

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