Therapy and Sports Center, Inc
412 12 Ave N
St Petersburg, FL 33701
Phone: **727-898-5001**
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THERAPY AND SPORTS CENTER
PHYSICAL THERAPY

Patient Information:

Patient Name:	DOB:
Address:	Apt #:
City:	State:
Zip:	
Cell Phone:	Work Phone:
Home Phone:	E-Mail Address:

Treatment Information:

Primary Complaint:	Date of Onset:_____ Date of Surgery:_____
Secondary Complaint:	Date of Onset:_____ Date of Surgery:_____
Referring MD:	Referring MD Phone Number:
Primary Care Doctor:	PCP Phone Number:

Emergency Contact:

Name:	
Phone:	Relationship:

Employment Information:

Employer Name:	Phone Number:
Job Title:	

Job Status (circle all applicable): Full-Time Part-Time Full-Duty Modified-Duty Off-Work Retired

Primary Insurance:

Insurance Name:	Group #:
ID #:	Claim #:
Policyholder Name:	Policyholder DOB:
Relation to Policyholder:	
Insurance Benefits: $	Annual Benefits:
Coinsurance:	Authorizations:

Every effort is made to be sure that the information given to you today is accurate. If a conflict exists between the information provided to you and the terms of your insurance plan, the terms of your insurance plan will govern. Final determination of coverage and patient responsibility is made at the time the claim is received and processed.
Initial: _____

Liability Injury
Are you receiving care for injuries sustained in a Motor Vehicle Accident? Yes No
Are you receiving care for injuries from a Workman's Compensation Accident? Yes No
If yes, what state did the accident occur in? _____
What was the date of your accident? ____/____/_____

Appointment Reminders
Would you like to receive appointment reminders via e-mail or text message? Yes No
Preferred method (circle one) : E-mail Text
If text, please provide your cell-phone service provider: _____

Have you recently had Home health? Yes No
If yes, when were you discharged?_____
Have you had Physical Therapy treatment elsewhere, this year? Yes No
If yes, where, and how many visits?_____

Patient or Guardian Agreement:
☐ I authorize the release of my information as requested by my insurance plan for payment.
☐ I understand that I have been given a description of my insurance benefits. I understand my insurance contract is the final basis for benefit determination and I am responsible for any amount not paid by my insurance company.
☐ I give my consent for treatment rendered by Therapy and Sports Center.
☐ I will strive to keep and arrive on time to my appointments and I understand multiple missed appointments may result in a status of non-compliance, and/or a cancellation fee.

Signature of Patient or Guardian: _____ Date _____

THERAPY & SPORTS CENTER – Patient Medical History Form

Name: _____ D.O.B: _____ Date: _____

Referring Dr: _____ /#: _____ Primary Care Dr: _____ /#: _____

SOCIAL HISTORY: What is your occupation: _____ □ Full Time □ Part Time □ Unemployed □ Self Employed □ Retired □ Homemaker □ Student □ Other: _____

Do you live alone? Yes / No *List any physical barriers in your residence that cause you difficulties: _____

*IS YOUR CONDITION RELATED TO AN AUTOMOBILE, WORK RELATED OR SLIP & FALL INJURY? □YES □ NO

If yes, when was the date of injury: _____ In what State did the injury occur? _____

Claim Adjuster's Name: _____ Phone#: _____ Fax#: _____

Do you have an attorney? □ Yes □ No Attorney Name/Firm: _____ Phone #: _____

Have you had surgery for this injury? YES / NO Date of surgery: ___/___/___ Type of surgery: _____

MEDICAL HISTORY: Height: _____ Weight: _____ Do you/have you ever smoked?: □Yes □ No

How would you rate your overall health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Please list any allergies: _____

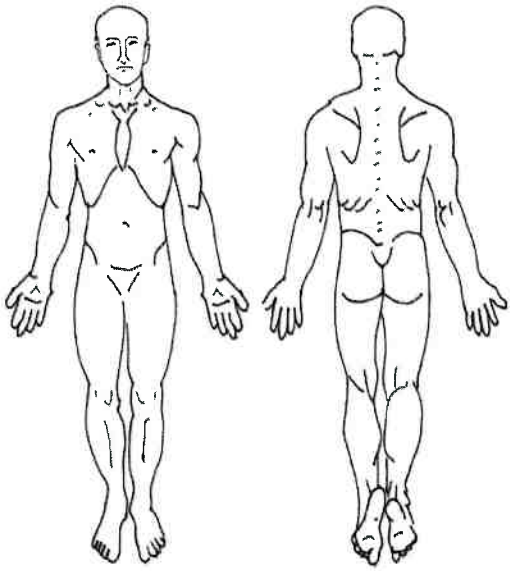
Please list current Medications: _____

Do you now have or have you ever had ANY of the following?

	YES	NO
Asthma, bronchitis or emphysema		
Shortness of breath/chest/pain		
Coronary heart disease/angina		
Heart attack or heart surgery		
Do you have a pacemaker?		
High blood pressure		
Stroke/TIA Date: ___/___/___		
Blood clot/emboli		
Epilepsy/seizures		
Anemia		
Infectious diseases		
Diabetes		
Cancer or chemotherapy		
Arthritis/swollen joints		
Osteoporosis		
Severe/frequent headaches		
Vision/hearing difficulties		
Dizziness/fainting		
Weight loss/energy loss		
Hernia		
Sleeping prob/difficulties		
Any joint/metal implants		
Joint replacements		
Shoulder injury/surgery		
Elbow/hand injury/surgery		
Neck/back injury/surgery		
Knee injury/surgery		
Leg/ankle injury/surgery		
Are you pregnant?		

On the body diagram below SHADE IN THE AREA(s) you are having pain, tingling or numbness with this episode

INDICATE: X for pain, = for numbness, * for tingling, # for burning



On a scale of 0 (no pain) to 10 (severe/disabling pain), rate your pain at its BEST: _____ / WORST: _____

On a scale of 0% (worst) to 100% (best) what percentage of normal function are you able to perform? (This includes work performance, home activity, sports, socially with friends: _____

CURRENT EPISODE: When did your symptoms this episode start: Date: _____ Describe your symptoms: _____

How often do you experience your symptoms? Constantly: _____ Frequently: _____ Occasionally: _____ Rarely: _____

How much have your symptoms interfered with your daily activities?

Never: _____ A little bit: _____ Moderately: _____ Quite a bit: _____ Extremely: _____

Have you had similar symptoms in the past? Yes: _____ / No: _____

Who did you see for your symptoms: No One: ____ Medical Doctor: ____ Chiropractor: ____ Physical Therapist: ____ Other: _____

What treatment(s) did you receive? X-Rays: _____ MRI: _____ CT Scan: _____ Surgery: _____ Other: _____

Patient Signature: _____ **Date:** _____