



In order to provide you with the utmost quality care, it is important for us to have information on your health history. It will remain a confidential part of your Medical Record. **Please help us by filling out this form COMPLETELY.**

Name: _____ Date: _____

When and what do you think initially caused your pain? Date pain started: _____

What makes your symptoms worse? _____

What makes your symptoms better? _____

Reason for Physical Therapy? _____

What are your goals for PT? _____

What leisure activities would you like to return to? _____

Are you employed? Yes No Are you off of work due to your injury? Yes No

Is this a work related injury? Yes No Occupation _____

If out of work due to this injury when do you plan on returning? _____

Date of last x-ray _____ MRI _____ CT _____

Are you currently seeing any of the following? (Please Circle)

Dentist Psychiatrist / Psychologist Occupational Therapy Chiropractor Neurologist
 Massage Therapy Physical Therapist (Other than at Advanced Physical & Sports Therapy)

Please check yes or no if you have now, or in the past, experienced any of the following:

Tuberculosis	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Head Injury	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Cancer	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Neck Injury	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Heart problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Back Injury	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Circulation problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Pregnancy	Yes <input type="checkbox"/>	No <input type="checkbox"/>
High blood pressure	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Are you currently Pregnant?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Blood Clots	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Bowel / Bladder problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Pacemaker	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Hernia	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Stroke	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Fracture	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Emphysema	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Thyroid problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Shortness of Breath	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Alcoholism	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Asthma	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Chemical Dependency	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Fainting / Dizziness	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Raynaud's Disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Hepatitis	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Multiple Sclerosis	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Anemia	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Rheumatoid Arthritis	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Kidney Disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Other Arthritic Conditions	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Ulcer	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Implants of any type	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Diabetes	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Depression	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Hypoglycemia	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Allergies	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Seizures	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Are you allergic to bee stings?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Concussion	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Do you feel safe at home?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Frequent Headaches	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Are you in a relationship where you are being hit, kicked, slapped or otherwise hurt?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

If you checked yes to any of the above please comment: _____

Please list any surgeries, injuries, accidents or other conditions for which you have been treated or hospitalized including the approximate date and reason:

Date	Reason	Date	Reason
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

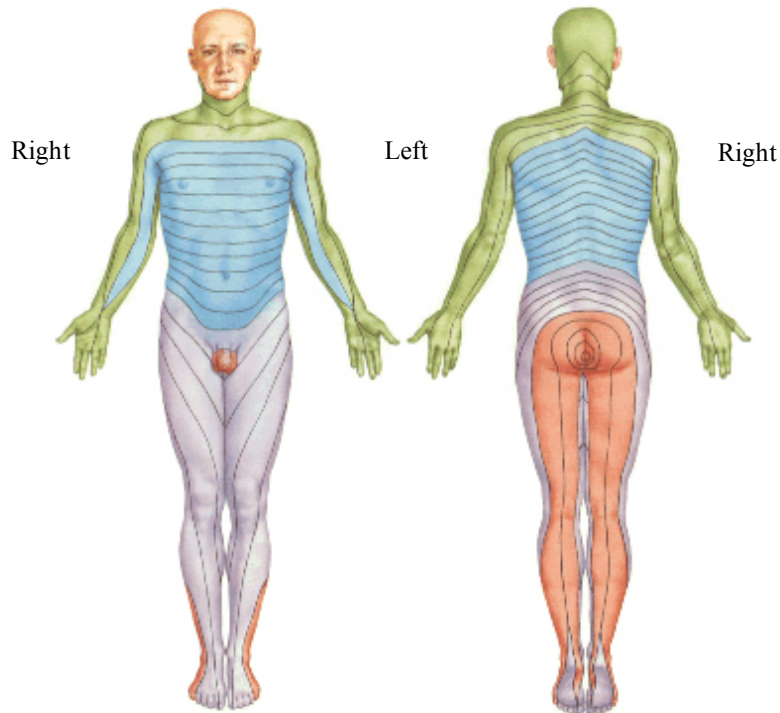
Please list any and all PRESCRIPTION medication that you are currently using (INCLUDING pills, injections, and or patches) How many mg and frequency:

Have you recently noted:

Unexplained Weight loss/gain	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Fever / Chills / Sweats	Yes <input type="checkbox"/>	No <input type="checkbox"/>		
Nausea / vomiting	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Numbness / Tingling	Yes <input type="checkbox"/>	No <input type="checkbox"/>		
Fatigue	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Is your sleep interrupted by pain?	Yes <input type="checkbox"/>	No <input type="checkbox"/>		
Weakness	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If so, how many times / night?	1-2	3-5	6-9	>10

Please **shade in area where you are experiencing pain / symptoms**. Then use the following descriptions with **arrows and the numbers corresponding to the symptoms listed below to point to the shaded areas** to help us understand your symptoms. Please indicate if you have any surgical scars on your body.

1. Stiffness
2. Swelling
3. Lack of full motion
4. Weakness
5. Numbness
6. Tingling
7. Cramping
8. Paralysis
9. Cold



Pain Scale:

Please circle the number which corresponds most accurately with the **worst pain** you have experienced in the last week).
 No pain 0 1 2 3 4 5 6 7 8 9 10 Need emergency room care

(Please circle the number which corresponds most accurately with the **least pain** you have experienced in the last week)
 No pain 0 1 2 3 4 5 6 7 8 9 10 Need emergency room care

(Please circle the number which corresponds most accurately with the **average pain** you experience **while doing normal daily activities**)
 No pain 0 1 2 3 4 5 6 7 8 9 10 Need emergency room care

I certify that this is accurate and complete to the best of my knowledge.

Signature: _____ **Date:** _____

PATIENT INFORMATION:

Name _____ Male Female Date of Birth ____ / ____ / ____ Age: _____
First Last MI

Mailing Address _____ City _____ State _____ Zip _____

Home Phone # _____ Work Phone # _____ Social Security # _____ - _____ - _____

Married Divorced Single Separated Child Other Driver's License # _____

Employer: _____ **E-Mail Address:** _____

Referring Physician: _____ Phone #: _____ Diagnosis: _____

Primary Physician: _____ Phone #: _____ Date of Injury / Illness _____

Is your injury related to Work Auto Other If Auto related what state? _____

INSURANCE INFORMATION:

Primary Insurance: _____ Address _____

ID # _____ Group # _____

Secondary Insurance: _____ Address _____

ID # _____ Group # _____

Name of Policy Holder _____ Policy Holders Date of Birth _____ Policy Holders SS# _____

IN CASE OF AN EMERGENCY CONTACT:

Name _____ Relationship: _____

Address _____ City _____ State _____ Zip _____ Phone #: _____

Please Print Name _____

Signature of the Patient / Insured _____ Date _____

Release of Information

I _____ do hereby authorize the release of my Private Health Information,

FROM: Advanced Physical & Sports Therapy
 562 Castle Pines Parkway, # C-6
 Castle Rock, CO 80108
 Fax: (720) 733-3656

TO: _____

Please forward the following information:

_____ **Complete Medical Record**

_____ **X-ray Reports**

_____ **MRI Reports**

_____ **CT Reports**

_____ **Chart Notes**

Date: _____ Patient Signature _____

Signature of Parent or Guardian (if applicable)

ACKNOWLEDGEMENT FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS

My PHI (“Protected Health Information”) means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or is a reasonable basis to believe the information may identify me.

I understand that diagnosis or treatment of me by ADVANCED PHYSICAL & SPORTS THERAPY may be conditioned upon my consent as evidenced by my signature on this document.

RELEASE OF INFORMATION

I hereby authorize the use and disclosure of my PHI by telephone or in writing. This may including reports of diagnosis, treatment prognosis, recommendation, benefits payable, as well as any other data pertinent to my treatment, by ADVANCED PHYSICAL & SPORTS THERAPY to the physician who referred me for therapy, as well as any organization responsible for payment of my account. I also authorize the release of any information by telephone or in writing for utilization and quality review purposes.

I understand I have the right to revoke this consent, in writing, at any time, except to the extent that **Douglas T. Heckenkamp, M.P.T. or ADVANCED PHYSICAL & SPORTS THERAPY** has taken in reliance on this consent.

I understand that I have the right to review ADVANCED PHYSICAL & SPORTS THERAPY’S **Notice of Privacy Practices** prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my PHI that may occur in my treatment, payment of my bills or in the performance of healthcare operations of the facility. This notice may be made available to me upon my request.

ADVANCED PHYSICAL & SPORTS THERAPY reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for a copy at my next appointment.

In order for our therapists to provide top quality care we are unable to allow children to accompany their parents to their appointments. We will not under any circumstances allow children to remain in the waiting area without adult supervision.

CONSENT FOR TREATMENT

I hereby consent to such treatment procedures and patient care which, in the judgment of my therapist and/or physician, may be considered necessary or advisable while I am a patient of ADVANCED PHYSICAL & SPORTS THERAPY.

Patient Signature

Date

Signature of Parent or Legal Guardian of Minor Patient

Relationship to Patient

Please Initial Appropriate Response:

_____ I have reviewed a copy of Advanced Physical & Sports Therapy’s Privacy Practices

_____ I have received a copy of Advanced Physical & Sports Therapy’s Privacy Practices

_____ I decline to receive or review a copy of Advanced Physical & Sports Therapy’s Privacy Practice