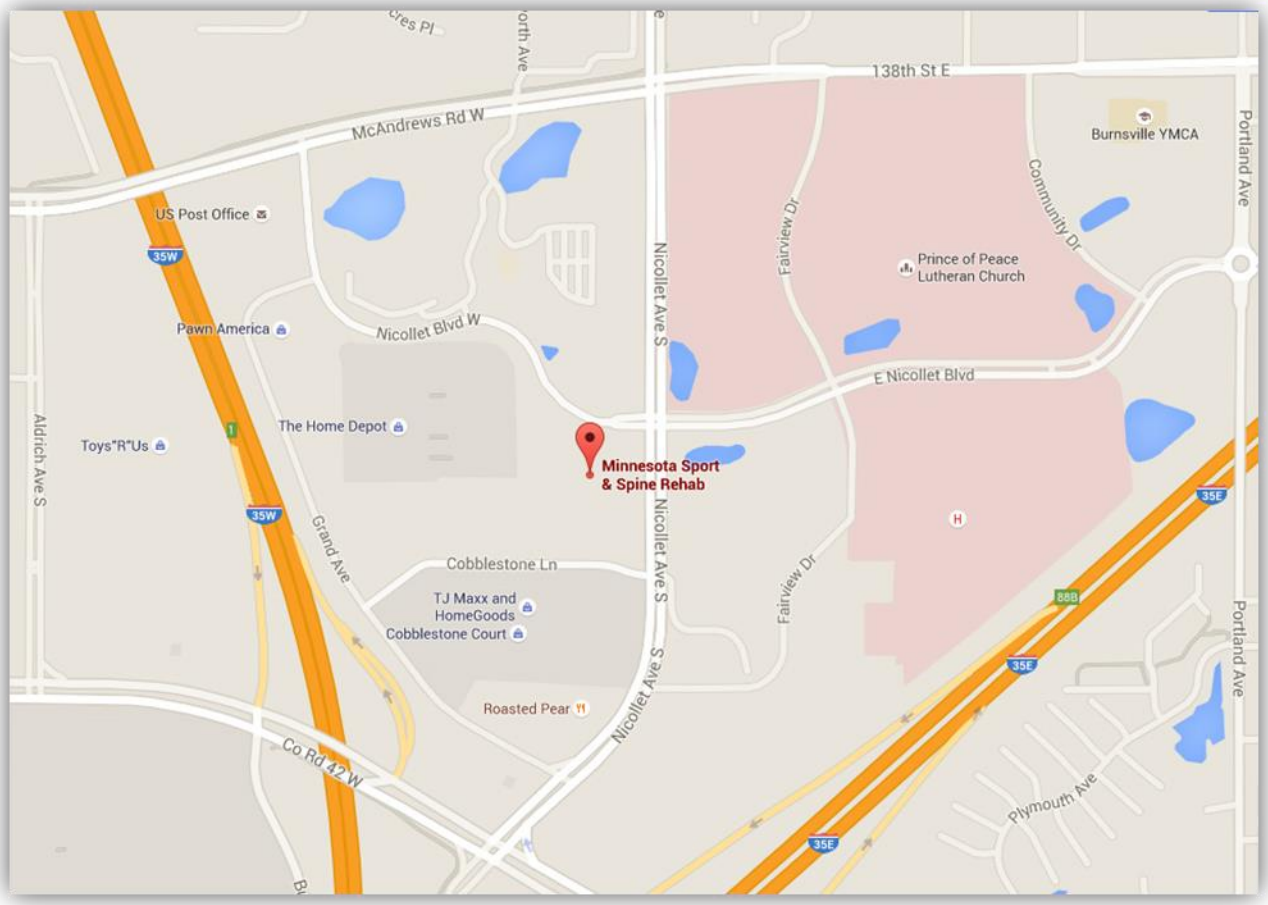


Minnesota Sport and Spine Rehabilitation
14000 Nicollet Avenue, Suite 200
Burnsville, MN 55337
Phone 952-892-6777
Fax 952-892-0792
For detailed directions, visit our website at www.MNSportAndSpine.com

Date: _____ Name: _____

DOB: _____ Acct: _____

Insurance: _____

Patient Health History and Information

Date: ___/___/___ **Age:** _____ **Height:** _____ **Weight:**_____ **Dominant hand:** R L **Could you be or are you pregnant:** Yes No

Sex: M F **Reason for Therapy:**_____

Please describe how your injury/problem occurred (i.e. fall, activity, work, auto, unknown)**:**_____

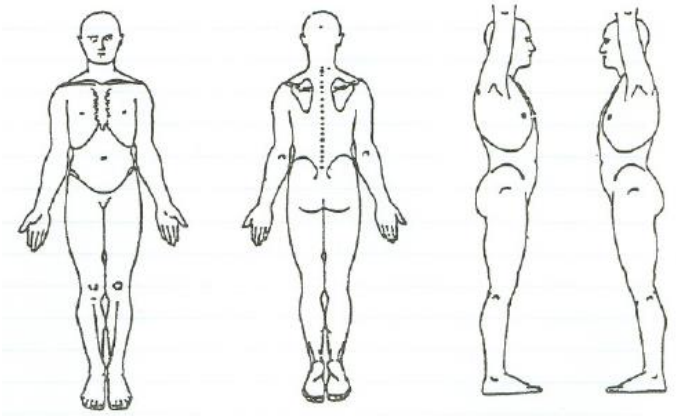
Date of injury or onset of symptoms: ___/___/___ **Recent surgery?** Yes No **Date:** ___/___/___ **Type:**_____

Please list any treatment you have received for this condition (i.e. Therapy, Chiropractor)**:**_____

For this condition have you had any of the following? None X-ray ___/___/___ MRI / CT scan ___/___/___

Injection: type: _____ ___/___/___ Surgery: type:_____ ___/___/___ Other:_____ ___/___/___

Using the key below indicate on the body diagrams where your symptoms are located.
X=Pain //= Numbness **O**=Tingling



Please rate your pain (0=none, 1=minimal, 10=severe)

At present:	0 1 2 3 4 5 6 7 8 9 10
At worst:	0 1 2 3 4 5 6 7 8 9 10
At best:	0 1 2 3 4 5 6 7 8 9 10

Please describe your pain/symptoms

Constant Intermittent Increasing Decreasing Staying the same
Sharp Dull Aching Burning Weakness Throbbing Other:_____

Which side are we seeing you for?: Right Left

What makes your symptoms worse? (i.e. heat, cold, rest, activity)_____

What makes your symptoms better? (i.e. heat, cold, rest, activity)_____

Please indicate your current limitations due to injury:

____ Sitting: _____ ____Standing: _____ ____Sleeping: _____

____ Going from sit to stand ____ Walking _____ ____ Lying down ____ Up/Down stairs

____ Reaching _____ ____ Squatting ____ Bending ____ Looking overhead

____ Taking a deep breath ____ Swallowing ____ Talking / Chewing / Yawning / All (circle one)

____ Turning head ____ Driving ____ Work

____ Self care / Hygiene _____ ____ Home activities _____

____ Repetitive activities _____ ____ Sports / Recreation _____

____ Other:_____

What are your goals for therapy?_____

Since your symptoms began have you had any of the following:

Fever / Chills	Yes No	Unexplained weight change	Yes No
Nausea / Vomiting	Yes No	Night sweats / pain	Yes No
Numbness genital/anal area	Yes No	Problems with vision / hearing / speech	Yes No
Dizziness / Fainting	Yes No	Difficulty with bowel/bladder function	Yes No
Unexplained weakness	Yes No	Other:_____	Yes No
Headaches	Yes No		

Who referred you to Physical Therapy? _____

Primary Physician:_____

How did you hear about MSSR Physical Therapy? Physician Friend/relative Website Previous patient Self Coach Other

Date: _____ Name: _____

DOB: _____ Acct: _____

Insurance: _____

GENERAL HEALTH HISTORY:

Have you had any falls or near falls in the past year? _____ Yes ____ No

Rate your overall health: Excellent Good Average Poor **Do you exercise?** Yes No _____x/week

Do you smoke? Yes No **Do you drink caffeinated beverages?** Yes No ____/week

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Occupation/job title: _____ Self Student Full time Part time Retired Unemployed

Living Situation: Alone Spouse Family Others

Physical activities at work: Sitting Standing Computer use Phone use Repetitive/Heavy lifting Other:_____

Employer:_____ **Current work duty:** Full duty Restricted duty **Work days missed:** _____

QRC (if you have one)**:**_____

Have you or anyone in your immediate (brother, sister, parent, grandparent) **family ever been diagnosed with any of the following:**

Allergies/asthma	Self	Family	No	Kidney problems	Self	Family	No
Cancer	Self	Family	No	Thyroid problems	Self	Family	No
High blood pressure	Self	Family	No	Epilepsy/dizziness	Self	Family	No
Heart trouble/angina	Self	Family	No	Tuberculosis	Self	Family	No
Diabetes	Self	Family	No	Anemia/blood disorder	Self	Family	No
Stroke	Self	Family	No	Multiple Sclerosis	Self	Family	No
Osteoporosis	Self	Family	No	Circular/vascular problems	Self	Family	No
Osteoarthritis	Self	Family	No	Chemical dependency	Self	Family	No
Rheumatoid arthritis	Self	Family	No	Pace maker/metal implants	Self	Family	No
Depression	Self	Family	No	AIDS/HIV	Self	Family	No
Headaches	Self	Family	No	Hepatitis	Self	Family	No
Bladder/bowel problem	Self	Family	No	Other:_____	Self	Family	No

---

Over the past 2 weeks, how often have you been bothered by any of the following problems?

1. Little interest in the pleasure of doing things: **0**- Not at all **1**- Several days **2**- More than half the days **3**- Nearly every day

2. Feeling down, depressed or hopeless: **0**- Not at all **1**- Several days **2**- More than half the days **3**- Nearly every day

Are there any other issues/concerns that you think we should know about that may or may not effect your ability to benefit from physical/occupational therapy treatment: ___Yes ____No _____

_____

Patient Signature:_____ **Date** ____/____/____

Reviewed by Therapist: _____ **Date** ____/____/____

MD follow-up: ____/____/____ □ None Scheduled

With-in 90days of last Medical history completion (date and initial any changes)
– Medical History reviewed by patient, changes noted and reviewed by therapist.

Patient Signature:_____ **Date** ____/____/____

Reviewed by Therapist: _____ **Date** ____/____/____

An Associate of Therapy Partners, Inc.

Patient Name:	Date of birth:	Date Completed:
Allergies/Adverse effects to medications:		

1. In order to provide optimal care it is important for us to maintain an up-to-date list of all your medications .
2. Please fill out the chart below. ****If you already have a complete list of your medications, please bring it and we will make a copy in lieu of completing this form.**

Name of <u>prescription medication</u> (brand or generic)	Dosage	Why are you taking this medication?	How often do you take it?	How do you take it? (by mouth, injection, etc.)
Example: *Lasix*	*20 mg.*	*High blood pressure*	*Two times a day*	*By mouth*

<u>Over the Counter medication</u> or <u>nutritional supplements</u>	Dosage	Why are you taking this medication?	How often do you take it?	How do you take it? (by mouth, injection, etc.)

Patient updated:	Date:		Patient updated:	Date:
Therapist reviewed:	Date:		Therapist reviewed:	Date:

MINNESOTA SPORT & SPINE REHABILITATION (An Associate of Therapy Partners, Inc.)

AUTHORIZATION TO TREAT: I voluntarily consent to therapy care encompassing evaluation and treatment procedures. I acknowledge that no guarantees have been made to me about the results of the exam and/or treatment to be provided in this healthcare facility. I authorize MSSR to provide such treatment. **MY HEALTHCARE PROVIDER, INSURER, OR PLAN MAY REQUIRE A PHYSICIAN REFERRAL OR PRIOR AUTHORIZATION. I MAY BE OBLIGATED FOR PARTIAL OR FULL PAYMENT FOR THERAPY SERVICES RENDERED.** Initials _____

PAYMENT AUTHORIZATION: I understand that all balances designated as 'the patient's responsibility' such as co-insurances, co-payments and deductibles are due and payable to MSSR. I agree to pay the charges for the care and treatment rendered to me that are not coved by insurance including any reasonable collection fees required to collect delinquent accounts. As part of working with my insurance carrier, I recognize that MSSR may be provided with information about my insurance coverage, and that on occasion MSSR may share some of this information with me. However, I understand that MSSR is not responsible for the accuracy of any insurance coverage information shared with me, and that I am solely responsible for reviewing my insurance plan and/or working with my insurance carrier to determine the scope and details of any available insurance coverage. This is not a guarantee of benefits. Initials _____

We have contacted your insurance regarding your benefits. This information will be printed on the registration form for you to review at check in. If your deductible has not been met or you have a balance, we would be happy to receive payment for your therapy services at each visit.

INSURANCE BENEFITS ASSIGNMENT: I authorize that the payment of my insurance benefits be made directly to MSSR for all services delivered; if I am paid directly I will promptly pay MSSR all monies paid to me. Initials _____

HIPAA PRIVACY POLICY: My signature below indicates that I have been given the Notice of Privacy Practices for MSSR. I recognize that outside of purposes for treatment, for payment, for certain healthcare operations or as permitted or required by law I must give my written authorization to MSSR to release any of my protected healthcare information. Initials _____

CANCEL/NO SHOW POLICY: You may be charged $30 if you cancel less than 24 hours prior to your scheduled appointment or do not show up for an appointment. You may request a copy of our Cancelation Policy. Initials _____

RECORD RELEASE: I am aware that MSSR may release any/all medical information acquired in the course of treatment to myself, my insurance company, employer, QRC or other healthcare agencies, professionals, or persons who may provide healthcare services deemed necessary for continuing my medical care. Initials _____

I would like MSSR to disclose my Protected Health Information to individuals other than those listed above. **YES NO**
(If YES, you must complete an Authorization to Release PHI form)

REMINDER CALLS: As a service to patients, we provide appointment reminder call and other calls (ie. Weather closure) that maybe placed using prerecorded message. By providing your number, you consent to receive such calls. Initials _____

Date: _____ **Patient's Printed Name**: _____

Signature of Patient or Patient Representative: _____
(REQUIRED SIGNATURE (Update Annually)

Patient Representatives Printed Name and Relationship if applicable: _____

REVIEW AND INITIAL BELOW ONLY IF APPROPRIATE

MEDICARE PATIENTS ONLY: Are you currently, or in the last 30 days have you received any type of Home Health Services or physical/speech/occupational therapy from a home health care agency, transitional care facility, or nursing home? **YES NO If YES, we cannot treat you until you have been discharged. Medicare will not pay our services.** You may request Medicare Cap information.
Initials_____

SELF REFERRAL OR OUT OF STATE REFERRAL: I understand that if I have been referred by a physician who is not licensed in the state of MN and I am being treated at a clinic in MN, I will be considered a Self-Referral and can be treated for 90 days. After that time, if I would like to continue treatment, I will need to obtain an order from a physician who is licensed in the state of MN. The same 90 day rule pertains if I have not been referred by a physician and I am self-referring. Initials _____

PAYMENT AUTHORIZATION – PROMPT PAY: Your services will not be billed to your insurance company or do not qualify for coverage. Charges must be paid in full at the time of service in order to receive the prompt pay discount. The amount charged is determined by the case's complexity. Cost of the evaluation is $_____and follow up is $_____. If a supply or orthotic is issued, there will be an additional charge. I do not want my services billed to an insurance company, and will not do so myself.
Initials _____