

Physical Therapy Dynamics & Sports Medicine  
Patient Information Form

MR. <input type="checkbox"/>	MRS. <input type="checkbox"/>	MS. <input type="checkbox"/>
NAME:		SPOUSE NAME:
PARENT NAME (If minor):		
ADDRESS - Number & Street Name:		City, State & Zip Code:
HOME PHONE #:		WORK PHONE #:
EMPLOYER:		OCCUPATION:
ADDRESS - Number & Street Name:		City, State & Zip Code:
SOCIAL SECURITY #:		DATE OF BIRTH:
SPOUSE/PARENT EMPLOYER:		Phone #:
ADDRESS - Number & Street Name:		City, State & Zip Code:
SPOUSE/PARENT SS#:		SPOUSE/PARENT DOB:
Date of injury:		
Is this a work related injury?   YES <input type="checkbox"/> NO <input type="checkbox"/>		
Do you have a lawyer representing you?   YES <input type="checkbox"/> NO <input type="checkbox"/>		
Please list name of lawyer:		Phone #:
Who is your primary physician?		
Did the physician who issued the prescription for Physical Therapy refer you to our facility for treatment?   ___ Yes   ___ No		
If the answer is No, please list who referred you to our facility.		
How did you hear about our facility?		
When is your next scheduled appointment with the referring physician?		
List two emergency contacts (nearest relative or friend):		
Name: _____		Relationship: _____ Phone # _____
Name: _____		Relationship: _____ Phone# _____



**Patient Consent Form**

By signing this form, you are granting consent to Physical Therapy Dynamics & Sports Medicine to use and disclose your protected health information, when it is appropriate and necessary, for the purposes of treatment, payment and health care operations. When doing so, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment, or health care operations, in order to provide your best interest. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change from time to time without notice. If we change our Notice, you may obtain a copy of the revised Notice by contacting our organization at (818) 348-0580 or by accessing our website at [www.ptdynamics.net](http://www.ptdynamics.net).

You have the right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations but this must be done in writing. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

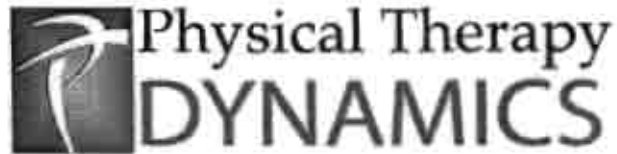
You have the right to revoke this consent in writing, except to this or the extent we already have used or disclosed your protected health information in reliance on a prior signed consent.

---

Signature of Patient or Legal Representative

---

Date



**HISTORY OF PRESENT CONDITION**

1. What are your symptoms?
2. When did your symptoms begin?
3. Was the **onset** of this episode gradual or sudden?
4. Which of the following **best describes** how your injury occurred? (check all that apply)

<input type="checkbox"/> lifting	<input type="checkbox"/> trauma	<input type="checkbox"/> hit by a ball
<input type="checkbox"/> MVA (car accident)	<input type="checkbox"/> degenerative process	<input type="checkbox"/> dental appointment
<input type="checkbox"/> a fall	<input type="checkbox"/> during recreation/sports	<input type="checkbox"/> throwing
<input type="checkbox"/> cumulative trauma	<input type="checkbox"/> running	<input type="checkbox"/> unknown
<input type="checkbox"/> overuse	<input type="checkbox"/> blow to the face	<input type="checkbox"/> List other below

5. Since onset, are your symptoms getting:

<input type="checkbox"/> Better	<input type="checkbox"/> Worse	<input type="checkbox"/> No Change
---------------------------------	--------------------------------	------------------------------------

6. Have you had similar symptoms in the past?

<input type="checkbox"/> Yes	<input type="checkbox"/> No
------------------------------	-----------------------------

Yes      No

7. Nature of pain/symptoms (check all that apply)

<input type="checkbox"/> Sharp	<input type="checkbox"/> Throbbing	<input type="checkbox"/> Periodic	<input type="checkbox"/> Constant
<input type="checkbox"/> Dull	<input type="checkbox"/> Aching	<input type="checkbox"/> Occasional	<input type="checkbox"/> List other below

8. As the **DAY** progresses, do your symptoms:

<input type="checkbox"/> Increase	<input type="checkbox"/> Decrease	<input type="checkbox"/> Stay the same
-----------------------------------	-----------------------------------	--

9. Does the pain wake you at night?

<input type="checkbox"/> Yes	<input type="checkbox"/> No
------------------------------	-----------------------------

10. Do you have pain/stiffness upon getting out of bed in the morning?

<input type="checkbox"/> Yes	<input type="checkbox"/> No
------------------------------	-----------------------------

11. In what position do you sleep?

<input type="checkbox"/> Right side	<input type="checkbox"/> Stomach	<input type="checkbox"/> Chair/recliner	<input type="checkbox"/> List other below
<input type="checkbox"/> Left side	<input type="checkbox"/> Back	<input type="checkbox"/> Back,side,stomach	

12. Other Medical Symptoms? (check all that apply)

<input type="checkbox"/> Bowel/Bladder difficulty	<input type="checkbox"/> Dizziness/Fainting attacks	<input type="checkbox"/> Malaise
<input type="checkbox"/> Fever/Chills	<input type="checkbox"/> Weakness	<input type="checkbox"/> Vision/Hearing problems
<input type="checkbox"/> Genital/Anal numbness	<input type="checkbox"/> Weight gain	<input type="checkbox"/> None noted
<input type="checkbox"/> Numbness	<input type="checkbox"/> Night Pain/Sweats	<input type="checkbox"/> List other below

13. What aggravates your symptoms? (check all that apply)

<input type="checkbox"/> Sitting	<input type="checkbox"/> Reaching	<input type="checkbox"/> Coughing/sneezing
<input type="checkbox"/> Going to/rising from sitting	<input type="checkbox"/> Standing	<input type="checkbox"/> Taking a deep breath
<input type="checkbox"/> Lying down	<input type="checkbox"/> Squatting	<input type="checkbox"/> Looking up overhead
<input type="checkbox"/> Walking	<input type="checkbox"/> Sleeping	<input type="checkbox"/> Swallowing
<input type="checkbox"/> Going up/down stairs	<input type="checkbox"/> household activities	<input type="checkbox"/> Stress
<input type="checkbox"/> recreation/sports: please specify		
<input type="checkbox"/> repetitive activities/motions		
<input type="checkbox"/> Oral activities: please specify		
<input type="checkbox"/> List other:		

14. What relieves your symptoms? (check all that apply)

<input type="checkbox"/> Sitting	<input type="checkbox"/> Rest	<input type="checkbox"/> Massage
<input type="checkbox"/> Heat	<input type="checkbox"/> Standing	<input type="checkbox"/> Medication
<input type="checkbox"/> Cold	<input type="checkbox"/> Walking	<input type="checkbox"/> Nothing
<input type="checkbox"/> Stretching	<input type="checkbox"/> Exercise	<input type="checkbox"/> List other below
<input type="checkbox"/> Wearing splint/orthosis	<input type="checkbox"/> Lying down	

15. Have you had any previous treatment for this condition? (check all that apply)

<input type="checkbox"/> None	<input type="checkbox"/> Bracing/taping	<input type="checkbox"/> TENS unit
<input type="checkbox"/> Medication (oral)	<input type="checkbox"/> Injection into the spine	<input type="checkbox"/> Acupuncture
<input type="checkbox"/> Joint manipulation DC/DO	<input type="checkbox"/> Injection into the skin/muscle	<input type="checkbox"/> Bed Rest
<input type="checkbox"/> Exercise	<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Overnight hospitalization
<input type="checkbox"/> Massage therapy	<input type="checkbox"/> Hypnosis	<input type="checkbox"/> Casting
<input type="checkbox"/> Traction	<input type="checkbox"/> Biofeedback	<input type="checkbox"/> List other below

16. Have you had any of the following tests? (check all that apply)

<input type="checkbox"/> None	<input type="checkbox"/> MRI	<input type="checkbox"/> Bone Scan	<input type="checkbox"/> Vestibular
<input type="checkbox"/> Xrays	<input type="checkbox"/> Arthrogram	<input type="checkbox"/> NCS	<input type="checkbox"/> List other below
<input type="checkbox"/> CT scan	<input type="checkbox"/> Stress Xray test	<input type="checkbox"/> Fluroscope	

### **MEDICATION**

Are you currently taking any medication for your condition?

<input type="checkbox"/> Prescription: please specify
<input type="checkbox"/> Non-prescription: please specify
<input type="checkbox"/> None
<input type="checkbox"/> List other:

## Insurance Information Form

Health and accident policies are an arrangement between you and your insurance company. Notwithstanding any such arrangement, you are personally financially responsible for all services rendered in our office. All unpaid charges will be billed directly to you, the patient. We accept assignment of benefits after your insurance coverage has been verified. Your insurance company will send payment directly to our office. We will promptly credit all received payments from your insurance company. Any balance remaining unpaid after payment by any insurance company will remain your responsibility to pay.

Patient Name (PRINT): \_\_\_\_\_ Insurance Company: \_\_\_\_\_

DEDUCTIBLE:\$ \_\_\_\_\_ (per year).

In order to meet your calendar year deductible we require that you, the patient, pay \$180.00 (one-hundred eighty dollars) per visit, prior to treatment until your deductible is met, also \$180.00 is our per visit cash price.

COPAYMENT:\$ \_\_\_\_\_ (per visit). The patient is responsible for the estimated percentage before treatment is rendered.

Have you had any physical therapy visits with any physical therapist within this year? YES NO \_\_\_\_\_ (number of visits).

Have you had any chiropractor, acupuncture, speech therapy, or occupational therapy visits any time this year? YES NO \_\_\_\_\_ (number of visits).

Our office will not enter into a dispute between you and your insurance company over claims. This is your responsibility and obligation. \_\_\_\_\_ (Patient's initials).

You acknowledge and agree that you or your legal representative will be financially responsible for, and pay promptly when billed, all charges for any services rendered to you by us that may ultimately be determined by your insurer to be not covered services, not authorized, or not medically necessary. \_\_\_\_\_ (Patient's initials).

If you receive any checks from your insurance carrier, you are responsible to sign the check on the back and turn it in to our office within 5 business days. \_\_\_\_\_ (Patient's initials).

### ADDITIONAL CHARGES

Returned check charge: \$25.00 per check

Cancellation charge: \$25.00 for a NO-SHOW appointment or a cancellation that is not given within a 24-hour notice (or by 2P.M. on a Friday afternoon for an appointment the following Monday). We require a credit card on file that we are allowed to charge if patient does not show up at appointment or call before required 24 hour period.  
\_\_\_\_\_ (Patient's initials)

Late payment charge: \$10.00 or 1.5% (whichever is greater) will be added to your account along with a collection service and/or attorney fees for delinquent accounts. There will be a \$15.00 office charge for the copying of medical records.

PRIVATE & MEDICARE INSURANCE – The fees charged in our office are comparable to those charged by other physical therapists in this area with similar qualifications.

WORKER'S COMPENSATION – If you are hurt on the job, your employer's workers compensation insurance will pay 100% of your care, upon authorization from the adjuster.

PERSONAL INJURY/AUTO ACCIDENT – If you have Med-pay coverage on your automobile policy we will bill them for prompt and direct payment. Med-pay will cover your doctor bills regardless of who was at fault. If there is no Med-pay coverage we will bill your health insurance and any balance will be billed to you upon completion of services.

My signature below states that I have read the above, and have been informed of my insurance benefits, as stated by my insurance company. I am aware of my financial responsibility to Physical Therapy Dynamics. I understand and agree to the above terms and conditions. I agree that a photostatic or facsimile copy of this document is as valid as the original.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_