

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Sex (M / F)

Address \_\_\_\_\_  
(number) (street) (city) (state) (zip code)

Social Security# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Birth Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age \_\_\_\_\_

Phone # (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell # (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Email \_\_\_\_\_

Married ( ) Single ( ) Other ( ) \_\_\_\_\_ Spouse's Name \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Work Address \_\_\_\_\_

IN CASE OF AN EMERGENCY, CONTACT \_\_\_\_\_

Name	Relationship	Phone #
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What are your health goals? (Check one of the following)

☐ Reduce symptoms only      ☐ Reduce symptoms and show me how to prevent flair-ups      ☐ Reduce symptoms, prevent flair-ups and maintenance care

Is this injury work related? (YES / NO)      Is this injury due to a motor vehicle accident? (YES / NO)

**\* IF YOU ANSWERED YES TO EITHER OF THE TWO PREVIOUS QUESTIONS, PLEASE NOTIFY THE FRONT DESK \***

*Check any of the following symptoms you are currently experiencing or have experienced within the past 6 months.*

- ☐ Low Back Pain
- ☐ Pain Between Shoulders
- ☐ Neck Pain
- ☐ Headaches
- ☐ Arm Pain/Numb/Tingling
- ☐ Leg Pain/Numb/Tingling
- ☐ Joint Pain/Stiffness
- ☐ Walking Problems
- ☐ Difficulty Chewing
- ☐ Weakness

☐ Allergies  
☐ Loss of Sleep  
☐ Fever/Night Sweats  
☐ Eczema (skin rash)  
☐ Weight Loss/Gain

☐ Bladder Trouble  
☐ Painful Urination  
☐ Excessive Urination  
☐ Discolored Urine

☐ Vision Problems  
☐ Dental Problems  
☐ Sore Throat  
☐ Ear Pain/Ringing  
☐ Hearing Difficulty

☐ Difficulty Urinating  
☐ Impotence  
☐ Sterility

- ☐ Chest Pain
- ☐ Short of Breath
- ☐ Blood Pressure
- ☐ Heart Problems
- ☐ Wheezing
- ☐ Lung Problems
- ☐ Varicose Veins
- ☐ Arm/Leg Swelling
- ☐ Asthma
- ☐ High Cholesterol
- ☐ Bruise Easily

- ☐ Menstrual Irregularity
- ☐ Menstrual Cramping
- ☐ Sterility
- ☐ Breast Pain

- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Confusion
- ☐ Depression
- ☐ Fainting
- ☐ Convulsions
- ☐ ADHD/Hyperactivity
- ☐ Anxious
- ☐ Tremor/Shaking

- ☐ Gas/Bloating
- ☐ Heartburn
- ☐ Poor Appetite
- ☐ Excessive Appetite
- ☐ Excessive Thirst
- ☐ Decreased Appetite
- ☐ Colitis
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Black/Bloody Stool
- ☐ Hemorrhoids
- ☐ Liver Problems
- ☐ Abdominal Pain
- ☐ Frequent Nausea

\*\*\*ARE YOU PREGNANT? (YES / NO)\*\*\*

Do you give us permission to send your medical doctor an updated report on your status? (YES / NO)

Please list any surgeries you have had and when.

Please list any medications you are taking.

**PATIENT SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

# NEW PATIENT COMPLAINT(S)

Name \_\_\_\_\_ (Complete #1-10) Date \_\_\_\_\_

1. What is your **worst** complaint? \_\_\_\_\_

When and How did your condition begin? \_\_\_\_\_

Rate your pain/discomfort on the scale. (circle) (none) = 0 1 2 3 4 5 6 7 8 9 10 = (severe)

How often do you experience this complaint? (circle) Occasionally (0-25% of the day) Intermittently (26-50% of the day) Frequently (51-75% of the day) Constantly (76-100% of the day)

How are your symptoms changing? (circle) Improving Not Changing Worsening

2. What is your **second worst** complaint? \_\_\_\_\_

When and How did your condition begin? \_\_\_\_\_

Rate your pain/discomfort on the scale. (circle) (none) = 0 1 2 3 4 5 6 7 8 9 10 = (severe)

How often do you experience this complaint? (circle) Occasionally (0-25% of the day) Intermittently (26-50% of the day) Frequently (51-75% of the day) Constantly (76-100% of the day)

How are your symptoms changing? (circle) Improving Not Changing Worsening

3. Briefly describe any other complaints. \_\_\_\_\_

4. How much have these symptoms interfered with the following activities? (check all that apply)

## Work

\_\_\_ Not at all  
\_\_\_ A little bit  
\_\_\_ Moderately  
\_\_\_ Quite a bit  
\_\_\_ Extremely

## Social Activities

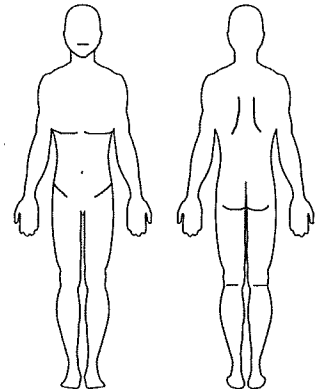
\_\_\_ Not at all  
\_\_\_ A little bit  
\_\_\_ Moderately  
\_\_\_ Quite a bit  
\_\_\_ Extremely

5. Circle any other symptoms you are experiencing.

(Sharp Pain) (Dull Ache) (Shooting Pain)  
(Burning Pain) (Throbbing Pain) (Popping) (Weakness)

6. Please indicate on the diagram to the right where you experience your symptoms. (Use the key below)

Pain XXX Numbness OOO Tingling √√√  
Stiffness /// Burning + + +



7. Who have you seen for your symptoms?(check) \_\_\_ No One \_\_\_ Medical Doctor \_\_\_ Chiropractor \_\_\_ Physical Therapist \_\_\_ Other

a. What treatment did you receive and when? \_\_\_\_\_

b. Circle any tests have you had for your symptoms? (X-Rays) date:\_\_\_\_ (CT Scan) date:\_\_\_\_ (MRI) date:\_\_\_\_ (Other)

8. Have you had similar symptoms in the past? ( YES / NO )

If yes, when was the last time you experienced those symptoms? \_\_\_\_\_ How long did your symptoms last? \_\_\_\_\_

9. What is your occupation? \_\_\_\_\_ Are you required a disability note for your employer / teacher? ( YES / NO )

10. **Family History:** Does anyone in your immediate family (including your grandparents) have any of the conditions listed? (Circle all that apply)

Arthritis, Asthma, Birth Defects (i.e. heart defects), Cancer, Diabetes, Genetic Conditions (i.e. Cystic Fibrosis), Heart Disease, Mental Illnesses (i.e. Alzheimer's, Parkinson's), Obesity, Seizures

**DOCTORS NOTES:** \_\_\_\_\_

**SD Elite Physical Therapy**  
**410 S. Melrose Drive Suite 200**  
**Vista, CA 92081**

**Consent for treatment:** I, as a patient, consent to physical therapy at SD Elite Physical Therapy as prescribed by my referring provider. I consent to maintain the confidentiality of other patients of the facility and not to disclose to anyone anything discussed at the facility by anyone other than myself.

Initials: \_\_\_\_\_

**Authorized Release of Information:** I hereby authorize SD Elite Physical Therapy to release medical records pertaining to my treatment to any entity that is responsible for payment of physical therapy charges. I understand that this authorizes my insurance company to pay any benefits directly to SD Elite Physical Therapy. In addition, I further understand that I am ultimately responsible for any remaining co-insurance or co-payment.

Initials: \_\_\_\_\_

**HIPPA Patient Information Consent:** I understand that SD Elite Physical Therapy may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand I have the right to restrict how my personal health information I used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand SD Elite Physical Therapy will consider requests for restrictions on a case by case basis but does not have to agree to requests for restrictions. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

Initials: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## OFFICE POLICIES / PROCEDURES AGREEMENT AND CUSTOMARY FEE SCHEDULE

### FINANCIAL ARRANGEMENTS

I understand and agree that health and accident policies are an arrangement between an insurance company carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

### INSURANCE BILLING/PAYMENT

Patients are ultimately fully responsible for services provided by our office. For your convenience, our office will make an effort to verify your insurance benefits. However, please note that verification of benefits is not guaranteed. Your insurance company makes the final determination of insurance benefits when they consider the claim. Patients are fully responsible for payment of services not authorized or covered by their insurance company. Patients that are represented by an attorney in PI cases must notify our office the same day if changing or canceling representation.

### PAYMENT ARRANGEMENTS

We understand that occasions arise when it may be necessary for you to request to be billed rather than pay at the time of service. This may include setting up a payment plan for those who may require extensive treatments. Payment is due within 30 days of the service rendered. If there are legitimate financial problems, please discuss them with our office manager prior to the 30 days so that we may find a workable solution. If an account is not paid within 30 days and no payment arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account. You will also be charged a monthly interest of 10% based off your principal balance until all fees are paid.

### APPOINTMENT SCHEDULING

Canceling or rescheduling appointments requires a 24 hour notice otherwise you will be charged a fee for the missed scheduled service.

### NOTICE OF PRIVACY POLICY

We are required by law to make sure your medical information is protected; give you notice describing our legal duties and privacy practices with respect to medical information about you; and follow the terms of the notice that is currently in effect. By signing below you are acknowledging that you have received our Notice of Privacy Policy.

### NOTICE OF PRIVATE PRACTICES/ BUSINESSES AND PATIENT'S FREEDOM OF CHOICE

There are separate practices/ businesses within this office. Each entity is owned and operated as separate businesses and may have separate fee schedules and different treatment techniques. I understand that each service offered at this facility are owned and operated as separate businesses and hold each business harmless from any act or omission which may occur by any of the other businesses during the course of my treatment at this facility. Circumstances may arise such as emergencies, or doctor vacation or sick leave and you may request to be treated by another doctor within this office. If you are treated by another doctor you may be charged a different fee. Patients are free to choose any doctor or organization that may be recommended by our doctors. You do not have to use the facilities at our office for treatments and we can assist you on finding an alternative locations or sources.

### CONSENT TO TREAT MINOR

I, \_\_\_\_\_ the parent or legal guardian, who has permission to make medical decisions for \_\_\_\_\_, a minor child, authorize any necessary treatment at SD Elite Physical Therapy for my minor child and fully agree to the above terms.

\_\_\_\_\_  
PRINT NAME

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

# SD Elite Physical Therapy

## Acknowledgement of Receipt of Notice of Privacy Practices

*This form will be retained in your medical record.*

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### NOTICE TO PATIENT

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We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice.

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

I acknowledge that I have **received and had the opportunity to review** the Notice of Privacy Practices on the date below on behalf of \_\_\_\_\_ **SD Elite Physical Therapy**.

I understand that the Notice describes the uses and disclosures of my protected health information by **SD Elite Physical Therapy** and informs me of my rights with respect to my protected health information.

\_\_\_\_\_  
*Patient's Signature or that of Legal Representative*

\_\_\_\_\_  
*Printed Name of Patient or that of Legal Representative*

\_\_\_\_\_  
*Today's Date*

\_\_\_\_\_  
*If Legal Representative, Indicate Relationship*

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### FOR OFFICE USE ONLY

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We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ Other (please specify): \_\_\_\_\_

\_\_\_\_\_  
*Employee Name*

\_\_\_\_\_  
*Today's Date*