SYNERGY
PHYSICAL THERAPY & SPORTS MEDICINE

Personal Information

Name: _____Birth Date:_____SS #_____

Address: _____City/ State/ Zip Code:_____

Phone:_____ E-mail: _____

Parent/Emergency Contact Name: _____ Relationship: _____

Parent/Emergency Contact Phone: _____ Birth Date: _____SS #_____

WORKER'S COMPENSATION ONLY:

Case Manager/Claim Adjuster: _____ *Phone:*_____

How did you hear about us? ☐ Web Search ☐ Friends/Family ☐ Physician Referral ☐ Social Media ☐ Advertisement

History

Do you exercise? ☐ Yes ☐ No If yes, how often? _____

Do you smoke? ☐ Yes ☐ No If yes, how often? _____

Allergies: _____

List all medications you are currently using: (We can make a copy if you have a list.) _____

_____

Previous surgeries (Related to current complaint): _____

Have you had physical therapy in the last calendar year? _____ If so, where?_____

Complaint

What is your major complaint? _____

Surgery Date/Symptoms Began: _____ Possible Cause: _____

Previous treatment for complaint: _____

Symptom-Aggravating Factors: _____

Symptom-Relieving Factors: _____

Time of Day Symptoms are Best: _____ Time They are Worst: _____

Current Duration of Pain: ☐ Intermittent ☐ Constant ☐ With Certain Motions

Level of Pain: **0 (No pain) - 10 (Very severe) Scale** Current: _____ Best:_____ Worst:_____

Is your pain getting better or worse?_____ Have you had this injury before?_____

Referring Physician: _____ Physician Follow-Up Date: _____

Do You Have Any of the Following Today? (Check All That Apply)

☐ Stroke	☐ AIDS/HIV	☐ Anemia	☐ Angina	☐ Parkinson's	☐ Asthma
☐ Arthritis	☐ Blood Clots	☐ Cancer _____	☐ Circulation Problems	☐ Depression	☐ Diabetes
☐ Lung Issues	☐ Heart Problems	☐ High/Low Blood Pressure	☐ Joint/Bone Infection	☐ Multiple Sclerosis	
		☐ Musculoskeletal Problems	☐ Rheumatoid Arthritis		

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Patient HIPPA Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability act of 1996 (HIPPA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPPA. I Understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, pay the health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this _____ day of _____, 20____

Print Patient Name: _____

Signature: _____

Relationship to Patient: _____

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Consent for Treatment

I, the undersigned due hereby agree and give my consent for Synergy Physical Therapy & Sports Medicine to furnish physical therapy to myself or depended, which is considered necessary and proper in evaluating and treating myself or dependent for my/their physical condition.

I have read and fully understand the above consent form.

Patient/Guardian Name: _____

Patient/Guardian Signature: _____

Date: _____