BACKtoGOLF PERFORMANCE & FITNESS

NAME_____ DATE OF BIRTH_____

PHONE #_____ CELL#_____ SOCIAL SECURITY #_____
(REQUIRED FOR WORK COMP)

MAILING ADDRESS _____ _____ _____ _____
Street or PO Box City State Zip

REFERRING MD _____ OCCUPATION_____ POSITION_____

Please describe your current complaint or limitation: _____

When did the condition begin? _____

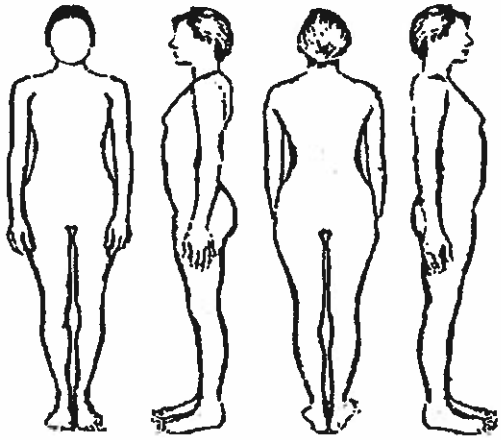
What is your goal for physical therapy? _____

Please describe the nature of your pain & indicate on the picture the location of your symptoms (*select all that apply*):

[ ] Sharp Pain [ ]Dull Pain [ ]Throbbing [ ]Shooting

[ ] Burning [ ]Tingling [ ]Numbness [ ] Tender

[ ]Constant [ ]Frequent [ ] Occasional [ ] Intermittent



Intensity of pain at rest: 0 1 2 3 4 5 6 7 8 9 10

Intensity of pain with movement: 0 1 2 3 4 5 6 7 8 9 10

What causes pain to increase? _____

Date of Surgery (if applicable) _____

Activity Level (Circle One): LOW/SEDENTARY MEDIUM HIGH ATHLETE/SPORTS _____

Please check all boxes that apply:

PAST	PRESENT		PAST	PRESENT	
[ ]	[ ]	High Blood Pressure	[ ]	[ ]	Angina
[ ]	[ ]	Heart Attack	[ ]	[ ]	Stroke
[ ]	[ ]	Asthma	[ ]	[ ]	HIV/AIDS
[ ]	[ ]	Tumor	[ ]	[ ]	Cancer (Location:_____)
[ ]	[ ]	Systemic Lupus	[ ]	[ ]	Hepatitis
[ ]	[ ]	Epilepsy	[ ]	[ ]	Diabetes
[ ]	[ ]	Rheumatoid Arthritis	[ ]	[ ]	Pregnancy
[ ]	[ ]	Drug/Alcohol Dependence	[ ]	[ ]	Tobacco/Smoking
[ ]	[ ]	Other _____			

Current Medications: _____

Hospitalization/Surgical Procedures: _____

X_____ X_____ ____/____/____

Patient Signature **Guardian Signature (if patient is <18 years old)** **Date**

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

BACKtoGOLF PERFORMANCE & FITNESS

I understand that under Health Insurance Portability and Accountability Act (HIPPA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of you *Notice of Privacy Practices*. I also understand that this practice has the right to change its *Notice of Privacy Practices* and that I may contact the practice at any time to obtain a current copy of the *Notice of Privacy Practices.*

PLEASE ASK OUR FRONT DESK IF YOU WOULD LIKE TO RECEIVE A COPY OF THE NOTICE OF PRIVACY PRACTICES.

I have reviewed the NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT above and am signing below to verify that all of my questions have been answered and that I understand all policies as stated above.

X_____ **X**_____ _____/_____/_____

Patient Signature **Guardian Signature (if patient is <18 years old)** **Date**