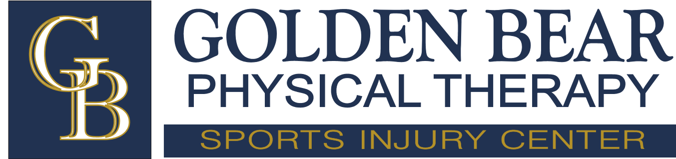


Patient Name: ___________________________ E-mail: _____________________________ Date: _____________

AUTHORIZATION OF TREATMENT

Thank you for choosing **GOLDEN BEAR PHYSICAL THERAPY** as your health care provider. We are committed to your treatment being successful. I, hereby, authorize Golden Bear Physical Therapy to treat my condition as prescribed by the referring physician. _______ **(please initial)**

INSURANCE POLICY

As a courtesy, we have contacted your insurance company to verify your insurance and benefits. According to your insurance company, this is not a guarantee payment. I authorize Golden Bear Physical Therapy all payment for services rendered. _______ **(please initial)**

PRIVACY ACTS (HIPPA)

I also authorize Golden Bear to send all information regarding my injuries/illness to my doctor and/or insurance carrier. I acknowledge that I am the patient (or legal guardian of the patient) listed above, and the information contained on this form has been explained to me. I, also authorize release of medical records. ______ **(please initial)**

I have read, understand, and agree to Authorization of Treatment, the Insurance Policy, and Privacy Acts (Hippa) policy.

_________________________________ _______________________

Patient Signature Date

APPOINTMENT and PAYMENT AGREEMENT

Patients are seen by appointment only. We make every effort to be on time for our patients and ask that you extend the same courtesy to us. If you cannot keep an appointment, please notify our office immediately. This courtesy on your part makes it possible to give an appointment to another person who needs treatment. **We reserve the right to charge $15 for appointments broken or cancelled without 24 hour notice.** _______________ (please initial)

Co-payments and Co-insurance are due at the time of the service.
If you need to arrange a payment plan, please contact our office at (209) 576-0021.

Repeated tardiness or not showing for scheduled appointments 3 or more times will result in your future appointments being cancelled (if you are a workers comp patient, your case manager and physician will be notified).

We appreciate patients arriving early for appointments; however, arriving early does not ensure you will be seen before your scheduled appointment time.

Thank you for your cooperation!

_________________________________ ___________________

Patient Signature or Responsible Party Date

GOLDEN BEAR
PHYSICAL THERAPY
SPORTS INJURY CENTER

HEALTH HISTORY

To insure that you receive a complete and thorough evaluation, please provide us with the most accurate, important, and up-to-date background information. Thank you.

Name: ______________________Date:_____________

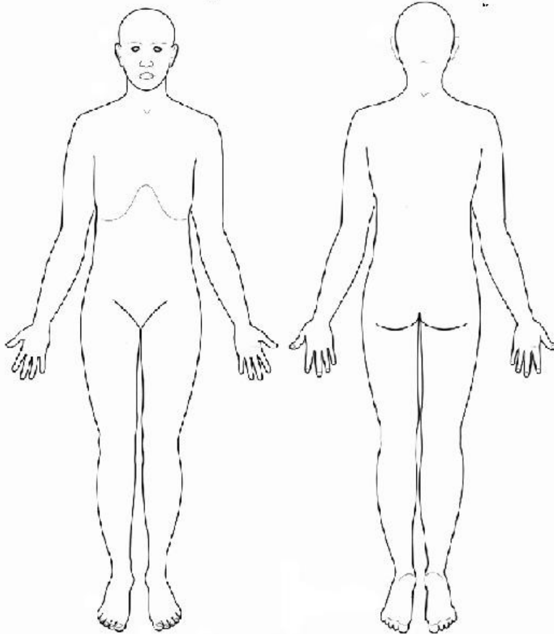
PRESENT CONDITION

Please briefly describe your symptoms: ______________

____

____

Please localize your **pain** or **abnormal** symptoms/ sensations by marking on the body diagram below.



Pain Scale: 1 2 3 4 5 6 7 8 9 10

When did you first notice symptoms: ______________

Did your symptoms begin ***gradually*** *or* ***suddenly****?*
(circle one)

How did your injury occur (if you have had surgery, please answer according to your pre-operative injury):

lifting　　an impact injury
a MVA (car accident)　　a dental appointment
a fall　　throwing
overuse (cumulative trauma)　　an incident at work
degenerative process　　unknown
during recreation/sports　　running
other:_____________________________________

Please list any recent/relevant surgeries or hospitalizations:
Surgery/Hospitalization　　Date

____

____

***Since the onset of your condition, are your symptoms getting*:**
better　　worse　　no change

Have you experienced similar symptoms in the past?　　yes　　no

More than one episode?　　yes　　no

Nature of pain/symptoms:
aching　　occasional
throbbing　　constant
periodic　　other
dull　　sharp

As your day progresses, do your symptoms:
increase　　decrease　　stay the same

Does the pain wake you at night?
yes　　no

Since the onset of symptoms, have you experienced one of the following: *(Check all that apply)*
difficulty controlling bowel or bladder function
fever or chills
numbness
any dizziness or fainting attacks
weakness
unexplained weight change (loss or gain)
night pain/sweats
malaise (vague feeling of bodily discomfort)
problems with vision/hearing

What aggravates your symptoms? *(Check all that apply)*
sitting　　repetitive activities
going to/rising from sitting　　household activities
lying down　　standing
walking　　squatting
up/down stairs　　sleeping
reaching overhead　　coughing/sneezing
reaching in front of body　　taking a deep breath
reaching behind back　　looking up overhead
reaching across body　　swallowing
talking, chewing, yawning　　stress
recreation or sports　　sustained bending
other

What eases your symptoms? *(Check all that apply)*

sitting	walking
heat	exercise
cold	lying down
stretching	massage
wearing a splint/orthotic	medication
rest	other___________
standing	

What type of treatment have you had for this condition?

medication	muscle/skin injections
joint manipulation	chiropractor
exercise	physical therapy
massage therapy	biofeedback
traction	TENS unit
bracing/taping	other__________________
spinal injection	

Have you had any of the following tests for this condition?

X-ray	Bone scan
CT scan	Nerve Conduction Test
MRI	Fluroscope
Arthrogram	Vestibular
Stress test x-ray(Telos)	Other_______________

Test results: _____________________________________

MEDICATION

Please list any and all ***prescription*** *medication you are currently taking for this condition:* ___________________

____

____

Are you currently taking any of the following over-the-counter medications:

Aspirin	vitamins/mineral supplements
Tylenol	Advil/Motrin/Ibuprofen
corticosteroids	other_____________________
antihistamines	

GENERAL HEALTH

How would you rate your general health?

excellent	average	poor
good	fair	

Do you exercise outside of normal daily activities?

5+ days/week	occasionally
3-4 days/week	I do not work out
1-2 days/week	

What kind of athletic or recreational activities do you perform?

____

____

Are you currently employed? yes no

Occupation:_______________________________

Do you smoke?

yes no *packs per day:*________

Are you pregnant?

yes no *months:*______________

MEDICAL HISTORY

Personal medical history:

Cancer	Heart Conditions
Depression	Stroke
Lung Problems	Diabetes
High blood pressure	Arthritis
Thyroid problems	Allergies
Epilepsy/Seizures	Head injury
Multiple Sclerosis	Rheumatoid
Mental/behavioral disorders	Osteoporosis
Parkinson 's disease	Fibromyalgia
Stomach problems	Broken bone
Circulation/vascular problems	Other________

Infectious diseases: ______________________

Have you been exposed to:

HIV/AIDS Tuberculosis Hepatitis

Family or primary care physician:

____

I, the undersigned, state that I have answered this health history completely and to the best of my knowledge:

____

Signature

____

Date