Referring Physician: **S.P.O.R.T. PHYSICAL THERAPY CLINIC**

PATIENT INFORMATION (Please print)

SOC. SEC. NO. ___________ - _________ - _____________

PATIENT ____
Last Name First Name Middle Name

BIRTHDATE ____________________ AGE ________________

Maiden Name (if recently married) __________________________

SEX: ❑ MALE ❑ FEMALE

MARITAL STATUS: ❑ SINGLE ❑ MARRIED ❑ DIVORCED ❑ SEPARATED

PATIENT MAILING ADDRESS ____
Street City State Zip

HOME PHONE ______________ BUS. PHONE ____________ CELL PHONE _____________ OCCUPATION ___________________

EMPLOYER ____ ADDRESS ____

SPOUSE'S NAME ____________________ SPOUSE'S EMPLOYER __________________SPOUSE'S BIRTHDATE ___________________

IN CASE OF EMERGENCY Please contact:

NAME ____ PHONE NO. ____

ADDRESS ____ Relationship ____

COMPLETE IF PATIENT IS A MINOR OR STUDENT:

FATHER'S NAME __________________________ BIRTHDATE ___________________ SOC. SEC. NO. ________________________

ADDRESS ____ HOME PHONE ________________________
Street City State Zip

EMPLOYER ______________________________ BUS. PHONE___________________ HOME PHONE ________________________

MOTHER'S NAME _________________________ BIRTHDATE ___________________ SOC. SEC. NO. ________________________

ADDRESS ____ HOME PHONE ________________________
Street City State Zip

EMPLOYER ______________________________ BUS. PHONE___________________ HOME PHONE ________________________

INSURANCE INFORMATION (Primary)

Name of Insurance: ____

Policy No.: ____

Policyholder: ____

Policyholder Birthdate: ____________________________________

SECONDARY INSURANCE INFORMATION

Name of Insurance: ____

Policy No.: ____

Policyholder: ____

Policyholder Birthdate: ____________________________________

THIRD INSURANCE INFORMATION

❑ YES ❑ NO

❑ **NO INSURANCE Payment Agreement**______________________

If this visit pertains to an injury or accident please indicate below:

❑ AUTO ACCIDENT
❑ ON THE JOB
❑ OTHER ACCIDENT

DATE OF INJURY ____________________

Place of injury: ❑ Home ❑ Other State _____________________

What/how injured:

Insurance Co: ____

Address: ____

Phone #: ____

Employer: ____

Claim #:____

Claims Adjuster: ____

ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY:

I hereby authorize my insurance benefits to be paid directly to SPOR T Physical Therapy Clinic. I understand that I am responsible to pay for services rendered.

CONSENT FOR ADULT:

I hereby give my consent for the authorized personnel of SPOR T Physical Therapy Clinic to evaluate and, if appropriate, render subsequent treatment in accordance with the plan of care authorized by my physician (if applicable) or by my personal authorization.

CONSENT FOR MINOR:

As the above named minor 's parent or legal guardian, I hereby give my consent for the authorized personnel of SPOR T Physical Therapy Clinic to evaluate and, if appropriate, render subsequent treatment in accordance with the plan of care authorized by patient' s physician (if applicable) or by my personal authorization.

SIGN HERE x ____ **DATE** ______________________________

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Patient Consent for Purpose of Health Information
Treatment, Payment, or Healthcare Operations

I, ____, understand that as part of my health care, SPOR T Physical Therapy originates and maintains paper and/or electronic records describing my health history , symptoms, examinations and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A Basis for planing my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis information to my bill,
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that SPORT Physical Therapy is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the or ganization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this or ganization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that SPOR T Physical Therapy reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should SPOR T Physical Therapy change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

____

____

I understand that as part of this or ganzation's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

Complaints

You may complain to us or to the Secretary of Health of Human Services if you believe your privacy has been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

You may contact our Privacy Officer at (208) 746-7573 for further information about the complaint process.

Acknowledgement of Receipt of Privacy Notices, Complaint Procedure, and Consent for Treatment, Payment or Healthcare Operations.

I fully understand and accept/decline the terms of this consent.
Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to the party who accepts assignment.
Regulations pertaining to medical assignment of benefits apply.

Signed: ____ Date: ____

If not signed by patient, please indicate relationship to patient (e.g., spouse)

Relationship: ________________________________ Witnesses by: ____________________________________

Lewiston, ID

William A. Neumayer, P.T., OCS*
Kelly A Steiger, P.T., OCS*, SCS*, CSCS*
Adrienne M. Carlson, D.P.T.*
Michael F. Ward, P.T.
Cliff P. Knelsen, P.T.
Chris J. Lee, MPT, CSCS*

Clarkston, WA

MEDICAL HISTORY SCREENING FORM
SPORT Physical Therapy

Patient Name: __________________________ Date_____

SELECT YES OR NO...

Have you or any immediate family members ever been told you have...

	Self		Family	
Cancer?	YES	NO	YES	NO
Diabetes?	YES	NO	YES	NO
High Blood Pressure?	YES	NO	YES	NO
Heart Disease?	YES	NO	YES	NO
Angina/Chest Pain?	YES	NO	YES	NO
Stroke?	YES	NO	YES	NO
Osteoporosis?	YES	NO	YES	NO
Osteoarthritis?	YES	NO	YES	NO
Rheumatoid Arthritis?	YES	NO	YES	NO

In the past 3 months have you had or do you experience:

A change in your health?	YES	NO
Nausea/Vomiting?	YES	NO
Fever/chills/sweats?	YES	NO
Unexplained weight change?	YES	NO
Numbness or tingling?	YES	NO
Changes in appetite?	YES	NO
Difficulty swallowing?	YES	NO
Changes in bowel or bladder function?	YES	NO
Shortness of breath?	YES	NO
Dizziness?	YES	NO
Upper respiratory infection?	YES	NO
Urinary tract infection?	YES	NO

SELECT YES OR NO...

Do you have a history of:

Allergies/Asthma?	YES	NO
Headaches?	YES	NO
Bronchitis?	YES	NO
Kidney Disease?	YES	NO
Rheumatic Fever?	YES	NO
Ulcers?	YES	NO
Sexually transmitted diseases?	YES	NO
Seizures?	YES	NO

Are you currently:

Pregnant?	YES	NO
Depressed?	YES	NO
Under Stress?	YES	NO

Other Medical Conditions:

____

____

Is medication list included? YES NO

If no, why? ___________________________________

____

Do you currently have a pacemaker installed? YES NO

How are you able to sleep at night (check one):
Fine Moderate Difficulty Only w/Medication

Do you or have you in the past smoked tobacco?
Yes No

If yes, ____________ packs X ____________ years

Date of last physical examination: ________________________

Pain Rating:

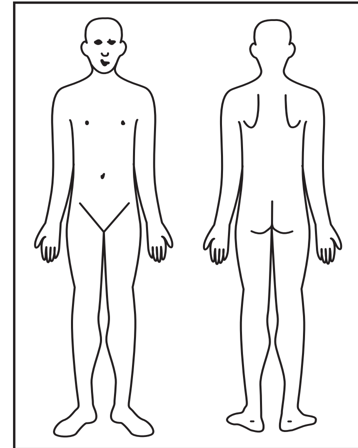
This list provides some examples that might describe your pain. Check all that apply.

- ❑ Sharp ❑ Burning ❑ Dull
- ❑ Throbbing ❑ Shooting ❑ Tingling
- ❑ Numb ❑ Tight ❑ Stabbing

Are your pain symptoms:

- ❑ Constant (Never quits)
- ❑ Intermittent (Relieved w/some positions or rest)
- ❑ Occasional (Daily or less)
- ❑ Infrequent (Once a week)

On the chart below, draw each area of your pain or symptoms.



Please list previous surgeries:__________________________

____

____

____

____

Therapist Initial: ____________________

Orthopaedic Rehabilitation *Sports Injuries* *Neck & Back Injuries* *Work Conditioning*

BRYDEN CANYON CENTER 328 Warner Drive, Suite 8 • Lewiston, ID 83501 Phone (208) 746-7573 Fax (208) 746-4519
TRI-STATE Medical Office Bldg. 1119 Highland Avenue, Suite 2 • Clarkston, WA 99403 Phone (509) 758-9404 Fax (509) 758-8267

*OCS—Orthopaedic Certified Specialist *CSCS—Certified Strength and Conditioning Specialist *DPT—Doctor of Physical Therapy *SCS—Sport Certified Specialist

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