NEW PATIENT INFORMATION FORM

Last Name: _____ **First Name**: _____ **MI:**_____ **Gender:**_____

Address: _____ **City**: _____ **State**: _____ **Zip**: _____

Home Phone: _____ **Cell Phone**: _____ **Work Phone**: _____

Date of Birth: ____/____/____ **Age**: _____ **SSN**: _____-_____-_____ **Marital Status:** _____

Email:_____

Employer Name: _____ **Occupation**: _____

Emergency Contact: _____ **Relation:** _____ **Phone:** _____

How Did You Hear About OC Sports & Rehab: _____

Referring Doctors Name (If any): _____**MD Follow-Up Visit Date:** _____

CANCELLATION POLICY: ***We Understand life happens and circumstances can arise, but please allow others to use your spot by giving us 12 hours advanced notice of appointment cancellations. Any NO SHOWS or LAST MINUTE cancels will be assessed a $50 fee.***

Patient or Guardian's Signature: _____ **Date:** _____

MEDICAL HISTORY QUESTIONNAIRE Today's Date: _____/_____/_____

Patient Name: _____ **Date of Birth**: _____/_____/_____ **Age**: _____

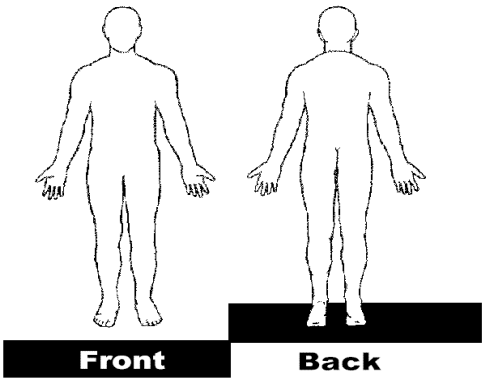
Height:_____ **Weight:**_____ **BMI:**_____ **Injury Location: Home / Work / Auto / Sport / Other**

Chief Complaint / Injury / Condition: _____ **Date of Onset:** _____

Describe how symptoms began: _____

Date of Surgery: _____ **Type of Surgery:** _____

Please describe any previous treatments / surgeries you received: _____



Please indicate your area of injury / concern on the diagram to the left:

Type of Pain: Sharp / Burning / Aching / Tingling / Numbness

Rate your pain (1 = mild, 10 = severe)
At its worst: 1 2 3 4 5 6 7 8 9 10
At its best: 1 2 3 4 5 6 7 8 9 10

What makes your pain **BETTER**:_____

What makes your pain **WORSE**:_____

Any diagnostic IMAGING performed? **YES / NO** **Type & Date:** _____
Do you currently take any PAIN MEDICATION? **YES / NO** **If Yes, What type?** _____
Are you currently taking any other medication? **YES / NO** **Type & Dosage:** _____

Do you currently have any METAL IMPLANTS? **YES / NO** **If Yes, Where?** _____
Do you currently have a PACEMAKER? **YES / NO**
Are you or could you be PREGNANT? **YES / NO**
Do you have a history of CANCER? **YES / NO** **If Yes, Where?** _____
Do you have HIGH BLOOD PRESSURE? **YES / NO**
Do you have any history of CARDIAC problems? **YES / NO** **If Yes, What?** _____
Have you ever had any BLOOD CLOTS? **YES / NO** **If Yes, Where?** _____
Are you DIABETIC? **YES / NO**
Do you get SWELLING in your extremities? **YES / NO** **If Yes, Where?** _____
Do you have a history of LYMPHEDEMA? **YES / NO**
Do you have NEUROPATHY present? **YES / NO** **If Yes, Where?** _____
Do you wear ORTHOTICS? **YES / NO**
How far can you walk before symptoms? (Please list distance walked or total time) _____
What position is MOST comfortable? **WALKING / STANDING / SITTING / LYING**
What position is LEAST comfortable? **WALKING / STANDING / SITTING / LYING**
What is your normal activity at work? **WALKING / STANDING / SITTING / LIFTING**
Have your symptoms been getting: **BETTER / STAYING THE SAME / WORSE**

Any other concerns/questions/information you may have: _____

FINANCIAL POLICY: I hereby agree to pay my account AS SERVICES ARE PROVIDED. If for any reason there is a balance owing on my account, I will pay promptly upon receipt of the statement.

OC Sports & Rehab cannot assume responsibility for incorrect information provided to us concerning your insurance policy. Our courtesy verification of eligibility and benefits does not guarantee that your insurance company will pay for all services provided. Your insurance policy is a contract between you and your insurance company. You are responsible for knowing your level of coverage and are ultimately responsible for the full payment of your bill.

Being referred to our clinic by a physician does not necessarily guarantee that your insurance will cover our services, that we are a contracted provider with your plan, or that we accept the same plans and carriers that your referring physician does. Please remember that you are 100% responsible for all charges incurred: your physicians' referrals, prescriptions, and our verification of your insurance benefits are not a guarantee of payment. **Please SIGN below that you have read, understood, and agree with all of the information presented above:**

Patient or Guardian's Signature: _____ Date: _____

ASSIGNMENT OF BENEFITS & RELEASE OF INFORMATION: I hereby authorize and assign my therapy insurance benefits to be paid directly to OC Sports & Rehab. I also authorize OC Sports & Rehab to release any necessary medical information to process my claims. By signing below, I authenticate that authorization for assignment of benefits and release of information by providers at OC Sports & Rehab.

Patient or Guardian's Signature: _____ Date: _____

CONSENT TO TREATMENT & THERAPEUTIC PROCEDURES: I, _____, hereby consent to the therapeutic procedures outlined below to be performed by OC Sports & Rehab and their associates. I agree to be evaluated and treated for functional loss due to related nerve, muscle, and skeletal dysfunctions and/or pain.

I understand that therapeutic procedures can include but are not limited to: joint and soft tissue mobilization, home exercise programs, functional training for posture and body mechanics, modalities, such as heat, ice, electrical stimulation, and ultrasound, and special procedures such as: taping and neuromuscular electrical stimulation.
I understand that I will be explained the purpose of the therapeutic procedures prior to receiving treatment and that I may refuse any therapeutic procedure or treatment at any time.
I understand that I may consult with other therapists and/or physicians at any time regarding my conditions
I understand that no guarantee of a successful outcome has been given to me.
I understand to inform my therapist of any changes in my condition at any time during my care.

I certify that I have read and understand the above consent statements:

Patient or Guardian's Signature: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES: *I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the notice. This information is available any time on our website www.ocsportsandrehab.com*

Patient or Guardian's Signature: _____ Date: _____