Patient Registration– PLEASE PRINT CLEARLY

Please select one: ☐ New Patient ☐ Returning Patient, Date last seen: ____month/_____year

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Patient Information

Full Legal Name: _____

Nickname/Preferred:_____

Address: _____Apt #_____

City: _____ State: _____ Zip Code: _____

Email Address: _____

Phone: ( ) _____-_____ ( ) _____-_____
Home Mobile

Birthdate: ____/_____/_____ Sex: ☐ Male ☐ Female

Have you been seen for physical therapy since the beginning of the calendar year? Yes / No
If yes, how many sessions? _____

Physician Information

Name of Physician: _____ Phone#: ( )_____

Name of Medical Group Affiliated: _____

Emergency Contact Information

Contact Name: _____

Relationship to Patient: ☐ Parent ☐ Spouse ☐ Sibling ☐ Other _____

Phone: ( ) _____-_____ ( ) _____-_____
Home Mobile

Please complete and return by fax at 510-656-3750, email to FrontDesk.ESPT@gmail.com or bring a copy to appointment

ELITE SPORTS Physical Therapy

Patient Name: _____

Medical History

Previous History of Similar Symptoms? ☐ No ☐ Yes Date of last encounter: ___/____/____

Medical History:
☐ No significant past medical history to affect treatment
☐ Alzheimer's
☐ Anxiety
☐ Cancer; Location: _____ Diagnosis date ___month/____year In Remission? ☐ No ☐ Yes
☐ Cerebral Vascular Accident ___month/____year
☐ Current Infection
☐ Depression
☐ Diabetes Mellitis ☐ Type 1 ☐ Type 2
☐ Fibromyalgia
☐ Fracture, list area(s) :_____
☐ Gastroesophageal Reflux Disease
☐ Gout
☐ Headaches/Migraines
☐ Heart Attack ___month/____year
☐ High Blood Pressure/Hypertension
☐ Immunosupression
☐ Lupus
☐ Neuropathy, list area(s) :_____
☐ Osteoarthritis, list area(s) :_____
☐ Parkinson's; diagnosis date ___month/____year
☐ Polymyalgic Rheumatica
☐ Psoriatic Arthritis
☐ Reynaud's disease
☐ Rheumatoid Arthritis
☐ Other: _____

Medications

☐ Not Currently taking any medication

☐ Prescription (please list) :_____

☐ Over the Counter (please list) :_____

Surgical History

☐ Right ☐ Left
Type: _____ Date: ___month/____year

☐ Right ☐ Left
Type: _____ Date: ___month/____year

☐ Right ☐ Left
Type: _____ Date: ___month/____year

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ELITE SPORTS Physical Therapy

Patient Name: _____

Current Episode of Pain/Injury

Onset of Pain/Injury Date: ___/____/____ **Surgical Date: ___/____/____**

Cause of Current Episode (check all that apply):
□ Acute/<6 months □ Chronic/6+ months □ Post-surgical □ Work Related □ Sports Related
□ Repetitive ☐ Motor Vehicle Accident □ Overuse □ Unknown □ Other:_____

Description of Symptoms (check all that apply)

□ Ache □ Burning □ Dull □ Numbness □ Tingling □ Shooting □ Weakness □ Stiffness

□ Tightness □ Catching □ Locking □ Unstable

Pain level (indicate 0 is No pain; 10 is "take me to the hospital!")

Best: □ 0 □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

Worst: □ 0 □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

Average: □ 0 □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

How often do you experience symptoms?

□ Constantly (76%-100% of the time) □ Frequently (51%-75% of the time) □ Occasionally (26%-50% of the time) □ Intermittently (0%-25% of the time) □ Pain w/ movement only □ Pain w/ sports only

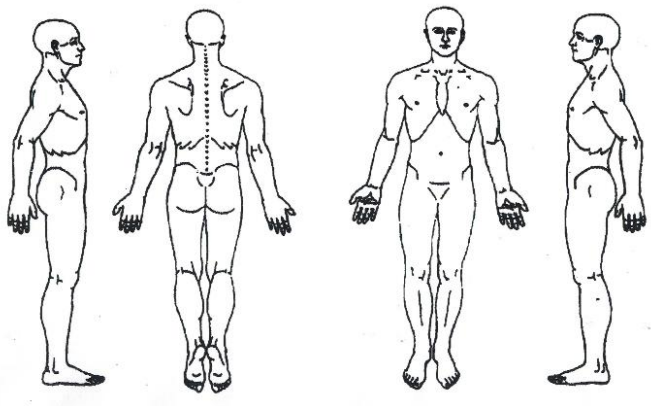
How are your symptoms progressing?

□ Neither Getting Better or Worse □ Progressively Worsening □ Improving, but slow

What specifically makes your symptoms worse?

_____

Indicate where you have pain or other symptoms by shading in the corresponding area:



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ELITE SPORTS Physical Therapy

Appointment Late Cancellation/No-Show/Missed Appointment Policy

I understand Elite Sports Physical Therapy's appointment cancellation policy and understand my responsibility to plan appointments accordingly and notify ESPT appropriately if I have difficulty fulfilling my scheduled appointments. Initial _____

Direct Access Disclosure

I have reviewed the Direct Access Disclosure and understand that after 45 calendar days or 12 visits, whichever comes first, I will require a physician's prescription for continued physical therapy treatment.

Initial _____

Consent To Treat

I hereby authorize Elite Sports Physical Therapy, through its appropriate personnel, to perform or have performed upon me, or the above named patient, appropriate assessment and treatment procedures relating to my condition.

I further authorize Elite Sports Physical Therapy to release to appropriate agencies, any information acquired in the course of my or the above named patient's examination and treatment.

I acknowledge that Elite Sports Physical Therapy reserves the right to refuse service to anyone choosing not to abide by facility policies or deemed to be disruptive to other patients or staff members.

Initial _____

Notice of Privacy Practices

I have reviewed the Notice of Privacy Practices and understand that the healthcare services provided will be kept on record and are confidential. Initial _____

Financial Policy and Patient Responsibility

I accept financial responsibility for services that I receive at **Elite Sports Physical Therapy**, which are not covered by my insurance. I agree to pay any balance owed after insurance reimbursement, and in signing, I have been notified by **Elite Sports Physical Therapy** of such policies.

Initial _____

I have received a copy, read and understood Elite Sports Physical Therapy's policies, terms and conditions.

_____ _____

Patient Signature Date

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