G2 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 ☐
Date of Birth

_____
Employer Work Phone

Responsible Party/Billing

_____
Last First M.

_____
Address

_____
City State Zip

_____
Home Phone Cell Phone

_____ Sex M ☐ F ☐
Date of Birth

Email Address:_____
Your e-mail address will be used for your Home Exercise Program

_____
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

In case of an Emergency, please contact: (*list a friend or relative that can be reached during office hours)*

Name: _____Phone: _____Relationship: _____

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 # _____

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

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

SPORTS + PHYSICAL THERAPY

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

I voluntarily give G2 Sports and Physical Therapy my consent to receive services which may include diagnostic procedures, examinations, and treatment according to the recommended plan of treatment as discussed with my therapist. I understand that physical therapy involves manual techniques that require appropriate physical contact by the health care provider and staff.

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

_____ _____

Patient (or Guardian) Signature **Date**

G2 Sports and Physical Therapy Late Cancelation/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 ***$130*** 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.***

By signing below, you acknowledge that you have read our policy and understand your commitment to a successful physical therapy outcome is essential. The cancellation fee is not covered by insurance and will be collected at the time of your next visit or billed directly to you as an out of pocket expense

_____ _____

Patient (or Guardian) Signature **Date**

G2 SPORTS + PHYSICAL THERAPY

INITIAL EVALUATION SUBJECTIVE HISTORY WORKSHEET (Page 1)

Patient Name: _____ DOB:_____ Date of Eval: _____

Describe the current problem that brings you here today:_____

When did your symptoms start? _____

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 (please provide report, or contact information for report): _____

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

Did you have surgery for this issue? □ Yes □ No Date of Surgery: _____

If Yes, what procedure did you have done? _____

Have you ever had treatment 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: _____

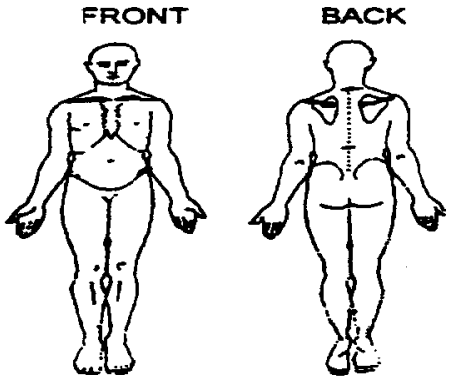
CURRENT COMPLAINTS

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":



Describe symptoms:

□ Constant □ Come and Go □ Ache □ Deep □ Superficial □ Dull □ Sharp □ Shooting □ Burning □ Numb/Tingling

□ Other: _____

Symptom 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 sleeping? □ Yes □ No If Yes, please explain: _____

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

FUNCTIONAL ABILITIES AND RESTRICTIONS

What activities or duties 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 □ Cooking □ Cleaning □ Vacuuming □ Laundry □ Yard Work □ Shopping □ Exercise:_____

□ Other: _____

What makes your pain WORSE?_____

What makes your pain BETTER?_____

Occupation: _____ Presently Working: □ Yes □ No If Yes, □ Full Duty □ Limited Duty:

Restrictions: _____ # Days Off Work: _____ Job Duties: _____

Are you now, or have you ever been disabled? □ Yes □ No If Yes, when? _____Please explain: _____

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

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 a handrail? □ Yes □No If Yes, which side going up? □ Right □ Left □ Both

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

G2 SPORTS + PHYSICAL THERAPY

INITIAL EVALUATION SUBJECTIVE HISTORY WORKSHEET (Page 2)

Patient Name: _____ DOB:_____ Date of Eval: _____

PREVIOUS MEDICAL HISTORY

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

Current Height: _____ Current Weight: _____

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? _____
_____

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)]:

_____
_____
_____
_____

Are you currently taking blood thinners/anticoagulants? Yes No
If yes, how long and for what condition_____

PATIENT GOALS FOR THERAPY

What are your goals for participating in Therapy?

1. _____
2. _____
3. _____

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: _____ Date:_____

THERAPIST COMMENTS: _____
_____
_____
_____
_____
_____