PLEASE SELECT THE SERVICE YOU ARE HERE FOR

PHYSICAL THERAPY	☐
ACUPUNCTURE	☐
MASSAGE	☐
RED CORD	☐
GRASTON TECHNIQUE	☐
DRY NEEDLING	☐
SPORTS SPECIFIC TRAINING	☐

CORE Physical Therapy and Sports Performance

NEW PATIENT REGISTRATION FORM

Thank you for choosing our practice. In order to serve you properly, we need the following information. Completing this information now will help us start your first visit without delay. All information will be confidential.

Date:__________ Patient Name: ______________________________ Date of Birth:__________

Street Address: ____

City/State/Zip:____________________________________ Home Phone:____________________

Cell Phone: ______________________________ Email Address: _________________________

Gender: Male or Female (Circle One) Marital Status:______________________

Emergency Contact:______________________ Phone:__________________________________

Relationship to patient:____

How did you hear about us?____

Referring Physician:________________________ Primary Care Physician:___________________

Is this injury the result of an accident? YES or NO (Circle one) *If no, please skip to next section

What type of accident? AUTO WORK SCHOOL OTHER Date of accident:________________

City & State where accident occurred:____________ Is an attorney involved in your case? YES or NO

Attorney's Name:_______________________________ Phone:____________________________

Address:____

Primary Insurance Company:___________________ Secondary Insurance Company:______________

- I consent to treatment necessary for the care of the above patient
- I authorized release of all medical records, copies of this authorization and any information necessary for my treatment or claim to my health care providers and their billing agents as needed
- I understand payments or charges is due at time of service, unless other financial arrangements are made prior to treatment and I accept full financial responsibility
- I authorized payments of medical benefits to Core Physical Therapy and Sports Performance from my insurance carrier
- I have read and fully understand the above consent for treatment, release of medical information, insurance authorization and mu financial responsibility.

___________________________________ ________________________

Patient Signature Date:

New Patient Medical Health Form

Name: ______________________ Referring Physician: ______________ Date: ____________

Age: ________ Height: ________ Weight: ________ Gender: Female ☐ Male ☐

Describe your reason for today's visit ______________________________

Date of Injury / onset of symptoms: ______________________ _____ Was the onset: Gradual ☐ Sudden ☐

Have you ever had this pain or injury before? Yes ☐ No ☐

If yes, explain: ______________________________

Please list any current prescription medications you are taking: ______________________________

____

Have you taken any over-the-counter medications in the past 2 weeks? *(Please circle Yes or No)*

Yes No Anti-Inflammatory Yes No Decongestant Yes No Vitamins / Supplements

Yes No Antihistamine Yes No Pain Killer Yes No Other

Have you had any diagnostic testing (X-Rays, MRI's, Bone Scan, EMG, etc?) ______________________________

____

Do you: Smoke Yes or No Number of packs / day ________ Drink alcohol Yes or No How often? ________

What are your goals for physical therapy? ______________________________

____

Please list any previous surgeries or any other condition for which you have been hospitalized:

Date (approximate) Surgery / Reason for hospitalization

______________ ______________________________

______________ ______________________________

______________ ______________________________

Have you had physical therapy previously? Yes No **If yes, please provide the following:**

Date (approximate) Injury

______________ ______________________________

______________ ______________________________

______________ ______________________________

Do you have a history of the following (Please circle Yes or No):

Cancer: Yes No
If yes, what type? ______________________________

Heart Disease / Heart Attack: Yes No

If yes, describe ____________________

Allergies: Yes No

If yes, list ____________________

Chemical Dependency (ex: alcoholism): Yes No

If yes, describe ____________________

Angina / Chest Pain	Yes	No
High Blood Pressure	Yes	No
Circulation Problems	Yes	No
Emphysema	Yes	No
Anemia	Yes	No
Stroke	Yes	No
Tuberculosis	Yes	No
Multiple Sclerosis	Yes	No
Pace Maker	Yes	No
HIV / AIDS	Yes	No
Kidney Disease	Yes	No
Depression	Yes	No
Asthma	Yes	No
Diabetes	Yes	No
Epilepsy	Yes	No
Rheumatoid Arthritis	Yes	No
Hepatitis	Yes	No
Thyroid Problems	Yes	No
Osteoporosis	Yes	No

In the past 3 months, have you experienced any of the following?

A change in your health	Yes	No
Fever / Chills / Sweats	Yes	No
Unexplained weight change	Yes	No
Numbness or Tingling	Yes	No
Changes in bowel or bladder function	Yes	No
Dizziness / Lightheadedness	Yes	No
Nausea / Vomiting	Yes	No
Fatigue	Yes	No
Shortness of Breath	Yes	No
Changes in appetite	Yes	No
Difficulty swallowing	Yes	No

For WOMEN:

Are you pregnant?	Yes	No
Are you taking fertility drugs?	Yes	No

Date of last physical examination: ____________________

____________________ Patient Signature

____________________ Date

____________________ Parent Signature for Minor

____________________ Date

CORE STAFF ONLY – Treating PT has review medical history with patient

____________________ **Physical Therapist Signature & License Number**

____________________ **Date**

Consent for Care

I, undersigned, consent the physical therapy treatment
administered by CORE Physical Therapy and Sports Performance (CORE PT/SP)

Consent for Use and Disclosure of Protected Health Information

I consent to the use or disclosure of my protected health information by CORE Physical Therapy & Sports Performance for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations. I understand that diagnosis or treatment of me may be conditioned upon my consent as evidence by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. CORE PT/SP is not required to agree to the restrictions that I may request. However, if CORE PT/SP agrees to the restriction that I request, the restriction is binding on CORE PT/SP. Your request must be in writing and it must state the specific restriction requested and to whom you want the restriction to apply.

I have the right to revoke this consent, in writing, at any time, except to the extent that CORE PT/SP has taken action in reliance on this consent.

My "protected health information" means health information, including demographic information, collected from me and created or received by my therapist, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical therapy or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review CORE PT/SP. Notice of Privacy Practices prior to signing this document. CORE PT/SP notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health care operations of CORE PT/SP. This Notice of Privacy Practices also describes my rights and CORE PT/SP duties with respect to my protected health information. CORE PT/SP reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Please be advised that CORE PT/SP practices an open gym environment. This means that if your treating provider is discussing your private health information with you, someone in close proximity may overhear the conversation. If you have concerns with this, please bring this to the attention of your therapist.

____

Patient Signature (or parent if minor) Date

Dear Patient,

Welcome to CORE Physical Therapy & Sports Performance. Thank you for your confidence and trust in scheduling an appointment with our clinic. We are always dedicated to quality care for all our patients and we are always here to discuss your problems. Together we will work through the most appropriate solution. To ensure this, we are providing some simple guidelines to follow:

1) We require 24 hours notice in the event of a cancellation.
2) Please be prompt with your scheduled appointment so we can maximize your treatment. If you are arriving late your treatment time will be limited.
3) Co-payments are due at the time of service. We accept payments by credit card, cash or check
4) For your health's benefit we have developed both a formal evaluation process and a discharge process. In each of these, the Physical Therapist may prepare a report for your doctor.
5) Please bring or wear proper clothing to make your body part (s) accessible for treatment.
6) Please be compliant with your home exercise program. This will help to accelerate your recovery time.
7) In case of inclement weather, please call ahead of time to confirm your appointment
8) Most importantly, please communicate with your therapist! The more information that is known, the better we can conquer your problem.

By following these simple guidelines, together we can reach your goal in the shortest amount of time. Thank you again for choosing us as your rehabilitation provider.

Please sign to acknowledge that you have read and understood the guidelines.

______________________	______________
Patient signature	Date
______________________	______________
Signature of Legal Guardian, Health Care Agent or other Personal Representative	Date

Notice of Privacy
Practices & Patient Acknowledgement

To Our Valued Patient:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation and money. We want you to know that all of our employees, managers and therapists continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule". We strive to achieve the very highest standards of ethics and integrity when performing services to our patients.

It is our policy to properly determine appropriate use of PHI in accordance with the government rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

It is our policy to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of privacy and integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

NOTICE OF PRIVACY

The department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule provides standards for health care providers to follow when disclosing health information about the patient that is needed to carry out treatment, payment or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information. We want to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. You may request restrictions pertaining to parties you do not want PHI released to. You will be asked to authorize release of PHI to any party that is not directly connected to your treatment or payment of health care operations.

If you have any questions, comments or objectives to the privacy policies on this form, please ask to speak with our HIPAA Privacy Officer. You have the right to review our entire notice of privacy policies upon request.

Please sign this form to acknowledge that you have read this notice of our privacy policies:

Patient Name: ______________________ Signature: ______________________

Date: ______________________

If minor, signature of parent or guardian: ______________________

For Office Use Only

A "good faith effort" was made to get a signature from the patient. Signature was not attained due to the following:

____

To our valued **CORE** patients:

Please be advised that your insurance carrier may elect to mail payments (checks) directly to you for treatment at our facility. If this should occur, simply endorse the back of the check and bring it to our office so we may apply the payment to your account.

______________________________ ____________
Patient Signature Date

______________________________ ____________
Signature of Legal Guardian, Health Care Agent or other Personal Representative Date

Wong-Baker FACES Pain Rating Scale

Tell Us If You Have Pain

Rating	Face	Description
10 9		Worst Possible Pain *(El peor dolor)*
8 7		Very Severe Pain *(Un dolor muy fuerte)*
6 5		Severe Pain *(Un dolor fuerte)*
4 3		Moderate Pain *(Un dolor moderato)*
2 1		Mild Pain *(Un dolor suave)*
0		No Pain *(Sin dolor)*

What is your:

1) HEIGHT______(inches)
2) WEIGHT________(lbs)

0= Very happy, no hurt

1= Hurts just a little bit

2= Hurts a little more

3= Hurts even more

4= Hurts a whole lot

5= Hurts as much as you can imagine (Don't have to crying to feel this much pain)

VEIN SCREENING FORM
Please complete left side of form only.

Date: ____________ Appt Time: ____________ Screening Provider: ____________

Name: ____________ Primary Care Physician: ____________

DOB: ____________ Sex: ☐M ☐F Insurance Provider: ____________

How did you hear about us? ____________

I. Vascular History

Do you have or have you ever been diagnosed with:

Varicose vein problems	☐ Y ☐N	Leg: ☐R ☐L
Phlebitis (vein redness/tenderness)	☐ Y ☐N	Leg: ☐R ☐L
Blood clots	☐ Y ☐N	Leg: ☐R ☐L
Deep vein thrombosis (DVT)	☐ Y ☐N	Leg: ☐R ☐L
Saphenous vein reflux	☐ Y ☐N	Leg: ☐R ☐L

Do you experience any of the following in your leg(s):

Aching/pain	☐ Y ☐N	Leg: ☐R ☐L
Heaviness	☐ Y ☐N	Leg: ☐R ☐L
Tiredness/fatigue	☐ Y ☐N	Leg: ☐R ☐L
Itching/burning	☐ Y ☐N	Leg: ☐R ☐L
Swelling	☐ Y ☐N	Leg: ☐R ☐L
Cramps	☐ Y ☐N	Leg: ☐R ☐L
Restless legs	☐ Y ☐N	Leg: ☐R ☐L
Throbbing	☐ Y ☐N	Leg: ☐R ☐L
Skin or ulcer problems	☐ Y ☐N	Leg: ☐R ☐L
Other:	☐ Y ☐N	Leg: ☐R ☐L

Which of the following do you currently do to improve your leg vein symptoms:

Medication for pain	☐ Y ☐N	What? ____________
Elevation of legs	☐ Y ☐N	What? ____________
Wear support hose	☐ Y ☐N	What? ____________

II. Family History

Have any of your family members had:

Varicose veins	☐ Y ☐N	Who? ____________
Vein stripping	☐ Y ☐N	Who? ____________
Blood coagulation disorder	☐ Y ☐N	Who? ____________
Blood clots	☐ Y ☐N	Who? ____________
Stroke, heart attacks or pulmonary emboli	☐ Y ☐N	Who? ____________

III. Vein Treatment History

Have you ever been treated for varicose veins with:

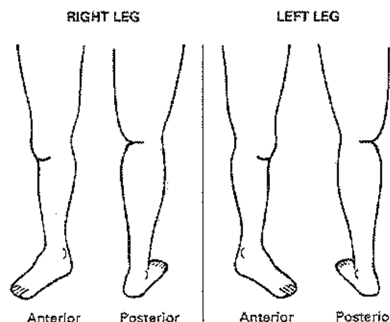
Sclerotherapy	☐ Y ☐N	Leg: ☐R ☐L
Laser therapy (spider veins)	☐ Y ☐N	Leg: ☐R ☐L
Phlebectomy	☐ Y ☐N	Leg: ☐R ☐L
Vein stripping surgery	☐ Y ☐N	Leg: ☐R ☐L
RF ablation (VNUS Closure®)	☐ Y ☐N	Leg: ☐R ☐L

IV. Personal Activities List

Does your work require:

Prolonged standing periods	☐ Y ☐N	
Prolonged sitting periods	☐ Y ☐N	
Do you exercise regularly?	☐ Y ☐N	
Do you smoke?	☐ Y ☐N	
Pregnancies	☐ Y ☐N	How many? ___

V. Vein Screening (to be completed by screening provider)



Physical Exam:

CEAP Clinical Signs:

RIGHT LEG (check all that apply)

☐ No signs of venous disease ☐ Spider veins
☐ Visible varicose veins ☐ Edema
☐ Pigmentation ☐ Healed ulcers ☐ Active ulcers

LEFT LEG (check all that apply)

☐ No signs of venous disease ☐ Spider veins
☐ Visible varicose veins ☐ Edema
☐ Pigmentation ☐ Healed ulcers ☐ Active ulcers

Clinical Assessment:

☐ Chronic venous insufficiency	☐ R ☐L
☐ Other: ____________	☐ R ☐L

Treatment Plan:

☐ Duplex ultrasound	☐ R ☐L
☐ Sclerotherapy	☐ R ☐L
☐ Medical compression stockings	☐ R ☐L
☐ Other: ____________	☐ R ☐L

Screening Provider Signature: ____________

Follow-Up Appointment

Date: ____________ Time: ____________

Physician: ____________

Physician Phone Number:

NOTES:

Acupuncture Informed Consent

I, the undersigned, agree to Acupuncture Treatment and have read and understood the following possible ill-effects that occur in some people, at some times, despite all usual care.

Fainting may occur, particularly if the patient is very hungry, very tired, very nervous or under the influence of alcohol or drugs. Patients will usually be treated lying down to minimize this possibility. Patients should arrive for treatment well rested, well fed and sober to prevent fainting from occurring.

Tiny bruising occurs if the Acupuncture site is moved by the patient during treatment or if a vessel is nicked during insertion. If the patient requires needles to be moved for any reason, they should lie still and ask the therapist to remove the needles.

All infection is avoided by use of sterile equipment. Sterility of needles is guaranteed by the Acupuncturist and by the manufacturer of the disposable equipment.

Please notify your practitioner of any pre-existing health conditions, including allergies, food sensitivities, thyroid conditions, if you are pregnant or may become pregnant and of any medications you are currently taking.

____
Print Name

____
Signature

____
Date