D&D SPORTS MED
DENTON • SANGER • AUBREY

D&D Sports Med

___ Denton ___ Sanger ___ Aubrey

Patient Information
Workers' Comp Patient

Patient Registration Information

Name: (First) (MI) (Last)	Social Security #:	
Date of Birth:	Address:	
Home Phone:	City:	State: / Zip:
Cell Phone:	Email address:	
Sex: Male Female	Marital Status: Single Married Other: _____	

Insured Party/Responsible Party Information

Relationship to Patient:	Social Security #:	
Name: (First) (MI) (Last)	Date of Birth:	
Address:	City:	State: / Zip:
Home Phone:	Work Phone:	
Sex: Male Female	Marital Status: Single Married Other: _____	

Patient's Employer Information

Employer:		
Employer Address:		
City:	State:	Zip:

Insured's Employer Information

Employer:		
Employer Address:		
City:	State:	Zip:

Injury Information

Date of Injury:	Description of Injury/How did injury occur?
Injury occurred: Work Auto accident Other: _____	

Emergency Contact Information

Emergency Contact: Phone #:

Relationship to patient:

How did you hear about us? Physician Friend/Family Phonebook Walk-In
Website Other: _____

Patient/Guardian Signature

I certify that the information provided above is true.

Patient/Guardian Signature: Date:

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Medical History Form

Patient's Name: _____ Patient's Age: _____

Describe the current symptoms for which you are seeking therapy: _____

Date of Injury/onset of condition: _____

Have you ever experienced these symptoms before? Yes (When) _____ No _____

Describe your symptoms (check all that apply):

_____ Pain	_____ Loss of strength	_____ Better with activity
_____ Ache	_____ Loss of motion	_____ Constant pain
_____ Balance Loss	_____ Worse in AM	_____ Night pain
_____ Numbness/Tingling	_____ Worse in PM	_____ Other: _____

Please rate your pain from 0-10 (0= no pain; 10 = emergency room pain)
Current = _____ Best = _____ when I _____ Worst = _____ when I _____

List 3 things you are unable to do as a result of your condition:
1. _____
2. _____
3. _____

What activities increase your symptoms? (Check all that apply)

_____ Sitting	_____ Standing	_____ Rising from chair	_____ Reaching overhead
_____ Walking	_____ Bending	_____ Sleeping	_____ Rolling over in bed
_____ Cooking	_____ Grasping	_____ Writing	_____ Lying on side
_____ Driving	_____ Running	_____ Throwing	_____ Cough/sneeze/strain
_____ Stairs	_____ Dressing	_____ Housework	_____ Computer work
_____ Other: _____			

Please indicate if you are currently experiencing any of the following (Check all that apply):

_____Dizziness	_____ Vision problems	_____ Hearing Loss	_____ Fever/sweats/chills
_____ Malaise	_____ Weakness	_____ Nausea/vomiting	_____ Night pain
_____ Changes in urinary/bowel frequency			

Tests and Results:

1.	X-Rays	YES	NO	Results: _____	Date: _____
2.	MRI	YES	NO	Results: _____	Date: _____
3.	CT Scan	YES	NO	Results: _____	Date: _____
4.	EMG	YES	NO	Results: _____	Date: _____
5.	Other: _____			Results: _____	Date: _____

Have you had surgery related to this condition? Yes _____ No _____

If yes, type of surgery: _____ Date of surgery: _____

Work History:

Are you presently working: Yes No If no, how many total days of work have you missed? _____

Are your work duties? Full Restricted How many hours per week do you work? _____

Who is your employer? _____ What type of work do you do? _____

What critical work duties have been most affected by your injury/condition? _____

_____

Please Indicate how you sustained this condition:

_____ Work related injury
_____ Cause unknown
_____ Motor Vehicle Accident
_____ Athletic/Recreation Injury
_____ Recurrence of prior condition
_____ Injury related to lifting
_____ Chronic
_____ OTHER: _____

Please list any other surgeries you have had, including type and date: _____

_____

_____

Have you had any physical therapy, occupational therapy, or chiropractic care since the beginning of this calendar year (including home health)? Yes _____ No _____

DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING:

Diabetes	Self _____	Family_____	Allergies: _____	Self _____	Family_____
Chest Pain/Angina	Self _____	Family_____	Thyroid Problems	Self _____	Family_____
Heart Disease	Self _____	Family_____	Osteoporosis/Osteopenia	Self _____	Family_____
High Blood Pressure	Self _____	Family_____	Arthritis	Self _____	Family_____
Heart Attack	Self _____	Family_____	Metal Implants	Self _____	Family_____
Pacemaker	Self _____	Family_____	Recent Fractures	Self _____	Family_____
Vascular Disease	Self _____	Family_____	Hernia	Self _____	Family_____
CVA/Stroke/TIA	Self _____	Family_____	Infectious Disease	Self _____	Family_____
Seizures	Self _____	Family_____	Dizziness/Fainting	Self _____	Family_____
Headaches	Self _____	Family_____	Nausea/Vomiting	Self _____	Family_____
Kidney Problems	Self _____	Family_____	Skin Abnormalities	Self _____	Family_____
Cancer: _____	Self _____	Family_____	Sexual Dysfunction	Self _____	Family_____
Bowel/Bladder Problems	Self _____	Family_____	Ringing in your Ears	Self _____	Family_____
Asthma	Self _____	Family_____	Depression	Self _____	Family_____
Liver/Gallbladder Problems	Self _____	Family_____	Anxiety	Self _____	Family_____
Special Dietary Guidelines	Self _____	Family_____	Do you use tobacco?	Self _____	Family_____
Are you Pregnant?	Yes _____	No _____	If Yes. How long have you used tobacco? _____		
Fibromyalgia	Self _____	Family_____	Average weekly usage: _____		
Concussion	Self _____				

If you answered "yes" to any of the above, please explain and give approximate dates: _____

_____

_____

Do you participate in any sports, exercise program, or activities on a regular basis? Yes _____ No _____

If yes, please describe: _____

Is there any other information regarding your past medical history that we should know about?_____

_____

_____

Have you experienced any falls in the last 12 months? Yes _____ No _____ If yes, how many? _____

Have you been injured from a fall during the last 12 months ? Yes _____ No _____

When are you scheduled to see your doctor again? _____

FOR OFFICE USE:

Clinician's Initials: _____

Today's Date: _____

To the best of my knowledge and belief, the information I have given above is accurate and true.

_____ _____ _____

Patient's Signature | Today's Date | Parent/Guardian Signature if applicable

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D&D Sports Med

PATIENT INFORMATION CONSENT FORM

I have been provided with a copy of ***D&D Sports Med*** 's Notice of Information Practices. I understand that ***D&D Sports Med*** may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that D&D Sports Med's PT/OT will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in ***D&D Sports Med***'s Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

_____
Patient Name

_____
Signature

_____
Date

I hereby consent to the release of personal health information (verbal or written) regarding my treatment and/or account information for services rendered at D&D Sports Med to the following individual(s):

_____ Person's Name	_____ Relationship to you
_____ Person's Name	_____ Relationship to you
_____ Person's Name	_____ Relationship to you
_____ My signature	_____ Today's Date

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D&D Sports Med
Worker's Compensation Policy

Thank you for choosing D&D Sports Med as your Physical/Occupational Therapy provider. We are committed to providing the best possible care for you. In order to achieve this goal, we need your assistance in understanding our policies. The following is a statement of our Worker's Compensation Policy. Please read and sign prior to your treatment.

REGARDING INSURANCE:

We will gladly discuss your proposed treatment and answer any questions relating to your worker's compensation insurance. It is our policy to call and verify benefits and employment, and obtain pre-authorization regarding your worker's compensation coverage. Per Texas law, we cannot bill you for any charges incurred as part of therapy for your compensable work injury.

However, Texas law also states that: "A health care provider may pursue a private claim ***only*** when the work-related injury is finally adjudicated by the Division as non-compensable." Should your claim be adjudicated as non-compensable, you will be responsible for any charges incurred here.

_____ **INITIALS**

MISSED APPOINTMENTS

Your attendance of your scheduled appointments is crucial to your recovery. Cancelling your appointment with less than 24 hours notice or especially no-showing for your appointment(s) is not only detrimental to your treatment and recovery, it also prevents us from scheduling someone else in your time slot. All absences and excessive tardiness will be reported to your physician, employer, and adjustor. Chronic non-compliance will result in discharge from your therapy, and a report reflecting non-compliance forwarded to your physician, employer, and adjustor.

_____ **INITIALS**

INFORMATION

I give permission to D&D Sports Med to release information, verbal and written, from my medical record to my physician, insurance company, rehab nurse, case manager, attorney, employer, related health-care provider, or other assignees as it relates to my treatment. I further authorize D&D Sports Med to obtain medical records from my physician or other medical professionals as it relates to my treatment.

_____ **INITIALS**

I have read, understand, and agree to this Worker's Compensation Policy. Any questions or concerns I had have been adequately addressed by the staff of D&D Sports Med. I am also aware of, and understand my responsibility to attend my therapy sessions.

_____
Patient's Signature

_____
Witness' Signature

_____
Date of signatures

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Medications

In order to gain a more comprehensive view of your condition, we need to know what medications you are taking. This includes **prescription medications, over-the-counter medications, vitamins, and any other supplements**. Please complete the form below and bring it with you to your first appointment. (You may bring a different list, but it MUST include all of the required information)

Name of Medication (Name of drug on package)	Dosage (usually in mg. or ounces, etc.)	Frequency (Daily, 2 X day, etc.)	Route of Administration (Orally, injection, etc.)	Changes or Comments
EXAMPLE: Coumadin	3 mg.	Daily	Orally	BIW as of 1/15/14

I attest that the above information is correct and true to the best of my ability. I acknowledge that I should inform my therapist of any changes that occur in my medication while a patient at D&D.

Printed Name

Signed by

Today's Date

Therapist's Signature/Date