Name: _____ Phone #: _____

Preferred name if different from insurance/ID: _____

Pronouns (circle): She/Her He/His They/Them Other: _____

Address: _____

SS number: _____ DOB: _____ Height: _____ Weight: _____

Emergency contact/relationship: _____ Phone #: _____

Circle appropriately

Are you latex sensitive? **YES NO** Do you smoke? **YES NO**

Do you have a pacemaker? **YES NO** Do you have hearing loss? **YES NO**

Are you currently pregnant or think you might be pregnant? **YES NO**

ALLERGIES: List any allergies: _____

_____

Have you RECENTLY noted any of the following (check all that apply)?

❑ fatigue	❑ numbness or tingling	❑ constipation
❑ fever/chills/sweats	❑ muscle weakness	❑ diarrhea
❑ nausea/vomiting	❑ dizziness/lightheadedness	❑ shortness of breath
❑ weight loss/gain	❑ heartburn/indigestion	❑ fainting
❑ difficulty maintaining balance while walking	❑ difficulty swallowing	❑ cough
❑ falls	❑ changes in bowel or bladder function	❑ headaches

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

❑ cancer	❑ depression	❑ thyroid problems
❑ heart problems	❑ lung problems	❑ diabetes
❑ chest pain/angina	❑ tuberculosis	❑ osteoporosis
❑ high blood pressure	❑ asthma	❑ multiple sclerosis
❑ circulation problems	❑ rheumatoid arthritis	❑ epilepsy
❑ blood clots	❑ other arthritic condition	❑ eye problem/infection
❑ stroke/ head injury	❑ bladder/urinary tract infection	❑ ulcers
❑ anemia	❑ kidney problem/infection	❑ liver problems
❑ bone or joint infection	❑ sexually transmitted disease/HIV	❑ hepatitis
❑ chemical dependency (i.e., alcoholism)	❑ pelvic inflammatory disease	❑ pneumonia

Circle appropriately

During the past month have you been feeling down, depressed or hopeless? **YES NO**

During the past month have you been bothered by having little interest or pleasure in doing things? **YES NO**

Is this something with which you would like help? **YES YES, BUT NOT TODAY NO**

Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? **YES NO**

Has anyone in your immediate family (parents, brothers, sisters) EVER been diagnosed with any of the following conditions (check all that apply)?

❑ cancer	❑ diabetes	❑ tuberculosis
❑ heart problems	❑ stroke	❑ thyroid problems
❑ high blood pressure	❑ depression	❑ blood clots

Please list all medications you are currently taking: (including dosages and frequency):

-Blood Pressure Medication	-Heart Medication	-Anti-coagulants (blood thinners)
-Muscle Relaxants	-Pain Killers	-Diabetes Medication (i.e. insulin)
-Steroids	-Anti-inflammatories	-Other Medications (state condition)

Have you ever taken steroid medications for any medical conditions? **YES NO**

Have you ever taken blood thinning or anticoagulant medications for any medical conditions? **YES** **NO**

Please List all surgeries you have had (include dates): _____

_____

What date (roughly) did your present symptoms start? _____

What do you think caused your symptoms? _____

My symptoms are currently: ❑ Getting Better ❑ Getting Worse ❑ Staying about the same

Treatment received so far for this problem (chiropractic, injections, etc) _____

_____

Please list special tests performed for this problem (x-ray, MRI, labs, etc) _____

_____

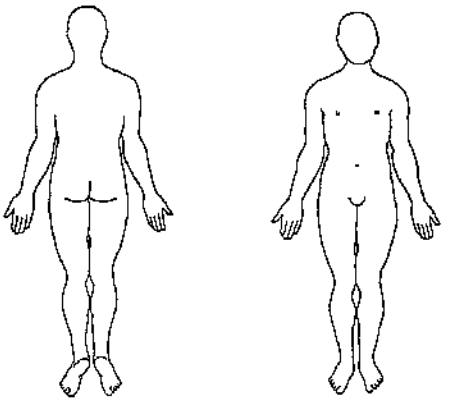
Have you ever had this problem before: ❑ Yes ❑ No When_____ Treatment rec'd_____

Occupation, including activities that comprise your workday: _____

Leisure activities, including exercise routines:_____

Body Chart:
Please mark the areas where you feel symptoms on the chart to the right with the following symbols to describe your symptoms:

↓ **Shooting/sharp pain**
O **Dull/aching pain**
||| **Numbness**
= **Tingling**



My symptoms currently: ❑ Come and go ❑ Are Constant ❑ Are constant, but change with activity

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Aggravating Factors: Identify important positions or activities that make your symptoms worse:

_____

_____

Easing Factors: Identify important positions or activities that make your symptoms better:

_____

_____

How are you currently able to sleep at night due to your symptoms?
❑ No problem sleeping ❑ Difficulty falling asleep ❑ Awakened by pain ❑ Sleep only with medication

When are your symptoms worst? ❑ Morning ❑ Afternoon ❑ Evening ❑ Night ❑ After exercise

When are your symptoms the best? ❑ Morning ❑ Afternoon ❑ Evening ❑ Night ❑ After exercise

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Using the 0 to 10 the scale, with 0 being *"no pain"* and 10 being the *"worst pain imaginable"* please describe:
Your current level of pain while completing this survey: _____
The best your pain has been during the past 24 hours: _____
The worst your pain has been during the past 24 hours: _____

I certify that the above information is accurate to the best of my knowledge.

_____ _____

Patient/Guardian Signature – Relationship to Patient *(Date)*

Pappas OPT
PHYSICAL SPORTS & HAND THERAPY

Consent to Treat

1. I have presented myself to this facility for therapy treatments and consent to the care (history, physical examination, treatment, etc.) that will be provided by my therapist.
2. I realize I have the right to refuse any treatments or procedures to the extent permitted by law. I acknowledge that the delivery of health care does not guarantee results of any treatments at this facility.
3. I understand that information from any medical record(s) kept by this facility may be used for educational, administrative, and/or facility approved purposes when my personal identity will not be revealed.
4. I hereby authorize the release of medical information necessary to process my insurance and authorize payment directly to the provider of service. I am responsible for any services not covered by this authorization. I have read and fully understand the Patient Financial Responsibilities Form.
5. Worker's Compensation - I hereby authorize Pappas OPT to receive my records related tomy work injury.

Photo/Video Authorization

I grant to Pappas OPT and its affiliated entities, and its representatives and employees (collectively the "Company") the right to take photographs and\or videos of me in connection with my participation in physical/occupational therapy services. I authorize the Company, to copyright, use and publish the same in print and/or electronically. I agree that the Company may use such photographs of me with or without my name and for any lawful purpose, including for example such purposes as publicity, illustration, advertising, and Web content and waive any right to compensation, therefore. I understand that I may revoke this authorization but only in writing delivered to the clinic office manager. I understand that if I choose to revoke this Authorization, the revocation will not be effective for any uses and/or disclosures of my protected health information that have already been made in reliance on this Authorization.

☐ Agree or ☐ Decline

Notice of Privacy Practices

By signing this form, I acknowledge that Pappas OPT has made its' Privacy Notice available to me, which explains how my health information will be handled in various situations. I understand that I may discuss my concerns and/or any questions I have concerning this Privacy Notice with Pappas OPT Specialists representatives.

Communication: I authorize Pappas OPT to communicate with me via **Email** and/or **Text message**.

EMAIL: _____ Cell phone number: _____

Is the reason for therapy the result of an MVA or Work-Related Injury? ____Yes, date_____ ____No

Have you had other therapy this year? ____Yes How Many? _____ ____No

Have you had Home Health Care? ____Yes If yes, D/C Date: _____ ____No

Release of Information

I authorize the following individuals to receive information regarding my diagnosis, treatment, and billing:

Name	Relationship

Authorization

I acknowledge, as indicated by my signature below, that I have read and fully understand this consent form. By signing this form, I am acknowledging my understanding of the "Notice of Privacy Practices" and authorizing persons listed on the Information Release to receive my health information.

_____ _____

Patient/Guardian Signature – (relationship to patient) Date

Pappas OPT
PHYSICAL, SPORTS & HAND THERAPY