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 for clinic communication/appointment reminders: _____

Contact phone number: ( ) _____-_____ Home / Mobile

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

How would you like to be referred as: He/Him/His She/Her/Hers They/Them

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

Physician Information

Referring Physician (First/Last Name): _____

Emergency Contact Information

Name: _____ Phone#: ( )_____

How would you like to receive your ESPT Billing Statements?

☐ **US Mail** (paper statements) – ☐ Billing address same as above
If different: _____

☐ **Email** (electronic statement) – ☐ Email address same as above
If different: _____
Statements are delivered from ESPTPAY@gmail.com with your statement attached as PDF

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: _____

Please review and select all that apply:

Musculoskeletal	Neurological	Endocrine	Cardiopulmonary	Other
☐Use of cane or walker ☐Osteoarthritis ☐Rheumatoid Arthritis ☐Polymyalgic Rheumatica ☐Psoriatic Arthritis ☐Lupus ☐Fibromyalgia ☐Osteoporosis ☐Osteopenia ☐Headaches ☐Migraines ☐Bulging Disc ☐Leg Cramps ☐Restless Legs ☐Jaw pain/TMJ ☐History of Falling ☐Gout ☐"Double Jointed" ☐History of fracture ☐ Other:	☐Numbness ☐Tingling ☐History of Stroke/TIA ☐Dementia ☐Post-Polio ☐Parkinson's Disease ☐Multiple Sclerosis ☐Epilepsy/seizures ☐History of Concussion ☐Other:	☐Diabetes ☐Kidney Dysfunction ☐Bladder Dysfunction ☐Liver Dysfunction ☐Thyroid Dysfunction ☐Other:	☐High Blood Pressure ☐Hypertension ☐Heart Arrhythmia ☐Pacemaker ☐History of Blood Clots ☐Anemia ☐Asthma ☐Shortness of Breath ☐COPD ☐HIV/AIDS ☐Congestive Heart Failure ☐Other:	☐Anxiety ☐Depression ☐History of Cancer ☐Eating Disorder ☐Gastroesophageal Reflux Disease (GERD) ☐Incontinence

☐No medical conditions listed above apply to me

Medications

☐Not Currently taking any medication

☐Medication prescribed for current condition: _____

☐Prescription (please list or provide copy) : _____

☐Over the Counter (please list) : _____

Surgical History

☐ Right ☐ Left Type:_____Date: _____ year; Full Recovery? ☐ Yes ☐ No

☐ Right ☐ Left Type:_____Date: _____ year; Full Recovery? ☐ Yes ☐ No

☐ Right ☐ Left Type:_____Date: _____ year; Full Recovery? ☐ Yes ☐ No

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ELITE SPORTS Physical Therapy

Patient Name: _____

Current Episode of Pain/Injury

Onset of Pain/Injury Date:_____/_____/_____ **Surgical Date (if applicable):** _____/_____/_____

Previous History of Similar Symptoms? ☐ **No** ☐ **Yes**

☐ <5 episodes ☐ >5 episodes ☐ Last for days only ☐ Last for weeks ☐ Last for months

Cause of Current Episode (check all that apply):

☐ Acute/<6 months ☐ Chronic/6+ months ☐ Post-surgical ☐ Work Related
☐ Sports-Related ☐ Repetitive/Overuse ☐ Motor Vehicle Accident ☐ Unknown

Description of Symptoms (check all that apply)

☐ Ache ☐ Burning ☐ Dull ☐ Numbness ☐ Tingling ☐ Shooting ☐ Weakness ☐ Swelling

☐ Stiffness ☐ Tightness ☐ Catching ☐ Locking ☐ Unstable ☐ Sharp ☐ Other:

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?

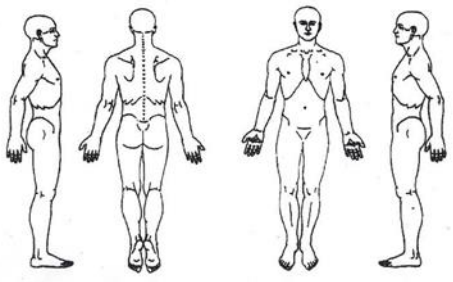
☐ Constantly (76%-100% of the time) ☐ Frequently (51%-75% of the time) ☐ Occasionally (26%-50% of the time) ☐ Intermittently (0%-25% of the time) ☐ Pain w/ movement or stretching ☐ Pain w/ sports or high impact or heavy lifting

How are your symptoms progressing? ☐ Neither Getting Better or Worse ☐ Progressively Worsening ☐ Improving, but slow

Please list 3 activities that you find difficult because of this problem, and circle the number that corresponds with your ability to perform each activity.

		Unable									No Limitations
1.	_____:	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
2.	_____:	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
3.	_____:	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10

What activities makes your problems worse? _____

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

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A ELITE SPORTS Physical Therapy

Appointment Late Cancellation/No-Show/Missed Appointment Policy

I understand ESPT's appointment policies and missing my appointment may result in a $75 fee which will be collected at the next appointment. I also understand that repeated late cancellations or no-shows may result cancellation of all my upcoming appointments and subject to same-day scheduling only. It is my responsibility to plan appointments accordingly and notify ESPT for timely changes to my schedule.

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 (Staff and Student Physical Therapists), to perform or have performed upon me, 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 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. I understand that failure to pay my statement balances after multiple notification letters may be sent to a Collection's Agency to recover unpaid balances.

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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