South Bay Sports Medicine Physical Therapy, Inc. Patient Intake Information

PATIENT INFORMATION			
First Name:	Last Name:	Middle Initial:	Date:
Address:	City:	State:	Zip:
Birth Date:	Age:	(Please circle) Male Female	SSN:
Home Phone	Mobile Phone	Email address:	
Referred By: (please circle) Physician:		Ins Plan	Family Member Friend
Former/Current Patient Saw Passing By	Website	Yellow Pages	Other:
EMERGENCY CONTACT			
Name of Local Friend or Relative:		Phone:	
CARE PROVIDER INFORMATION			
Referring Dr:	City:		
Phone:			
INSURANCE INFORMATION: (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)			
Primary Ins Name:	Subscriber/Member ID#		
Group/Account/Policy #:			
Name of Primary Subscriber (if different than patient)		Birth date:	
Patient's Relationship to Subscriber: (please circle) Self	Spouse	Child	Other:
Secondary Ins Name:	Subscriber/Member ID#		
Group/Account/Policy #:			
Name of Primary Subscriber (if different than patient)		Birth date:	
Patient's Relationship to Subscriber: (please circle) Self	Spouse	Child	Other:
AUTO OR WORK INJURY CLAIMS (PLEASE BE AS THOROUGH AS POSSIBLE)			
Type of Accident: (Please circle)	Auto	Work	
Ins Carrier Name:			
Claims address:	City:	State:	Zip:
Adjuster/Claims Manager:	Phone:		Ext:
Adjuster Email:			
Claim #:	Date of Injury/Accident:		
Primary Treating Physician (PTP):	Phone:		
Name of Attorney: (where applicable)		Phone:	
Law Firm:			
Address:	City:	State:	Zip:
Atty email:			

I authorize South Bay Sports Medicine Physical Therapy (SBSM) to release any information required for the processing and/or payment of my claims. I authorize my insurance benefits to be paid directly to SBSM. I also authorize my referring and treating provider(s) to release information about my condition and treatment to SBSM as necessary to process my claims and provide me with the best treatment possible. I authorize SBSM to perform an evaluation and provide me with treatment as recommended by my physician; I also authorize my minor child (or child over whom I have guardianship) to be evaluated and treated by the physical therapists and staff of SBSM according to their discretion without the presence of a parent or legal guardian.

PATIENT/GUARDIAN SIGNATURE: _____ DATE: _____

PRINT NAME: _____ RELATIONSHIP: (if not patient) _____

PAST MEDICAL HISTORY FORM

Patient Name _____

BLOOD PRESSURE	YES	NO
Hypertension	☐	☐
Low Blood Pressure	☐	☐
Normal Blood Pressure	☐	☐

HEART DISEASE	YES	NO
Heart Attack	☐	☐
Atherosclerotic Disease	☐	☐
Myocardial Infarction	☐	☐
Rheumatic Heart Disease	☐	☐
Heart Murmur	☐	☐

MUSCLE CONDITION	YES	NO
Carpal Tunnel R/L	☐	☐
Tennis Elbow R/L	☐	☐
Back/Neck Problems	☐	☐
Limited Limb Movement	☐	☐

LUNGS	YES	NO
Asthma	☐	☐
Emphysema	☐	☐
Shortness of Breath	☐	☐

JOINT CONDITIONS	YES	NO
Upper Extremity	☐	☐
Dislocation	☐	☐
Lower Extremity Dislocation	☐	☐

OTHER CONDITIONS	YES	NO
Muscular Dystrophy	☐	☐
Rheumatoid Arthritis	☐	☐
Multiple Sclerosis	☐	☐
Epilepsy	☐	☐
Gout	☐	☐
Fibromyalgia	☐	☐
Diabetes	☐	☐
Hearing Loss	☐	☐
Poor Eyesight	☐	☐
Fainting	☐	☐
Polio	☐	☐

Other: _____

_____

_____

_____

EXERCISE	WORK ACTIVITY	STRESS LEVEL	HABITS	
☐ None	☐ Sitting	☐ Low	☐ Smoking	Packs a Day _____
☐ 1-2 x Week	☐ Standing	☐ Medium	☐ Alcohol	Drinks a Week _____
☐ 3-4 x Week	☐ Light Labor	☐ High	☐ Coffee/Soda	Cups a Week _____
☐ 5+ x Week	☐ Heavy Labor			

What types of exercise do you perform? : _____

What things cause stress in your life? :

Are you taking any seizure medication? ☐YES ☐NO If yes list name: _____

Are you taking any medications that might affect your lungs, heart, consciousness or general well-being while participating in therapy?

☐YES ☐NO If yes list name: _____

List all medications you a currently taking: _____

List all surgeries in the past two years (Including dates): _____

Are you pregnant? ☐ YES ☐ NO What week?: _____

Have you had any injuries related to work? ☐ YES ☐ NO If yes list body part and date.: _____

Have you had any Auto Accidents ☐ YES ☐ NO If yes list body part and date.: _____

Have you had Physical Therapy or Massage Therapy before? ☐ YES ☐ NO Where:

_____ _____

Signature of Patient, Parent, Guardian, Personal Representative Date

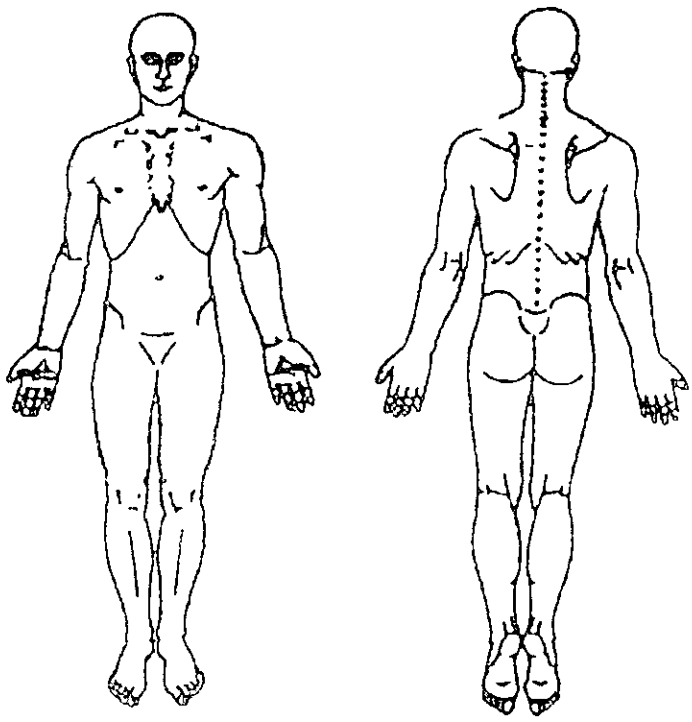
PAIN AND SYMPTOM STATUS REPORT

Name: _____ Date: _____

Using the symbols below, please indicate the type of pain you are experiencing by drawing at the appropriate location(s) on the body outline.

Ache	Burning	Numbness
MMMM	--- --- ---	O O O O
M	--- ---	O O O

Pins & Needles	Stabbing	Other
■ ■ ■ ■ ■ ■	/ / / / /	x x x x
■ ■ ■ ■ ■	/ / / /	x x x x



Chief Complaint and Visual Analog Scale

My Chief Complaint is: _____

Approximate date symptoms/problems first began: _____

How injury occurred (if known): _____

Please circle on the scale below to indicate your CURRENT level of pain:												
No Pain	0	1	2	3	4	5	6	7	8	9	10	Worst pain imaginable
Please circle on the scale below to indicate your BEST level of pain:												
No Pain	0	1	2	3	4	5	6	7	8	9	10	Worst pain imaginable
Please circle on the scale below to indicate your WORST level of pain:												
No Pain	0	1	2	3	4	5	6	7	8	9	10	Worst pain imaginable

Additonal comments: _____

Gary Coleman, MAPT
Mike Fischvogt, PT
Gregory Petersen, MPT
Sean C. Ryan, MPT
Allen DeWit, DPT, OCS

south bay
Sports Medicine Physical Therapy
experience • motivation • results

CANCELLATION POLICY

Dear Patient: _____

Please be advised of our office cancellation policy.
We require at least **24** hours notice for any cancellations.

We make sure to have staff available to take care of you at your appointment time and would appreciate your consideration to avoid missed appointments.

A fee of **$50** will be charged on any missed appointments without **24 hours** notice.

Thank you for you consideration.

Patient signature: _____

Date: _____

Gail Fischvogt & Dayna Coleman
Practice Administrators

3878 West Carson Street, Suite 100 • Torrance, California 90503
Phone: 310.543.4655 • Fax: 310.543.1743 • www.SportsMedPT.com

NOTICE OF PATIENT INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED HOW YOU CAN GET ACCESS TO INFORMATION. PLEASE REVIEW IT CAREFULLY.

SOUTH BAY SPORTS MEDICINE PHYSICAL THERAPY, INC.'S LEGAL DUTY

SOUTH BAY SPORTS MEDICINE PHYSICAL THERAPY, INC. is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

SOUTH BAY SPORTS MEDICINE PHYSICAL THERAPY, INC. uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, we may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

SOUTH BAY SPORTS MEDICINE PHYSICAL THERAPY, INC. may also use or disclose your personal health information without prior authorization for emergencies, research studies, auditing purposes, and public heath/statistical purposes. We also provide information when required by law. In any other situation, our' policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

SOUTH BAY SPORTS MEDICINE PHYSICAL THERAPY, INC. may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes. You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. SOUTH BAY SPORTS MEDICINE PHYSICAL THERAPY, INC. will consider all such requests on a case-by-case basis, but the practice is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that we may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our Privacy Officer at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on our health information practices or if you have a complaint, please contact the following person:

SOUTH BAY SPORTS MEDICINE PHYSICAL THERAPY, INC.
Attn: Privacy Officer
3878 WEST CARSON STREET • SUITE 100
TORRANCE, CA 90503

PATIENT INFORMATION ACKNOWLEDGEMENT FORM

I have read and fully understand South Bay Sports Medicine Physical Therapy's (SBSM) Notice of Information Practices. I understand that SBSM may use or disclose my health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. This potentially includes, but is not limited to: release of medical information to your insurance company, treating physician(s) and staff, nurse case managers and/or insurance adjusters. I understand that I have the right to request restrictions on how my personal information is disclosed for the above-mentioned purposes. Such requests will be considered on a case-by-case basis, but SBSM reserves the right to not agree to any requests for restriction of the release of medical information where not required by state and/or federal law.

AUTHORIZATION TO RELEASE INFORMATION TO FAMILY MEMBERS

Many of our patients allow family members such as their spouse, parents, children or others to call and discuss their care. Please indicate below anyone with whom you wish to grant us permission to speak to regarding things such as: appointment scheduling; your treatment plan; billing and collection issues and your therapist's observations and recommendations about your medical treatment.

I authorize South Bay Sports Medicine Physical Therapy to release and discuss my protected health information (PHI) with the following individual(s):

1. _____ Relationship to Patient: _____
2. _____ Relationship to Patient: _____
3. _____ Relationship to Patient: _____

I hereby consent to the use and disclosure of my personal health information for the purposes indicated in SBSM's Notice of Information Practices and as indicated above. I understand that I have the right to revoke this at any time by notifying SBSM in writing, except where we have already made disclosures in reliance on your prior consent.

Signature: _____

Print Name: _____

Date: _____