ELITE
Physical Therapy

D1

Name: _____ DOB: _____

To help us better evaluate your condition, please complete this form to the best of your knowledge. If you have any questions please ask for assistance. Thank you

MEDICAL HISTORY: PLEASE CHECK ANY CONDITION YOU HAVE A HISTORY OF (items not checked are understood to be negative).

_____ High blood pressure	_____ Abnormal Bleeding	_____ Bowel or bladder problems
_____ Heart Problem	_____ Asthma	_____ Autoimmune disorder
_____ Abnormal Heart Rate	_____ Emphysema	_____ Recent weight loss/gain
_____ Pacemaker	_____ Chronic Heartburn	_____ Diabetes
_____ Angina (chest pain)	_____ History of ulcers	_____ Arthritis
_____ Shortness of breath	_____ High cholesterol	_____ Seizures/Epilepsy
_____ Osteoporosis	_____ Night Sweats	_____ Cancer/Tumors
_____ Dizziness	_____ Hearing problems	Location _____

Other: _____

Do you have a history of fractures?	YES	NO	Where _____
Do you have a history of back/neck pain?	YES	NO	When _____
Do you have metal implants?	YES	NO	Where _____
Do you smoke?	YES	NO	How much per day? _____
Do you exercise regularly?	YES	NO	How often _____
Do you have any known allergies?	YES	NO	Please list: _____
Are you allergic to latex?	YES	NO	
Are you pregnant or suspect pregnancy	YES	NO	

MEDICATIONS: Please list the name of any medciations you are currently taking:

_____

_____

SURGERIES: Please list all surgeries, including date:

_____

_____

DIAGNOSTIC TESTS: Please check test(s) for current problem only

( ) X-Rays ( )CT Scan ( )MRI ( )Bone Scan ( )EMG ( )Bone Density ( )Blood Chemistry

( )Ultrasound ( )Other please specify _____

I believe all information to be true and complete

Signature _____ Date _____

Patient Information Sheet

Patient _____ Physician _____

Personal Information

Birthdate _____ Age _____ Social Security # _____

Home Address _____

Street/City/State/Zip _____

Home Phone _____ Cell Phone _____ Sex _____

Marital Status: ___ Married ___ Single ___ Divorced ___ Widowed Spouse's Name_____

Emergency Contact _____ Relation _____ Phone _____

Employment Information

Student: Full-time _____ Part-time _____ If so, where _____

Employed: Full-time _____ Part-time _____

Employer _____Occupation _____

Address _____ Work Phone _____

Primary Insurance Coverage

Insurance Company _____Group # _____

Policy Holder's Name _____ Birthdate _____

Relationship of Patient to Policy Holder _____

D1 Sports Medicine Email Agreement

D1 Sports Medicine along with D1 Elite Physical Therapy always strive to provide the highest quality service. Your opinion matters and allows us to refine what we do and how we do it. To continue to deliver the highest quality care available we would like to send you a survey to get your feedback. If you are willing to participate please fill in the below. We can also send home programs via email.

- o I would like to receive surveys and home exercises by email
- o I DO NOT want to receive emails

Patient Name:_____

Email address:_____

NO SHOW POLICY

To ensure that we are able to provide appropriate and consistent service for you, we ask that you make every effort to attend all scheduled appointments.

If you are unable to attend a scheduled appointment, please call to notify our staff of your intended absence 24 hrs in advance at 325-690-9700. We understand unforeseen circumstances arise and we ask that you please notify us as soon as possible.

Punctuality: Your time is very valuable as is ours. If you are more than 15 minutes late for your appointment, that appointment will have to be rescheduled. We will make every effort to accommodate you at that time, but it isn't always possible.

No Shows: If you fail to call ahead and do not keep your appointment, we will call you to remind you of our clinic's No Show Policy. If a second missed appointment occurs without an advanced notice, you will lose your next appointment time. It will be your responsibility to call us to reschedule. If there is a third No Call/No Show, you will be discharged as a patient.

****Note:** If you are a Worker's Compensation Patient, your employer and insurance carrier will be notified of any no-show appointments. FAILURE TO KEEP APPOINTMENTS WILL RESULT IN DISCHARGE FROM OUR MEDICAL PRACTICE.

I have read, understand and agree to follow these conditions.

_____ _____

Patient/Other Legally Responsible Person Signature Date