Physical Therapy Sports Institute

1515 W. Florida Ave, Ste E
Hemet, CA 92543
Phone: 951.658.3121

Patient Information

Full Name: _____
First *M.I.* *Last*

Social Security Number or Government ID: _____

☐ Male ☐ Female Date of Birth: ____ / ____ / _____ Marital Status: ☐ S ☐ M ☐ D ☐ W

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Email Address: _____ Cell: (____) _____

How would you like appointment reminders? ☐ Email ☐ Text ☐ Home ☐ Alternate ☐ Cell Phone

Home Phone: (____) _____ Alternate Phone: (____) _____

DL#: _____ State Issued: _____ **Please provide a copy for our records**

Employer: _____ Occupation: _____
(REQUIRED FOR WORKER COMPENSATION CASES)

Physician Information

Referring Physician: _____ Date of Current Injury: _____

Office Address: _____ Ph: _____
Street *City* *State* *ZIP Code*

Appointment Policy

I understand that my doctor has prescribed therapy for me and that physical therapy is an ongoing process which requires regular attendance to be optimally effective. I understand that if I am late for an appointment, I may have to reschedule my appointment or may have to accept an abbreviated treatment for that day. I understand that if I cancel or no-show for three consecutive appointments, Physical Therapy Sports Institute has the right to discharge me from care for being non-compliant with my physician's orders.

I understand and agree that Physical Therapy Sports Institute requires 24-hour advance notice of cancellation. If I fail to give 24-hour notice of cancellation or fail to show up for an appointment, I may be subject to a $25 administrative charge which is not covered by insurance.

Signature: _____ Date: _____

Relationship to Patient: ☐ Mother ☐ Father ☐ Legal Guardian

Authorization for Treatment

I hereby consent to and authorize all therapy treatments, which in conjunction with the judgment of my attending physician, may be considered necessary and/or advisable for the diagnosis and/or treatment of the patient named above at Physical Therapy Sports Institute.

Signature: _____ Date: _____

Relationship to Patient: ☐ Mother ☐ Father ☐ Legal Guardian

Physical Therapy Sports Institute

1515 W. Florida Ave, Ste E
Hemet, CA 92543
Phone: 951.658.3121

Financial Policy and Insurance Information

I understand and agree that insurance claim forms will be submitted to my insurance company as a matter of convenience only, and that I am responsible for all charges regardless of my existing medical coverage. I understand that I am responsible for all supplies, such as braces or exercise equipment, which I am provided during treatment, if they are not covered by my insurance plan. I understand that I will pay for supplies upon receipt and Physical Therapy Sports Institute (PTSI) will bill my insurance company and refund me any monies received by them from my insurance company for said supplies.

I hereby give authorization for payment of insurance benefits to be made directly to PTSI for services rendered. In the event that my insurance company forwards payments directly to me, instead of PTSI, I will immediately deliver said payment to PTSI.

I understand and agree that I am wholly responsible and liable for payment of all charges assessed for professional services rendered and will pay any sum due, upon demand. I understand and agree that if it becomes necessary for PTSI to utilize an outside collection agency or commence court action, for the collection of any outstanding charges, I will be responsible for the outstanding balance (plus a $35 processing fee), and in addition, attorney fees, court costs and other expenses of litigation.

Signature of Person Responsible for Charges: _____ Date: _____

Primary Insurance

Name of Subscriber: _____ Birthdate: ____ / ____ / _____

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

Address of Subscriber: _____
(If different than patient) *Street Address* *City* *ST* *Zip*

Phone #s: ( ) _____ Social Security Number: _____
(If different than patient)

Insurance Co: _____ Phone: ( ) _____

Subscriber #: _____ Group #/Name: _____

Subscriber's Employer: _____ Phone: ( ) _____

Secondary Insurance

If you have NO Secondary Insurance Coverage, Initial Here: _____ Date: _____

Name of Subscriber: _____ Birthdate: ____ / ____ / _____

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

Address of Subscriber: _____
(If different than patient) *Street Address* *City* *ST* *Zip*

Phone #s: ( ) _____ Social Security Number: _____
(If different than patient) *Street Address* *City* *ST* *Zip*

Insurance Co: _____ Phone: ( ) _____

Subscriber #: _____ Group #/Name: _____

Subscriber's Employer: _____ Phone: ( ) _____

Patient Name: _____ Date of Birth: ____ / ____ / _____

Medical History

Allergies	☐ Yes	☐ No	Depression	☐ Yes	☐ No	Multiple Sclerosis	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No
Anxiety	☐ Yes	☐ No	Dizzy Spells	☐ Yes	☐ No	Parkinsons	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Emphysema/Bronchitis	☐ Yes	☐ No	Rheumatoid Arthritis	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Fractures	☐ Yes	☐ No	Seizures	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Gallbladder Problems	☐ Yes	☐ No	Speech Problems	☐ Yes	☐ No
Cardiac Conditions	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No	Strokes	☐ Yes	☐ No
Cardiac Pacemaker	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Thyroid Disease	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No	Incontinence	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Circulation Problems	☐ Yes	☐ No	Kidney Problems	☐ Yes	☐ No	Vision Problems	☐ Yes	☐ No
Currently Pregnant	☐ Yes	☐ No	Metal Implants	☐ Yes	☐ No			

Describe any other conditions or precautions:

Falls History

Injury as a result of a fall in the past year? ☐ Yes ☐ No Date of Fall: _____

Two or more falls in the last year? ☐ Yes ☐ No Dates of Falls: _____

Surgical History

Body Region: _____ Surgery Type: _____ Date of Surgery: _____

Body Region: _____ Surgery Type: _____ Date of Surgery: _____

Body Region: _____ Surgery Type: _____ Date of Surgery: _____

Body Region: _____ Surgery Type: _____ Date of Surgery: _____

Body Region: _____ Surgery Type: _____ Date of Surgery: _____

Current Medications

Drug: _____ Dosage: _____ Reason for Taking: _____

Drug: _____ Dosage: _____ Reason for Taking: _____

Drug: _____ Dosage: _____ Reason for Taking: _____

Drug: _____ Dosage: _____ Reason for Taking: _____

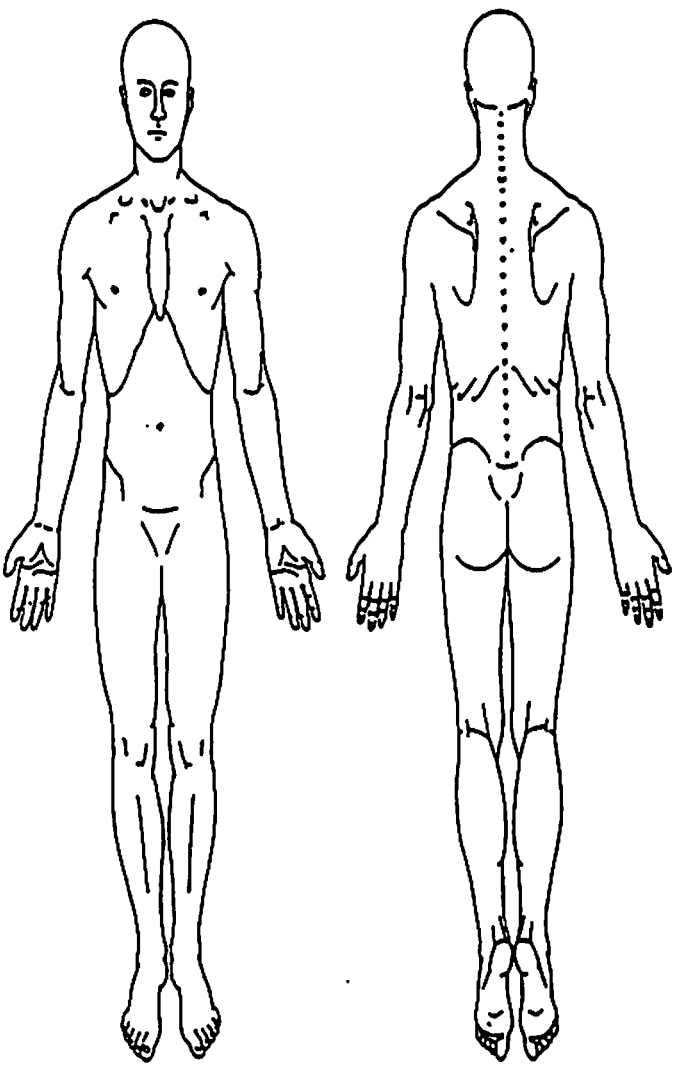
Drug: _____ Dosage: _____ Reason for Taking: _____

Physical Therapy Sports Institute

1515 W. Florida Ave, Ste E
Hemet, CA 92543
Phone: 951.658.3121

Name: _____ Date: _____

Graphic Pain Assessment

PAIN INTENSITY SCALE		PAIN LOCATIONS BODY DIAGRAMS
10	Pain as bad as it could be	
9	Excruciating	
8		
7	Severe	
6		
5	Moderate	
4		
3	Mild	
2	Slight	
1		
0	No Pain	

1. Draw a line on the pain intensity scale at the point that best describes your pain at the present time.
2. Draw the location of your pain on the body diagram above.
3. If you have any other symptoms such as tingling or numbness, draw these as dotted line.

Please describe the details of your injury, including the date of injury and any treatment of the injury:

Physical Therapy Sports Institute

CONSENT FOR PATIENT CONTACT

I, _____, herby give my consent for the Therapist and staff at PHYSICAL THERAPY-SPORTS INSTITUTE, INC. to contact me regarding appointments and confidential health information via (please check all that applies).

__ Message with spouse / friend / caregiver: _____

__ Mail

__ Answering machine / Voicemail – home / work (please circle)

__ Fax #: _____

__ Cell phone #: _____

__ E-mail address: _____

__ DO NOT CONTACT ANYONE OTHER THAN ME PERSONALLY

_____

Patient Name (please print)

_____ _____

Patient Signature Date

1515 West Florida Avenue - Suite E - Hemet - California - 92543 - Phone: 951.658.3121 - Fax: 951.652.6994