PERFORMANCE®
MEDICINE & SPORTS THERAPY

PATIENT INFORMATION:

Name (Last, First, Middle) _____ Today's Date _____

Birthdate _____ Soc. Sec. # _____ Home Phone _____

Email address _____ Cell Phone _____

Address _____ Work Phone _____

City _____ State _____ Zip _____ Sex: ☐ M ☐ F

☐ Check if Minor (less than18) Marital Status: ☐ Single ☐ Married ☐ Other

Who may we thank for referring you to our office? _____

EMERGENCY CONTACT INFORMATION:

Full Name:_____ Best Contact Number:_____

Relationship to Patient: Spouse/ Parent/ Child/ Other:_____

FINANCIAL INFORMATION **Please allow our staff to photocopy your insurance card and DL. Thank you**

□ **No Insurance, I will privately pay for my treatment.**

Primary Insurance: _____

Name of Subscriber: _____ Date of Birth of Subscriber: _____/_____/_____

Subscriber's Social Security No.: _____

Policy No.: _____ Group No.: _____

Secondary Insurance: _____

Name of Subscriber: _____ Date of Birth of Subscriber: _____/_____/_____

Subscriber's Social Security No.: _____

Policy No.: _____ Group No.: _____

□ **Workers' Comp** □ **Auto** **Date of Accident / Incident / Injury: _____**

Claim No: _____Name of Adjuster: _____

Phone No.: ( ) _____Insurance Billing Address:_____

Do you have an Attorney for your Workers Comp or Auto Injury? Yes or No
If yes, please provide your Atty's name and phone number: _____

ASSIGNMENT AND RELEASE- I hereby authorize payment directly to PMST of all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered for me or for my dependents. I authorize the doctors and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of my signature on all insurance submissions. I authorize a copy of this document to be used in place of the original. I have read and agreed to the above.

Signature: _____ Date: _____
If the patient is a minor (under 18 years of age), the responsible parent or guardian must sign above.

■ MEDICAL INFORMATION

Please state the reason(s) for your visit today: _____

_____

Primary Care Physician's Name _____ Phone _____

Onset of Symptoms:_____

Grade Intensity/Severity of Complaint: None (0) Mild (1-2) Mild- Moderate (2-4) Moderate (4-6) Mod-Severe (6-8) Severe (8-10)

How frequent is the complaint present? Come & Go/ Constant

Is the compliant/pain: Sharp/ Stabbing/ Burning/ Achy/ Dull/ Stiff & Sore/ Numb/ Other:_____

Does this complaint radiate/shoot to any areas of your body? No/ Yes

(Describe)_____

Does anything make the complaint better? Ice/ Heat/ Rest/ Movement/ Stretching/ OTC/ Other:_____

Does anything make the complaint worse? Sit/ Stand/ Walk/ Lying/ Sleep/ Overuse/ Other:_____

How does your condition affect your daily activities? (Describe) _____

Have you received any prior treatments for this condition? DC/ MD/ PT/ Massage/ ER/ Other:_____

Where? _____ Surgery? _____If so, Surgery Date:_____

Medications/OTC RX?_____

Diagnostic Testing? Xrays/ MRI/ CT/ Other:_____ When and What body part?_____

Acupuncture? Y or N Massage? Y or N

Describe any secondary complaints? _____

Surgeries- Date, Type and Reason:	**Major Injuries/ Traumas:**	**Major Hospitalizations:**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Lifestyle: (Your hobbies, Rec activities, Exercise, Diet, Health Goals) _____

_____

_____

Habits: Cigarettes- (#/day)_____ Alcohol- (amount/day)_____

Coffee/Tea- (Cups/day)_____ Rec. Drugs: (list) _____

Family History:

Heart Disease: Mother/ Father/ Siblings/ Maternal GM/ Maternal GF/ Paternal GM/ Paternal GF

Stroke: Mother/ Father/ Siblings/ Maternal GM/ Maternal GF/ Paternal GM/ Paternal GF

Cancer: Mother/ Father/ Siblings/ Maternal GM/ Maternal GF/ Paternal GM/ Paternal GF

Type of Cancer:_____

Any other family history that may be relevant:_____

Are you currently experiencing any of these symptoms? Please check all that apply.

General: (constitutional)
- ❑ Recent Weight Change
- ❑ Fever
- ❑ Fatigue
- ❑ *None in this Category*

Musculoskeletal:
- ❑ Low Back Pain
- ❑ Mid Back Pain
- ❑ Neck Pain
- ❑ Arm Problems _____
- ❑ Leg Problems _____
- ❑ Painful Joints
- ❑ Stiff/Swollen Joints
- ❑ Sore/Weak Muscles or Joints
- ❑ Muscle Spasms/Cramps
- ❑ Broken Bones
- ❑Other: _____
- ❑ *None in this Category*

Neurological:
- ❑ Numbness or Tingling Sensations
- ❑ Loss of Feeling
- ❑ Dizziness or Light-Headed
- ❑ Frequent or Recurrent Headaches
- ❑ Convulsions or Seizures
- ❑ Tremors
- ❑ Stroke
- ❑ Have you ever had a head injury?
- ❑ Ever been in an auto accident?
- ❑ Other: _____
- ❑ *None in this Category*

Mind/Stress:
- ❑ Nervousness
- ❑ Depression
- ❑ Sleep Problems
- ❑ Memory Loss or Confusion
- ❑ Other: _____
- ❑ *None in this Category*

Genitourinary:
- ❑ Sexual Difficulty
- ❑ Kidney Stones
- ❑ Burning/Painful Urination
- ❑ Change in Force/Strain w/Urination
- ❑ Frequent Urination
- ❑ Blood in Urine
- ❑ Incontinence or Bed Wetting
- ❑ Other: _____
- ❑ None in this category

Gastrointestinal:
- ❑ Loss of Appetite
- ❑ Blood in Stool
- ❑ Change in Bowel Movements
- ❑ Painful Bowel Movements
- ❑ Nausea or Vomiting
- ❑ Abdominal Pain
- ❑ Frequent Diarrhea
- ❑ Constipation
- ❑ Other: _____
- ❑ *None in this Category*

Cardiovascular & Heart:
- ❑ Chest Pains
- ❑ Rapid or Heartbeat Changes
- ❑ Blood Pressure Problems
- ❑ Swelling of Hands, Ankles, or Feet
- ❑ Heart Problems
- ❑ Other: _____
- ❑ *None in this Category*

Respiratory:
- ❑ Difficulty Breathing
- ❑ Persistent Cough
- ❑ Coughing Blood
- ❑ Asthma or Wheezing
- ❑ Lung Problems
- ❑ Other: _____
- ❑ *None in this Category*

Eyes and Vision:
- ❑ Wear contacts/glasses
- ❑ Blurred or Double Vision
- ❑ Glaucoma
- ❑ Eye Disease or Injury
- ❑ Other: _____
- ❑ *None in this Category*

Ears, Nose and Throat:
- ❑ Bleeding gums/Mouth sores
- ❑ Bad Breath or Bad Taste
- ❑ Dental Problems
- ❑ Swollen Throat or Voice Change
- ❑ Swollen Glands in Neck
- ❑ Ringing in the Ears
- ❑ Earache/Ringing/Drainage
- ❑ Sinus/Allergy Problems
- ❑ Nose Bleeds
- ❑ Hearing Loss
- ❑ Other: _____
- ❑ None in this category

Endocrine, Hematologic, and Lymphatic:
- ❑ Thyroid problems
- ❑ Diabetes
- ❑ Excessive Thirst or Urination
- ❑ Cold Extremities
- ❑ Heat or cold Intolerance
- ❑ Change in hat or glove size
- ❑ Dry Skin
- ❑ Glandular or Hormone Problem
- ❑ Swollen Glands
- ❑ Anemia
- ❑ Easily Bruise or Bleed
- ❑ Phlebitis
- ❑ Transfusion
- ❑ Immune System Disorder
- ❑ Other: _____
- ❑ *None in this Category*

Skin and Breasts:
- ❑ Rash or Itching
- ❑ Change in Skin Color
- ❑ Change in Hair or Nails
- ❑ Non-healing Sores
- ❑ Change of Appearance of a Mole
- ❑ Breast Pain
- ❑ Breast Lump
- ❑ Breast Discharge
- ❑ Other: _____
- ❑ *None in this Category*

Women Only:

Are you pregnant?
- ❑ Yes-Due Date _____
- ❑ No-Last Menstrual Period
- ❑ Infertility
- ❑ Painful or Irregular Periods
- ❑ Vaginal Discharge
- ❑ Other: _____
- ❑ *None in this Category*

Pregnancies with Outcome & Date

_____
_____
_____
_____

PRIVACY PRACTICES ACKNOWLEDGEMENT AND CONSENT FORM

♦ I have received your Notice of Privacy Practices and/or I have been provided an opportunity to review it.

♦ I agree that telephone messages regarding my appointments, prescription renewals, lab results, and all other Protected Health Information* ("PHI"), may be left for me on voicemail systems and answering machines at the following telephone numbers, in addition to any other numbers provided to you by me:

(__ __ __) __ __ __ - __ __ __ __ Home / Office / Cell / Other: _____

(__ __ __) __ __ __ - __ __ __ __ Home / Office / Cell / Other: _____

[If we need to contact you with lab results, please place a check mark next to the preferred contact number, if any.]

♦ I agree that my PHI may be shared with my spouse. ♦ I agree that my PHI may be shared with the following other people:

_____ _____

_____ _____

♦ I understand that I can change any of the foregoing agreements, at any time, by giving written notice to PMST.
**as defined in the Health Insurance Portability and Accountability Act of 1996 and its regulations, as may be amended from time-to-time ("HIPAA")*

Patient Name (print): _____

Signature: _____ **Date**: _____

Consent to Treat: I hereby authorize and give consent for the Chiropractic Physicians, Physical Therapists, NP, and Medical Doctors at PMST to examine and provide me treatment.

Signature: _____ **Date**: _____

Patient Consent for Photograph Use:

Photographs may be taken of patients when they are attending physical therapy or any other provided services. These photos may be used on the PMST website, social media, and/or posted within the clinic.

I give consent to Performance Medicine & Sports Therapy to use photographs of me or my child (or person for whom I am legal guardian). I understand the image may be seen by members of the general public that visit the clinic, website, or social media post by PMST. Although these photographs may be used without identifying information such as name, I understand that it is possible that someone may recognize me. By consenting to these photographs, I understand that I will not receive payment from any party.

Patient Name (print): _____

Signature: _____ **Date**: _____

If the patient is a minor (under 18 years of age), the responsible parent or guardian must sign above, and fill in the information below.

Parent/Guardian Name (print): _____ Relationship to Patient: _____

❑ Please check this box if you wish to decline