Attachment B1.003A
Attachment M7.005C

PATIENT INTAKE AND CONSENT FORM

Internal Use Only: A/C# Name A/C Type Office#

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 _____ Zip _____ Work Phone _____

Cell Phone _____

Responsible Party _____ E-mail _____

Address _____ Injury Area _____

City _____ Accident Related: ☐Yes ☐No

Phone Number _____ If Accident: ☐Auto ☐Work ☐Other

Relationship to Responsible Party _____ Nature of Accident _____

SS# _____

Employer _____

Address _____ Occupation _____

City _____ State _____ Zip _____ Contact at Employer _____

Referring Physician _____ Phone Number _____

Primary Insurance _____ Insured Name _____

Group # _____ ID # _____ Address _____ City _____

Insured Employer _____ State _____ Zip _____ Phone _____

Relationship to Insured _____ Insured Date of Birth _____ Insured Sex: ☐M ☐F

Second Insurance _____ Insured Name _____

Group # _____ ID # _____ Address _____ City _____

Insured Employer _____ State _____ Zip _____ Phone _____

Relationship to Insured _____ Insured Date of Birth _____ Insured Sex: ☐M ☐F

Emergency Contact _____ Daytime Phone Number _____

Are you receiving or have you received home health services? ☐Yes ☐No

Are you receiving or have you received other therapy services? ☐Yes ☐No

(Continued on next page)

PATIENT INTAKE AND CONSENT FORM

Please Initial Each as Applicable:

Internal Use Only:	A/C#	Name	A/C Type	Office#

CONSENT TO TREATMENT: I consent to rehabilitation and related services at Sport & Spine Clinic of Colby and Greenwood. In so doing, I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touching and/or direct contact of sensitive nature. _____

TREATMENT OF MINORS: I, as a 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. _____

LIABILITY: I know and agree that Sport & Spine Clinic of Colby and Greenwood is not responsible for loss or damage to personal valuables. _____

WAIVER AND RELEASE: I hereby release, discharge and acquit Sport & Spine Clinic of Colby and Greenwood, it's agents, representatives, affiliates, employees, or assigns, of and from any and all liability, claim, demand damage, cause 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. _____

AUTHORIZATION OF PAYMENT: I hereby assign all benefits directly to 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 service I receive, I will be financially responsible for payment. _____

NOTICE OF PRIVACY: I acknowledge receipt of Notice of Privacy Practices. _____

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

Patient/Guardian Signature_____ Witness Signature_____

Sport & Spine Colby/Greenwood
MEDICAL HISTORY FORM

PATIENT NAME: _____ **TODAY'S DATE:** _____
REFERRING PHYSICIAN'S NAME: _____ **DATE OF INJURY OR ONSET:** _____
PRIMARY CARE PHYSICIAN'S: _____ **ARE YOU PRESENTLY WORKING? YES NO**
CAUSE OF INJURY OR ONSET: _____ **DATE OF NEXT MD APPT:** _____

DO YOU CURRENTLY HAVE ANY "FLU TYPE" SYMPTOMS (I.E. FEVER, COUGHING)? YES NO
IF YES, WHAT SYMPTOMS: _____

DO YOU HAVE ANY OPEN CUTS, LESIONS OR WOUNDS? YES NO IF YES, WHERE: _____

HAVE YOU FALLEN IN THE PAST YEAR? (circle one) YES NO IF YES, HOW MANY TIMES: _____

IF YES TO FALLING, DID YOU SUSTAIN AN INJURY AS RESULT OF THE FALL? YES NO _____

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? _____ WEAR GLASSES/CONTACTS?: YES NO

HAVE YOU RECENTLY BEEN HOSPITALIZED OR HAD SURGERY? YES NO IF YES, WHEN_____
AND WHY_____

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

HAVE YOU HAD PRIOR PHYSICAL/OCCUPATIONAL 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: Medication _____**Reaction**_____ **Other** _____**Reaction**_____
ARE YOU ALLERGIC TO LATEX? (circle one) YES NO If yes what is the Reaction_____
Are you Allergic to Dexamethasone? YES NO If yes what is the Reaction_____

DO YOU CURRENTLY HAVE OR HAVE A HISTORY OF ANY OF THE FOLLOWING CONDITIONS? (check all that apply)

□ ANEMIA
□ ARTHRITIS
□ CANCER
□ CARDIOVASCULAR PROBLEMS
□ HOLTER MONITOR - currently wearing?
□ PACEMAKER
□ HIGH BLOOD PRESSURE □ controlled □ uncontrolled
□ LOW BLOOD PRESSURE
□ CURRENTLY PREGNANT
□ DIABETES □controlled □uncontrolled
□ DEPRESSION
□ DIZZINESS/FAINTING
□ FRACTURES
□ HEADACHES
□ HEPATITIS/HIV
□ KIDNEY PROBLEMS
□ MRSA (Methicillin Resistant Staphylococcus Aureus)
□ OSTEOPOROSIS
□ RESPIRATORY PROBLEMS
□ ASTHMA □ controlled □ uncontrolled
□ COPD □ controlled □ uncontrolled
□ Other
□ SEIZURES □ controlled □ uncontrolled
□ THYROID PROBLEMS
□ BLOOD THINNERS (Anticoagulants)

If checked any above, explain: _____

☐ **ANY OTHER MEDICAL PROBLEMS:** _____

SIGNATURE OF PATIENT: _____ **REVIEWED BY Therapist:** _____**Date**_____

This form must be completed in its entirety and must be provided to Sport & Spine Colby/Greenwood prior to initiation of therapy services. Revised 4.**16.15**

B

Pain Assessment

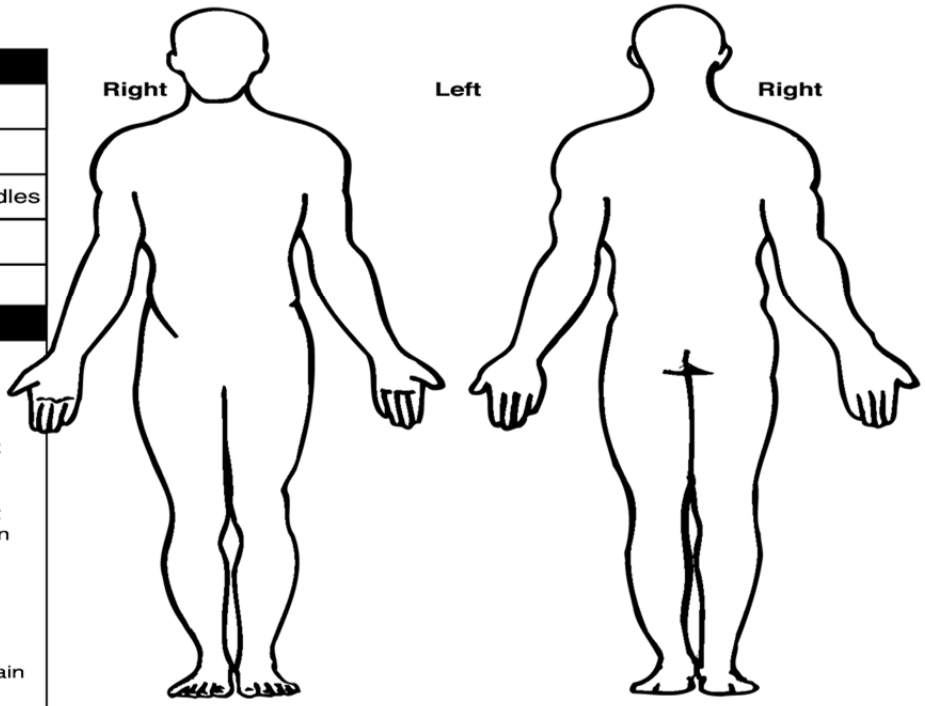
Patient Name: _____ Account #: _____DOS:_____

Instructions: Mark these drawings according to where you hurt (if the right side of your neck hurts, mark the drawing on the right side of the neck, etc.). Please indicate which sensations you feel by referring to the key below.

☐ RIGHT HANDED
☐ LEFT HANDED

KEY	
///////	Stabbing
XXXX	Burning
0000	Pins & Needles
====	Numbness
++++	Aching

PAIN LEVEL	
0	No pain
1	Mild pain; you are aware of it but it doesn't bother you
2	Moderate pain that you can tolerate without medication
3	Moderate pain that requires medication to tolerate
4-5	More severe pain; you begin to feel antisocial
6	Severe pain
7-9	Intensely severe pain
10	Most severe pain; it may make you contemplate suicide



CIRCLE YOUR CURRENT PAIN LEVEL
0 1 2 3 4 5 6 7 8 9 10

 www.aapmr.org

Note: Documentation of a follow-up plan is required when pain is present.

_____ _____ _____

Patient Signature **Evaluating Therapist / Credentials** **Date**