Welcome to SportMedicine of Atlanta

We strive to provide our patients with excellent service and quality care. Our commitment to your well-being and health care is something that we at ***SportsMedicine of Atlanta*** take very seriously.

Your commitment to your physical therapy program is critical to your success. We will recommend treatment and set goals for you. In order to reach those goals you must do your part and your most important part is to make each and every appointment.

We will give you an appointment card to keep track for your appointments. If you should misplace this, please give us a call to review your appointment dates. We expect you to keep all your appointments; however should you need to cancel please note that we require a 24-hour notice.

If you need to cancel please call our office within 24-hours of your scheduled appointment to reschedule. Our Phone number is 770-979-1400.

If you do not show for your scheduled appointment and have not called to cancel, you may be charged $25 for the missed appointment.

If you miss 3 consecutive appointments we may need to discontinue your treatment.

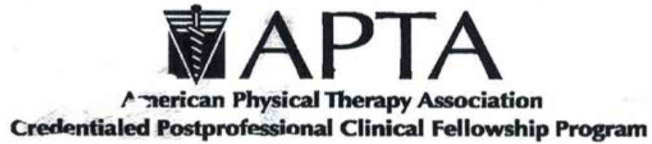
We thank you for choosing ***SportsMedicine of Atlanta*** and we are looking forward to working with you and helping you reach your goals.

The Staff at SportsMedicine of Atlanta

I have read and understand this policy:

______________________________ ______________________________

Patient/Guardian Date



PATIENT REGISTRATION

Presenting Area of Symptoms to be Diagnosed and Treated:

____

Today's Date: ________________

Name:

____
First MI Last

Address:

______________________________ ______________________________
Street PO Box Apt #

Address:

____
City State Zip

Home Phone: _____-______-_______ **Work Phone:** ______-______-________

Cell Phone: ______-______-_______

SS#: _______-_______-_______ **Male or Female** **Marital Status: M S D**

Date of Birth: ______________________ **E-Mail:** __________________________

How did you hear about us?

____

<u>Employer Information</u>

Occupation: ____

Employer: ____

Address: ______________________________ ______________________________
Street PO Box Apt #

Address: ____
City State Zip

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Primary Health Insurance Information

Primary Insured Name: ______________________________

Insured Date of Birth: ______________________________

Relationship to the Insured: ______________________________

Insured Phone #______________________________

Insured Address if Different from Patient:

Address: ______________________________

Street City State Zip

Health Insurance Co Name: ______________________________

Ins Phone # : ______________________________

Address: ______________________________

Street City State Zip

Group Number: ______________________________

ID Number: ______________________________

Contact Name: ______________________________

Secondary Health Insurance Information

Primary Insured Name: ______________________________

Insured Date of Birth: ______________________________

Relationship to insured: ______________________________

Insured Phone # : ______________________________

Insured Address if Different from Patient:

Address: ______________________________

Street City State Zip

Health Insurance Co Name: ______________________________

Ins Phone # : ______________________________

Address: ______________________________

Street City State Zip

Group Number: ______________________________

ID Number: ______________________________

Contact Name: ______________________________

CONSENT TO TREATMENT

I herebv authorize the professional staff at *SportsMedicine of Atlanta* to examine, diagnose and treat me for the signs and symptoms I present with.

Patient Signature	**Date**
Patient Printed Name	**Staff Witness Signature**
Parent or Guardian Signature (if under 18)	**Date**
Parent or Guardian Printed Name	**Staff Witness Signature**

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO HEALTH PROVIDER

Insurance Company/Companies Name(s):

____

I hereby instruct the above named insurance company/companies to pay by check made out to and mailed directly to: "*SportsMedicine of Atlanta*" for professional or medical expenses allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee and I have agreed to pay, in a current manner, any balance of said professional fees for non-covered services and/or fees, over and above the insurance payment or as required by my insurance policy. I understand that "*SportsMedicine of Atlanta*" complies with HIPPA and will protect my Protected Health Information (PHI) and will use it as allowable by law in the treatment, billing and collection pertaining to my care until my case is closed and full payment is received. I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney for the purpose of securing payment under this policy of insurance or to any Medical Provider associated with my case to effectively care for me. The authorization is in effect until 90 days from the date the last bill is collected.

HIPPA REGULATIONS A photocopy of this Assignment shall be considered effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney for the purpose of securing payment under this policy of insurance under the HIPPA guidelines.

Patient Name (Printed)	**Date**	**Patient Signature**
Parent or Guardian (Printed)	**Relationship**	**Parent or Guardian Signature**

Witness ______________________________

Date ______________________________

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I, ___________________ hereby give my written consent that SportsMedicine of Atlanta **release** any medical or billing records, upon request, to an insurance carrier, legal office, or other medical facility. I also give SportsMedicine of Atlanta permission to **obtain** any medical or billing records from an insurance carrier, legal office, or other medical facility.

Patient Signature　　　　　　　　　　Date

_______________________________________ _______________________________________

Witness Signature　　　　　　　　　　Date

_______________________________________ _______________________________________

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SPORTSMEDICINE OF ATLANTA
MEDICAL HISTORY AND SYSTEMS REVIEW

Date: _______

Name ______________________ **Age** ______________
Height ______________ **Weight** _______ **Occupation** ______________
Leisure Activities ______________________
Date of Injury ______________ **Sex** ______________
Describe the reason for your visit ______________________

When was the onset of your problem ______________________
Onset (Check One) Gradual _______ Sudden _______
How did the problem occur? ______________________
Was the injury a CONTACT or NON-CONTACT injury? ______________________
Did you hear any NOISE associated with the onset of the injury? ______________________
Where was the pain initially felt? ______________________
Now, where is the pain? ______________________

Type of Pain Dull _______ Sore _______ Constant _______ Intermittent _______
Sharp _______ Throbbing _______ Bruised _______ Burning _______

Have you had any previous or similar problems? ______________________
Did you have SWELLING immediately? ______________________
What is the length of time your symptoms have been present? ______________________

Are you CURRENTLY seeing any of the following:

Medical Doctor	YES	NO
Osteopath	YES	NO
Dentist	YES	NO
Psychiatrist/Psychologist	YES	NO
Physical Therapist	YES	NO
Chiropractor	YES	NO

If you have been seen by any of the above during the past three months, please describe for what reasons (illness, medical condition, physical exam, etc): ______________________

Please list any surgeries or other conditions for which you have been hospitalized, including the approximate date and reason for the surgery or hospitalization:

Date	Surgery / Hospitalization / Reason

Please describe any injuries for which you have been treated (including fractures, dislocations, sprains, strains) and the approximate date of injury:

Date	Injury

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Which of the following OVER-THE-COUNTER medications have you taken in the last week:

Aspirin	YES	NO
Tylenol	YES	NO
Advil/Motrin/Ibuprofen	YES	NO
Laxatives	YES	NO
Decongestants	YES	NO
Antacids	YES	NO
Vitamins/Mineral Supplements	YES	NO
Antihistamines	YES	NO
Other ______________		

Please list any PRESCRIPTION medication that you are currently taking (including pills, injections, and/or skin pat

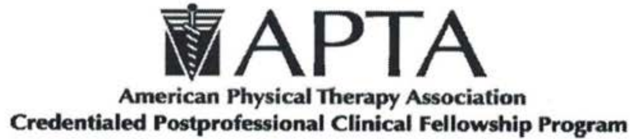
____
____
____
____
____
____

How much caffeinated coffee or other caffeine containing beverages do you drink per day? ______________
How many packs of cigarettes do you smoke per day? ______________
How many days per week do you drink alcohol? ______________

Have you or any of your family EVER been diagnosed as having any of the following:

Cancer	YES	NO
If yes, please describe what kind: ______________		
Heart Problems	YES	NO
High Blood Pressure	YES	NO
Asthma	YES	NO
Emphysema	YES	NO
Chemical Dependency (e.g. alcoholism)	YES	NO
Thyroid problems	YES	NO
Diabetes	YES	NO
Multiple Sclerosis	YES	NO
Rheumatoid Arthritis	YES	NO
Other Arthritic Conditions	YES	NO
Depression	YES	NO
Hepatitis	YES	NO
Tuberculosis	YES	NO
Stroke	YES	NO
Kidney Disease	YES	NO
Anemia	YES	NO
Epilepsy	YES	NO
Other ______________		

Date of last complete physical exam:
Month ________ Year ________ Physician ______________________



Patient Medical Information

In the past, have you had?

Yes	No		
_____	_____	Fractures/Broken Bones	What area ___________________ When ___________________
_____	_____	Sprains/Strains	What area ___________________ When ___________________
_____	_____	Surgeries	What area ___________________ When ___________________
_____	_____	Medical conditions or major illness	Please Specify ______________________

Please provide a list of **all** medications you are currently taking. ____

____

Any personal history of Hypertension/Diabetes/Cancer? Explain ____

Are you pregnant? ___ yes ___ no Other important information __________________________

Are you currently working? ___ yes ___ no If no, is it because of this injury? ___ yes ___ no

Have you had an injury to this area before? ___ yes ___ no If yes, explain ________________________________

____

What is your occupation and specific need of your job that you need help with? ____________________________

____

Do you participate in any hobbies or athletics that you have difficulty doing or would like to return to? If so, what are they? ____

Name all physicians, chiropractors, specialists, physical therapists, etc. you have seen in regards to this injury.

_____________________ _____________________ _____________________

Have you had any of the following in regards to this injury: (Circle all that apply)

Cat Scan MRI Bone Scan X-Rays Other ____________________

In case of emergency, who should we contact? Name: ____

Phone _______-________-________________ Relationship ________________________

____ ___________________________________

Patient Signature Date

SPORTSMEDICINE OF ATLANTA
Have You Had, Or Do You Experience:

Cardiovascular System	YES	NO
Elevated cholesterol	___	___
Sweating associated with pain	___	___
Palpitations	___	___
Swelling of extremities	___	___
History of Smoking	___	___
Orthopnea (difficulty breathing)	___	___

GI System	YES	NO
Difficulty swallowing	___	___
Heartburn	___	___
Jaundice (yellow appearance)	___	___
Specific food intolerance	___	___
Constipation	___	___
Diarrhea	___	___
Change in color of stool	___	___
Rectal bleeding	___	___
Gall bladder problems	___	___
Liver Problems	___	___

G.U. System	YES	NO
Dysuria (painful urination)	___	___
Hematuria (blood in urine)	___	___
Incontinence	___	___
Frequency of urination	___	___
Urinary urgency	___	___
Vaginal discharge	___	___
Dysmenorrhea (painful menstruation)	___	___
Post menopausal vaginal bleeding	___	___
Painful intercourse	___	___
Infertility	___	___
Hx of STD	___	___
Date of Last Period	___/___/___	

Pulmonary System	YES	NO
Dyspnea (labored breathing)	___	___
Wheezing	___	___
Prolonged cough	___	___
Sputum production	___	___
amount / color: ________________		

Endocrine System	YES	NO
Excessive thirst	___	
Excessive hunger	___	___
Polyuria (large volume of urine)	___	___
Excessive sweating	___	___
Fatigue	___	___
Weakness	___	___
Thyroid problems	___	___

Neurological System	YES	NO
Ataxia (poor muscular coordination)	___	___
Memory lapses	___	___
Confusion	___	___
Head Trauma	___	___
Neurological disorder	___	___
Tremors	___	___
Slurred speech patterns	___	___
Hearing/Visual disturbances	___	___

Other Systems	YES	NO
ENT (ears, nose, throat)	___	___
Integumentary (skin)	___	___
Lymphatic	___	___
Psychiatric	___	___
Musculoskeletal	___	___

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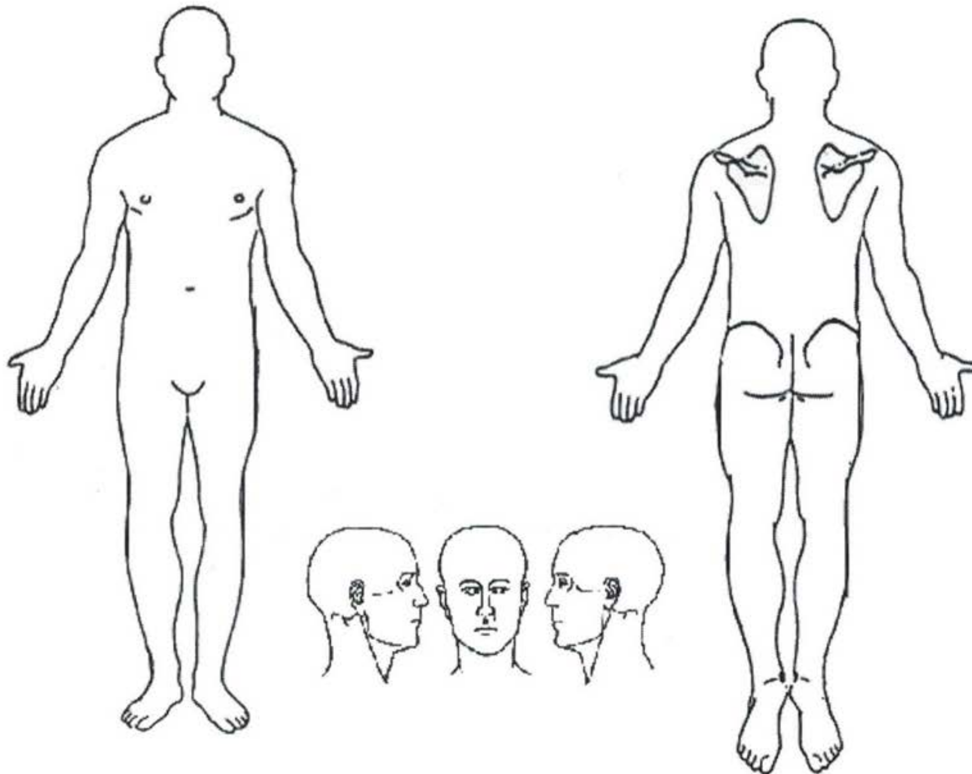
Where is your pain?

Please mark on the drawings below the areas where you feel your pain.



Please mark an **X** upon the line in the area which best indicates your current pain level:

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OSWESTRY LOW BACK PAIN AND DISABILTY QUESTIONNAIRE

Fairbank et al (1980)

Instructions: For each of the next 10 statements, place a check mark or X in the box next to the response which best reflects how you are feeling right now.

1. Pain Intensity	**2. Personal Care (Washing, Dressing, Etc.)**
☐ I can tolerate the pain I have without having to use painkillers. ☐ The pain is bad, but I can manage without painkillers. ☐ Painkillers give complete relief from pain. ☐ Painkillers give moderate relief from pain. ☐ Painkillers give very little relief from pain. ☐ Painkillers have no effect on the pain and I do not use them.	☐ I can look after myself normally without causing extra pain. ☐ I can look after myself normally, but it causes extra pain. ☐ It is painful to look after myself, and I am slow and careful. ☐ I need some help to manage most of my personal care. ☐ I need help every day in most aspects of self-care. ☐ I do not get dressed. I wash with difficult and stay in bed.
3. Lifting	**4. Walking**
☐ I can lift heavy objects without extra pain. ☐ I can lift heavy objects, but it gives extra pain. ☐ I can't lift heavy objects from off of the floor, but if they are conveniently positioned (e.g. on a table), I can manage. ☐ I can't lift heavy objects, but I can manage light to medium ones. ☐ I can only lift very light weights. ☐ I cannot lift or carry anything at all.	☐ Pain does not prevent me from walking any distance. ☐ Pain prevents me from walking more than 1 mile. ☐ Pain prevents me from walking more than ½ mile. ☐ Pain prevents me from walking more than ¼ mile. ☐ I can only walk using a stick or crutches. ☐ I am in bed most of the time and have to crawl to the toilet.
5. Sitting	**6. Standing**
☐ I can sit in any chair as lone as I like. ☐ I can sit in my favorite chair as long as I like. ☐ Pain prevents me from sitting more than 1 hour. ☐ Pain prevents me from sitting more than 30 minutes. ☐ Pain prevents me from sitting more than 10 minutes. ☐ Pain prevents me from sitting at all.	☐ I can stand as long as I want without extra pain. ☐ I can stand as long as I want, but it gives extra pain. ☐ Pain prevents me from standing for more than 1 hour. ☐ Pain prevents me from standing for more than 30 minutes. ☐ Pain prevents me from standing for more than 10 minutes. ☐ Pain prevents me from standing at all.
7. Sleeping	**8. Sex Life**
☐ Pain does not prevent me from sleeping well. ☐ I can sleep well only by using tablets. ☐ Even when I take tablets, I have less than 6 hours of sleep. ☐ Even when I take tablets, I have less than 4 hours of sleep. ☐ Even when I take tablets, I have less than two hours of sleep. ☐ Pain prevents me from sleeping at all.	☐ My sex life is normal and causes no extra pain. ☐ My sex life is normal, but causes some extra pain. ☐ My sex life is nearly normal, but is very painful. ☐ My sex life is severely restricted because of pain. ☐ My sex life is nearly absent because of pain. ☐ Pain prevents any sex life at all.
9. Social Life	**10. Traveling**
☐ My social life is normal and gives me no extra pain. ☐ My social life is normal, but increases the degree of pain. ☐ I can't participate in more energetic activities (e.g. tennis). ☐ Pain restricts my social life, and I don't go out as often. ☐ Pain restricts my social life to home. ☐ I have no social life because of pain.	☐ I can travel anywhere without pain. ☐ I can travel anywhere, but it gives me extra pain. ☐ Pain is bad when I travel, but I manage journeys over 2 hours. ☐ Pain restricts me to journeys of less than 1 hour. ☐ Pain restricts me to short, necessary journeys of less than 30 minutes. ☐ Pain prevents me from traveling (except to my health practitioner).
11. Changing Degree of Pain	
☐ My pain is rapidly getting better. ☐ My pain fluctuates, but is definitely getting better. ☐ My pain seems to be getting better, but improvement is slow. ☐ My pain is neither getting better nor worse. ☐ My pain is gradually worsening. ☐ My pain is rapidly worsening.	

Functional Interference Estimate

For each question below, please circle the appropriate number according to the following scale:

0	1	2	3	4	5
Pain usually or severely interferes		Pain occasionally interferes			Pain rarely interferes

Rate your ability to stand or sit	**0**	**1**	**2**	**3**	**4**	**5**
Rate your ability to engage in social activities (clubs, visiting relatives, etc).	**0**	**1**	**2**	**3**	**4**	**5**
Rate your ability to walk.	**0**	**1**	**2**	**3**	**4**	**5**
Rate your ability to participate in recreational activitie: (dancing, etc).	**0**	**1**	**2**	**3**	**4**	**5**
Rate your ability to perform work.	**0**	**1**	**2**	**3**	**4**	**5**

Reprinted with permission. Toomey TC, Mann D, Hernandez JT, Abashian SW. Psychometric Characteristics of a Brief Measeure of Pain-Related Functional Impairment. *Arch Phys Med Rehabil 1993; 74:1305-1308.*

Please describe the pain you have these days:

For each group of words, choose the ONE that best applies.

If there are groups of words that do not apply, you may omit them.

1.
Flickering
Quivering
Pulsing
Throbbing
Beating
Pounding

2.
Jumping
Flashing
Shooting

3.
Pricking
Boring
Drilling
Stabbing

4.
Sharp
Cutting
Lacerating

5.
Pinching
Pressing
Gnawing
Cramping
Crushing

6.
Tugging
Pulling
Wrenching

7.
Hot
Burning
Scalding
Searing

8.
Tingling
Itchy
Smarting
Stinging

9.
Dull
Sore
Hurting
Aching
Heavy

10.
Tender
Taut
Rasping
Splitting

11.
Tiring
Exhausting

12.
Sickening
Suffocating

13.
Fearful
Frightful
Terrifying

14.
Punishing
Grueling
Cruel
Vicious
Killing

15.
Wretched
Blinding

16.
Annoying
Troublesome
Miserable
Intense
Unbearable

17.
Spreading
Radiating
Penetrating
Piercing

18.
Tight
Numb
Drawing
Squeezing
Tearing

19.
Cool
Cold
Freezing

20.
Nagging
Nauseating
Agonizing
Dreadful
Torturing