Virginia Sports Medicine and Physical Therapy
MEDICAL HISTORY FORM

PATIENT NAME: ____ TODAY'S DATE: ________________________

REFERRING PHYSICIAN'S NAME: _____________________________ DATE OF INJURY OR ONSET: _____________

CAUSE OF INJURY OR ONSET: _______________________________ ARE YOU PRESENTLY WORKING? Y N

PRIMARY CARE PHYSICIAN'S NAME: __________________________ DATE OF NEXT MD APPT: ________________

WHAT IS YOUR REASON FOR ATTENDING THERAPY: ____

BECAUSE OF YOUR PROBLEM, WHAT SPECIFIC ACTIVITIES ARE YOU HAVING DIFFICULTY WITH?

1. ____
2. ____
3. ____

WHAT ARE YOUR PERSONAL GOALS/OUTCOMES YOU HOPE TO ACHIEVE FROM THERAPY?

1. ____
2. ____
3. ____

DESCRIBE YOUR GENERAL HEALTH: (circle one) EXCELLENT GOOD FAIR POOR
DO YOU USE TOBACCO? (circle one) YES NO IF YES, HOW MUCH? ______________________________

HAVE YOU RECENTLY BEEN HOSPITALIZED? YES NO IF YES, WHEN? ________________________________

HAVE YOU HAD PRIOR PHYSICAL THERAPY FOR THIS CONDITION? (circle one) YES NO
WHAT WAS DONE/WHAT WERE THE RESULTS:
____

HAVE YOU HAD PRIOR PHYSICAL THERAPY THIS CALENDAR YEAR? (circle one) YES NO
WAS IT RECEIVED AT: (circle one) HOSPITAL OUT PATIENT CENTER HOME HEALTH
FOR HOW LONG? ____

CURRENT MEDICATIONS: ____

ALLERGIES: ____

DO YOU NOW OR HAVE YOU EVER HAD ANY OF THE FOLLOWING CONDITIONS? (check all that apply):

_ ANEMIA	_ DEPRESSION	_ HEPATITIS/HIV	_ PACEMAKER
_ ARTHRITIS	_ DIABETES	_ HIGH BLOOD PRESSURE	_ RESPIRATORY PROBLEMS
_ ASTHMA	_ DIZZINESS/FAINTING	_ KIDNEY PROBLEMS	_ SEIZURES
_ CANCER	_ FRACTURES	_ LOW BLOOD PRESSURE	_ SUBSTANCE ABUSE
_ CARDIAC PROBLEMS	_ HEADACHES	_ METAL IMPLANTS	_ THYROID PROBLEMS

_ ANY OTHER MEDICAL PROBLEMS: ____ _ CURRENTLY PREGNANT

SIGNATURE OF PATIENT / PARENT / GUARDIAN: _________________________________ REVIEWED BY: ___________________

Virginia Sports Medicine and Physical Therapy

PATIENT INTAKE AND CONSENT FORM

SV	PT:

Internal Use Only	Account #	VA0	Account Type		Office #	0327
First Name		*MI*	*Date of Injury/Onset*		*Today's Date*	
Last Name			*Date of Birth*		*Age:*	
Address			*Sex* M F		*Marital Status*	S M D W
			Home Phone			
City	*State* VA	*Zip*	*Work Phone*			
Responsible Party			*Cell Phone*			
Address			*Injury Area*			
City	*State* VA	*Zip*	*Accident Related*	Yes	No	
Phone Number			*If Accident*	Auto	Work	Other
Relationship to Responsible Party			*Nature of Accident*			
Employer			*SS#*			
Address			*Occupation*			
City	*State*	*Zip*	*Contact at Employer*			
Referring Physician						
Primary Insurance			*Insured Name*			
Group #	*ID #*		*Address*		*City*	
Insured Employer			*State* VA	*Zip*	*Phone*	
Relationship to Insured			*Insured Date of Birth*		Insured Sex:	M F
Second Insurance			*Insured Name*			
Group #	*ID #*		*Address*		*City*	
Insured Employer			*State* VA	*Zip*	*Phone*	
Relationship to Insured			*Insured Date of Birth*		*Insured Sex:*	M F
Emergency Contact			*Daytime Phone Number*			

Are you receiving or have you recently received home health services?	YES NO
Are you receiving or have you recently received other therapy services?	YES NO
CONSENT TO TREATMENT: I consent to rehabilitation and related services at FACILITY. In so doing, I, understand, Acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touching, and/or direct contact of as sensitive nature	**X**________ Please Initial
TREATMENT OF MINORS: I, as parent/guardian of a minor receiving treatment hereunder, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so	**X**________ Please Initial
LIABILITY: I know and agree that FACILITY is not responsible for loss or damage to personal valuables	**X**________ Please Initial
WAIVER AND RELEASE: I hereby release, discharge and acquit FACILITY, it's agents, representatives, Affiliates, employees or assigns, of and from any and all liability, claim, demand, damage, case of , action or loss of any kind arising out of or resulting from my refusal to accept, receive or allow, Emergency and or medical services, including but not limited to ambulance service, Emergency Medical Technician, physician or urgent care services.	**X**________ Please Initial
AUTHORIZATION OF PAYMENT: I hereby assign all benefits directly to FACILITY and also authorize release of any medical records necessary to facilitate my treatment to process medical claims and as otherwise permitted or required in the Notice of Privacy Practices. I understand fully that in the event my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment.	**X**________ Please Initial
NOTICE OF PRIVACY: I acknowledge receipt of Notice of Privacy Practices	**X**________ Please Initial

I certify that all of the information provided herein is true and correct.

Patient/Guardian Signature: **X** ______________________________Witness Signature: ____________________________________

Virginia Sports Medicine and Physical Therapy
SOCIAL SERVICES/VOCATIONAL ADJUSTMENT SERVICES
NOTICE OF AVAILABILITY

Dear Patient:
Federal regulations require our clinic to evaluate the social work needs of our patients. Please take a few minutes to complete the following:

SEVEN SOCIAL QUESTIONS

1. Do you have a spouse, partner equivalent, or family member at home to assist with your care, if required? No _ Yes _

2. Are your needs being met in regard to obtaining and administering medications, changing dressings and making necessary brace adjustments, etc. No _ Yes _

3. Do you have a normal appetite? No _ Yes _

4. Do you sleep comfortably for 6-8 hours each night ? No _ Yes _

5. Do you have any barriers to mobility that are unresolved? (For example: difficulty with stairs, bathing, transportation, etc.) No _ Yes _

6. Do you have unresolved feelings regarding your current physical problems? (For example: anger, worry, depression, fear, etc.) No _ Yes _

7. Considering your current physical abilities, do you feel that your expectations of physical therapy will be met? No _ Yes _

In accordance with regulatory guidelines, our clinic will consider your individual need for and interest in social work/vocational adjustment intervention and provide *referrals* to local area service providers as appropriate in areas such as the following:

◊ Individual or family counseling
◊ Anxiety and stress management
◊ Vocational rehabilitation training
◊ Social integration and/or community re-entry
◊ Depression, anger, boredom or frustration issues
◊ Adjustment to physical disability or institution
◊ Financial assessment and management
◊ Discharge planning

Our evaluation, counseling and referral services are provided by a qualified professional licensed by the State.

No _ I do not have a need for social and /or vocational adjustment services.
Yes _ I do have a need for social and/or vocational adjustment services.

Notice Received and Acknowledged:

______________________________ ______________________
Patient / Parent / Guardian Signature Date

Comments: ____

______________________________ ______________________
Therapist Signature Date