Georgia Sports Physical Therapy

MEDICAL HISTORY QUESTIONNAIRE

Please provide Georgia Sports Physical Therapy with the most accurate information regarding your health status to the following questions:

Name:_____ Date:_____

Are you currently (check all that apply):
☐ Working with no restrictions.
☐ Working with restrictions.
☐ Unable to work because of your condition since: _____
☐ Unable to work due to other medical reasons.
☐ Retired / Unemployed / Homemaker

Are you currently seeing any of the following health care professionals for any conditions? (check all that apply):
☐ Medical Doctor ☐ Dentist ☐ Psychiatrist/ Psychologist
☐ Osteopath ☐ Physical therapist ☐ Chiropractor

If you have seen any of the above in the past six months, please provide further detail (i.e. - illness, medical conditions, injury, routine physical, etc.)

_____
_____
_____

Have you ever been diagnosed with any of the following conditions (check all that apply):

Yes No Heart complications
Yes No High blood pressure
Yes No Stroke
Yes No Rheumatoid Arthritis
Yes No Other Arthritic Problem
Yes No Epilepsy
Yes No Lung Disease
Yes No Emphysema/Bronchitis
Yes No Asthma
Yes No Chemical Dependency
Yes No Hearing loss/disorder
Yes No Eye Disease
Yes No Muscle disease/disorder
Yes No Multiple Sclerosis
Yes No Diabetes
Yes No Tuberculosis
Yes No Hepatitis
Yes No Kidney Disease
Yes No Thyroid Problems
Yes No Depression
Yes No Circulation Problems
Yes No Osteoporosis
Yes No Cancer:
if yes, please list type(s):_____
Yes No Past pregnancy
delivery (please circle): vaginal cesarean
Yes No Currently Pregnant? ___ months
Yes No Other: _____

Please list any surgeries or other conditions for which you have been hospitalized, including dates and reasons.

DATE	SURGERY	REASON

Please describe any injuries for which you have been treated (fractures, dislocations, sprains/ strains).

DATE/INJURY	DATE/INJURY

Has anyone in your immediate family (parents, brothers, sisters) ever received treatment for the following conditions?

Yes No Diabetes
Yes No Heart disease
Yes No Arthritis
Yes No High blood pressure
Yes No Epilepsy
Yes No Chemical dependency
Yes No Tuberculosis
Yes No Cancer
Yes No Headaches
Yes No Mental Illness

Have you taken any of the following over-the-counter medications in the past week?

Yes No Aspirin
Yes No Advil/ Motrin/ Ibuprofen
Yes No Tylenol
Yes No Decongestants
Yes No Antacids
Yes No Laxatives
Yes No Antihistimines
Yes No Vitamins/ Mineral Supplements
Yes No Other: _____

List all prescription medication you are currently taking (pills, injections, and skin patches):

_____
_____

Medicine Allergies: _____
How much caffeine per day? _____ **Cigarettes smoked per day?** _____ **Days a week you consume alcohol?**_____

Have you recently noted:

Yes No Weight loss/ gain
Yes No Nausea/ Vomiting
Yes No Fatigue
Yes No Weakness
Yes No Fever/ Chills/ Sweats
Yes No Numbness or tingling
Yes No Menstrual Irregularities
Yes No Bladder Irregularities
Yes No Rectal Bleeding

Form reviewed with patient: YES NO ***Therapist signature:***_____ ***Date:***_____

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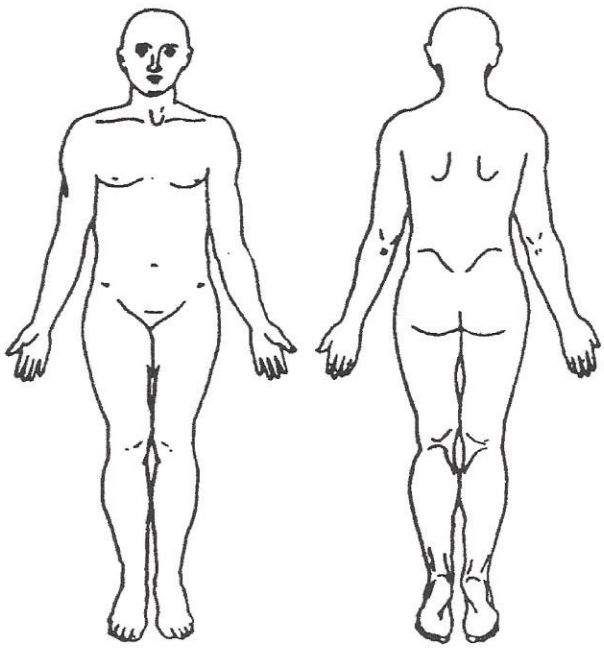
PAIN DIAGRAM AND RATING SCALE

Please use the diagram below to indicate the symptoms you have experienced over the past 24 hours. Clearly circle the region(s) that are causing discomfort. Be very precise when drawing the location of your pain.



Please circle you current level of pain on the following scale:

0 1 2 3 4 5 6 7 8 9 10

(no pain) (emergency room pain)

Please circle your worse level of pain in the last 24 hours on the following scale:

0 1 2 3 4 5 6 7 8 9 10

(no pain) (emergency room pain)

Please circle your best level of pain the last 24 hours on the following scale:

0 1 2 3 4 5 6 7 8 9 10

(no pain) (emergency room pain)

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Patient Authorization and Guarantee

RELEASE OF INFORMATION

I hereby authorize the release of any information by telephone or in writing, including reports of diagnosis, treatment, prognosis, recommendation, benefits payable, as well as any other data pertinent to my treatment, by Georgia Sports Physical Therapy to my physician(s), as well as any organization responsible for payment of my account, and any legal representative involved in my litigation. I also authorize the release of information by telephone or in writing for utilization and quality review purposes.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize that the payment of authorized benefits be made directly to Georgia Sports Physical Therapy for any services that are reimbursable by Medicare, Medicaid, or any third party sources.

VALUABLES

I hereby understand that Georgia Sports Physical Therapy is not responsible for valuables and personal property brought to the facility.

CONSENT OF TREATMENT

I hereby consent to such treatment procedures and patient care which, in the judgment of the treating clinician, may be considered necessary or advisable while I am a patient of Georgia Sports Physical Therapy.

GUARANTEE OF ACCOUNT

In consideration of services rendered to me by Georgia Sports Physical Therapy, I hereby guarantee payment for any and all services rendered to me in which are not covered or allowable by insurance, together with collection costs, including reasonable attorney fees. I understand that there may be a charge for supplies that are needed during my course of treatment that will not be covered by my insurance and for which I am financially responsible. I also understand that I may have a co-payment, co-insurance and/or deductible which I am fully responsible for paying. Although Georgia Sports Physical Therapy will inform me of my insurance coverage for physical therapy, it is ultimately my responsibility to understand my insurance benefit limitations and payments. I will immediately notify Georgia Sports Physical Therapy of any changes in my insurance coverage while receiving physical therapy.

MEDICARE

I hereby certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any such information needed for this or related Medicare claim. I request that the payment of authorized benefits be made on my behalf. I understand that I am responsible for any health insurance deductibles and co-insurance.

I, _____, by signing this document, acknowledge my consent to the above:
(Print Name)

Signature:_____ Date:_____

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CANCELLATION/NO SHOW POLICY

GSPT has recommended a course of treatment which can only be completed if you make your appointments. Our primary goal is to get you better as fast as possible. You will not help your recovery if you do not make your scheduled appointments. We understand there will be reasons that are legitimate for not showing for appointments so we will be as understanding as possible.

One of the difficulties of having a successful, busy practice is scheduling all the follow up visits patients require. Please understand that when you cancel late or do not show up without notification, we may not be able to fill your scheduled appointment slot with another patient. So when patients do not arrive for their appointments, it affects others who want to be seen. For this reason, patients **will be charged** for failure to make their scheduled appointments without proper cancellation notification. We require a **minimum of 24 hours'** notice for an appointment to be properly canceled. Earlier confirmation of a cancellation is recommended because it will allow us the possibility of filling your time slot with another patient.

The first late cancellation or "no show" is free of charge. Subsequent occurrences will result in a $50.00 fee per missed visit. This fee will be charged directly to the patient and not your insurance company. We appreciate your understanding and for choosing Georgia Sports Physical Therapy for your rehabilitation.

_____	_____	_____
Patient or Responsible Party	Signature	Date