _____ **# Days Off Work:** _____

Job Duties: ☐ Sitting ☐ Computer Work ☐ Bending ☐ Heavy Lifting ☐ Traveling ☐ Standing
☐ Reaching ☐ Crawling ☐ Twisting ☐ Walking ☐ Pushing/Pulling
☐ Gripping/Pinching ☐ Other: _____

Are you now, or have you ever been disabled (service or work)? ☐ Yes ☐ No **If Yes, when?** _____
If Yes, please explain: _____

What is your current living arrangement? ☐ Alone ☐ Spouse ☐ Partner ☐ Family ☐ Other: _____

Does your home have stairs? ☐ Yes ☐ No **If Yes, # of stairs:** _____

If Yes, do your stairs have handrail? ☐ Yes ☐ No **If Yes, which side going up?** ☐ Right ☐ Left ☐ Both

THERAPIST COMMENTS:

WORK HISTORY/ SOCIAL HISTORY/ INTERESTS/ LIVING ENVIRONMENT
PREVIOUS MEDICAL HISTORY/ MEDICAL PRECAUTIONS AND CONTRAINDICATIONS

How would you classify your general health? ☐ Good ☐ Fair ☐ Poor

In terms of your general health, please check ALL that apply:

☐ Allergies	☐ Anemia	☐ Liver/Gallbladder Problem
☐ Rheumatoid Arthritis	☐ **Recent Fever**	☐ Fibromyalgia
☐ Metal Implants	☐ **Ringing of the Ears**	☐ Asthma/Breathing Difficulties
☐ **Recent Headaches**	☐ **Recent Nausea/Vomiting**	☐ Seizures/Epilepsy
☐ **Recent Vision Changes**	☐ Heart Attack	☐ **Recent Dizziness/Fainting**
☐ Sexual Dysfunction	☐ **Cancer**	☐ **Recent Change in Bowel/Bladder Habits**
☐ Osteoarthritis	☐ Skin Abnormalities	☐ **Pain with Cough/Sneeze**
☐ Heart Palpitations	☐ Osteoporosis	☐ Smoking History
☐ Chest Pain/Angina	☐ Hernia	☐ Pacemaker
☐ Stroke/TIA	☐ Depression	☐ High/Low Blood Pressure
☐ Physical Abnormalities	☐ Surgeries	☐ Diabetes I or II
☐ Hypoglycemia	☐ Polio	☐ **Unexplained Weight Loss/Gain**
☐ **Night Pain**	☐ Intolerance to Cold/Heat	☐ Pregnancy (Currently)
☐ Urine Leakage	☐ Recent Fractures	☐ **Recent Unexplained Fatigue**
☐ Kidney Problems	☐ Heart Disease	☐ **Numbness/Tingling in Hip/Buttocks Area**

Is there any other information regarding your medical history or are there any factors that may complicate your ability to participate in therapy that we should know about? _____

_____

_____

Have you had any falls in the past 12 months? ☐ Yes ☐ No **If Yes, how many times?** _____

If Yes, please describe the nature of the fall (s): _____

If Yes, please describe if an injury(ies) occurred: _____

_____

THERAPIST COMMENTS:
☐ **See Attached List**

MEDICATIONS

Please list all of the medications [*with specific NAME, DOSAGE, FREQUENCY, and ROUTE (ie: by mouth)*] that you are currently taking [including over-the-counter, prescriptions, herbals, and vitamins/mineral(s)]:

_____

_____

_____

THERAPIST COMMENTS:
☐ **See Attached List**

PATIENT GOALS FOR THERAPY

What are your goals for participating in Therapy? _____

_____

_____

THERAPIST COMMENTS:

SIGNATURES

To the best of my knowledge I have fully informed you of the history of my problem and current status.

Patient's Signature: _____ **Date:** _____

Therapist's Signature: _____ **License #:** _____ **Date:** _____

Printed Therapist's Name: _____