Name: _____ Age: _____

Physician: _____ Next MD Appointment: _____

Occupation: _____

Date of Injury/Surgery: _____

Please mark (x) all that apply:

___ Osteoarthritis
___ Reumatoid arthritis
___ Heart Disease
___ High Blood Pressure
___ Diabetes – Type1 or Type 2
___ Allergies
___ Asthma
___ COPD
___ Osteoporosis
___ Bone Disease
___ Fractures
___ Hernia
___ Stroke
___ Chronic Headaches
___ Dizziness
___ Seizures
___ History of Cancer
___ Previous Surgeries
___ Metal Implants
___ Pacemaker/Defibrillator
___ Current Pregnancy
___ Bladder or Bowel Problems
___ Psychological
___ Current Infections
___ Unexplained Weight Loss
___ Other Health Conditions

Have you had any recent x-rays, CT scans, or MRI's for the current disorder?
YES____ NO____ If Yes, please explain: _____

Have you fallen within the past year?
YES____ NO____ If Yes, how many falls (____) and what were your injuries? _____
_____

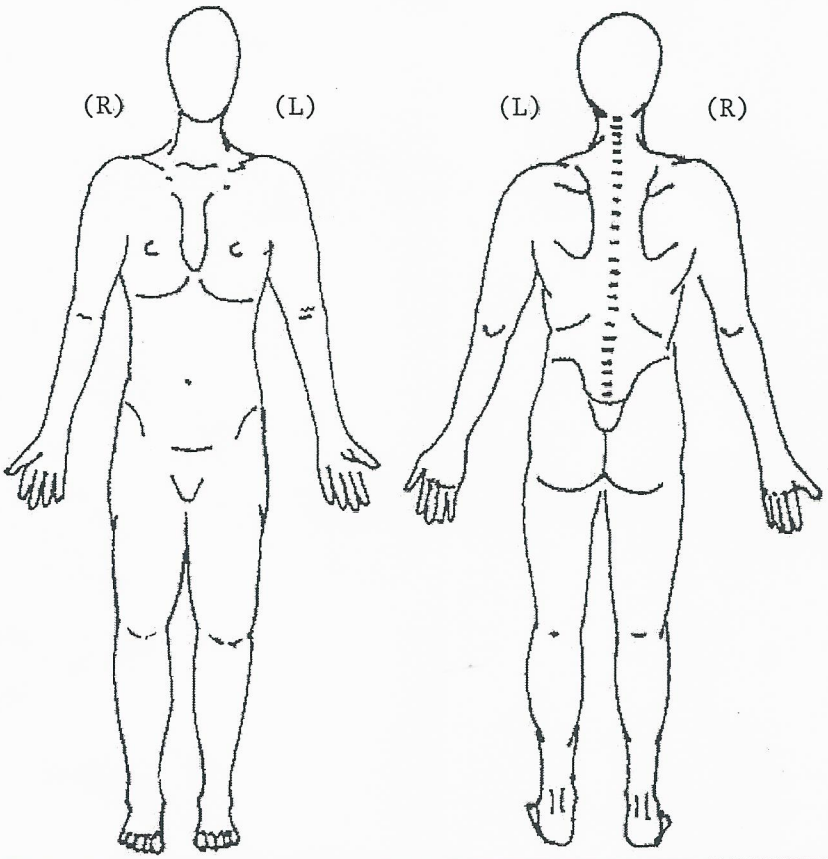
***Please provide current medications list with dosages: _____
_____
_____
_____

Pain Diagram and Pain Rating

Name:_____ Date:_____/_____/_____
mm dd yy

Please use the diagram below to indicate the symptoms you have experienced over the past 24 hours. Use the key to indicate the type of symptoms.

Key: Pins and Needles = 000000 Stabbing = //////
Burning = xxxxxx Deep Ache = zzzzzz



Please rate your current level of pain on the following scale (check one):

ə	ə	ə	ə	ə	ə	ə	ə	ə	ə	ə
0	1	2	3	4	5	6	7	8	9	10

(no pain) (worst imaginable pain)

Please rate your worst level of pain in the last 24 hours on the following scale (check one):

ə	ə	ə	ə	ə	ə	ə	ə	ə	ə	ə
0	1	2	3	4	5	6	7	8	9	10

(no pain) (worst imaginable pain)

Please rate your best level of pain in the last 24 hours on the following scale (check one):

ə	ə	ə	ə	ə	ə	ə	ə	ə	ə	ə
0	1	2	3	4	5	6	7	8	9	10

(no pain) (worst imaginable pain)

FINANCIAL POLICY

Payment is expected at the time of service, unless you have medical insurance. In that case, we will bill that company directly. Ultimately you are responsible for any expenses incurred, including charges denied, those applied to deductibles, or balances not picked up by secondary insurance.

Co-payments and deductibles are due at the time of service.

MEDICAID is limited to 20 treatments per year.

MEDICAL RELEASE

I request that payment of benefits be made on my behalf to Elkins Physical Therapy and Sports Injury Clinic (EPTSIC) for any services furnished by them. I authorize release to the Health Care Financial Administration and its agents any medical information needed to process this claim.

PRIVACY OF PATIENT HEALTH INFORMATION

I received a copy of Elkins Physical Therapy & Sports Injury Clinic's Notice of Privacy Practices as required by HIPAA.

I have read and understand the information in the financial policies and medical release.

ATTENDANCE POLICY

Please notify our office 24 hours in advance if it is necessary for you to reschedule an appointment. In such a case, please call our office and arrange for a make-up appointment. The make-up appointment needs to be in the same week, preferably the very next day.

_____ _____

SIGNATURE (Parent if minor) DATE

EPT