SPECIALIZED ORTHOPEDIC SOLUTIONS

Patient History Form

Name:_____ **Sex:** ○Male ◉Female Age: _____ Height:_____ft_____in Weight_____lbs

1. Are you currently working? ◉ Yes. ○ No. (last day worked:_____)
2. Please give your occupation and physical demands:_____.

   _____.
3. List your complaints or problems:_____.

4. Please rate the quality of pain between 1 - 10.

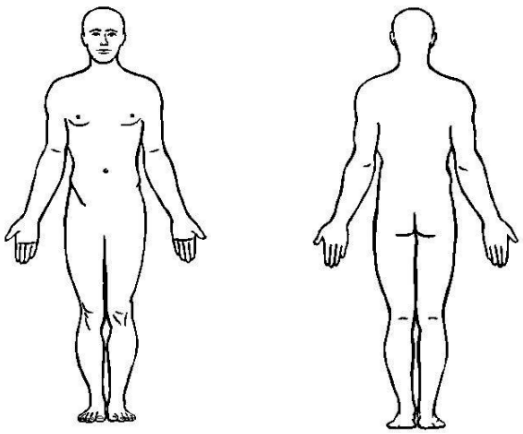
   ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10

   mild ***moderate*** ***extreme pain***

5. Please indicates painful areas by shading the models to the right:
6. Which of the following describes your pain: (check all that apply)

   ☐ **Sharp** ☐ **Dull** ☐ **Aching** ☐ **Tingling**

   ☐ **Numb** ☐ **Constant** ☐ **Variable** ☐ **Radiating**



7. How did your problem start? :_____.

   _____.
8. Are there any positions or activities that make your pain worse?_____.

   _____.
9. Are there any positions or activities that lessen your pain?_____.

   _____.
10. Please list any medication(s) you are taking for this problem:_____.

    _____.
11. What tests or treatment have you received for this problem?_____.

    _____.

Past Medical History

12. Have you ever had any of the following?

Heart / Vascular Disease	***Yes/No***
Congestive Heart Failure	
High Blood Pressure / Hypertension	
Heart Attacks	
Stroke / TIA	
Pacemaker	
Atherosclerotic Disease (CAD)	
Angioplasty	
Valve Disease	
Arrythmia	
Bypass Graft (CABG)	
Angina	

Lung Disease	***Yes/No***
Chronic Obstructive Disease (COPD)	
Recent Pneumonia	
Asthma	
Acquired Respiratory Distress Syndrome	
Emphysema	

General Medical Conditions	***Yes/No***
Arthritis (rheumatoid/osteo)	
Allergies	
Neurological Conditions (MS, Parkinson's, etc)	
Headaches	
Gastrointestinal Disease (ulcers, hernia, IBS, Crohns, liver/gall baldder)	
Visual Impairments	
Back Pain (neck, back, disc disease, etc)	
Hepatitis	
HIV / AIDS	
Osteoporosis	
Depression	
Kidney / Bladder / Prostate issues	
Incontinence	
Hearing Impairments	
Sleep Dysfunction	
Prosthesis	
Implants (metal, etc.)	
Cancer (active / remission)	
Diabetes	
Previous Surgeries (please write down	

13. Do you have metal anywhere in your body (other than teeth)? If so, where? _____

14. Are you pregnant? If yes, how many weeks/months? _____

15. List all allergies you have: _____

16. Have you ever had physical therapy treatments? If yes, when and for what? _____

17. Have you had any physical/occupational/chiropractic/speech therapy this year? If yes, how many treatments? _____

(Other therapies this year may limit your allowed number of PT visits with us)

To the best of my knowledge, the stated medical information is true and correct.

Date: _____ Signature: _____

SPECIALIZED ORTHOPEDIC SOLUTIONS

PHYSICAL THERAPY
HIPAA Privacy Authorization Form

Authorization for Use or disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

1. Authorization

◯ I authorize ◯ I do not authorize SPECIALIZED ORTHOPEDIC SOLUTIONS PHYSICAL/OCCUPATIONAL THERAPY to use and disclose the protected health information described below to individual/Healthcare Providers seeking the information.

2. Extent of Authorization

☐ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse) OR

☐ I authorized the release of my complete health record with the exception of the following information:

- ☐ Mental health records
- ☐ Communicable diseases (including HIV and AIDS)
- ☐ Alcohol / drug abuse treatment
- ☐ Other (please specify:_____

_____

3. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

4. This authorization shall be in force and effect until_____(date or event), at which time this authorization expires.

5. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

6. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

7. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature of patient or personal representative

Printed name of patient or personal representative and his or her relationship to patient

Date: _____

SPECIALIZED ORTHOPEDIC SOLUTIONS SOS

Physical Therapy

AUTHORIZATION TO PAY PHYSICAL THERAPY PROVIDER / FINANCIAL AGREEMENT

I hereby authorize **SPECIALIZED ORTHOPEDIC SOLUTIONS** to charge my insurance company for services rendered including, but not limited to, manual therapy, modalities for pain management, and therapeutic exercise for flexibility and strengthening. I further authorize **SPECIALIZED ORTHOPEDIC SOLUTIONS** to furnish my insurance company my treatment records upon request.

I authorize and instruct _____ insurance company to pay for my services by payment going to:

SPECIALIZED ORTHOPEDIC SOLUTIONS
9259 ETON AVE.
CHATSWORTH, CA 91311

Please read the following and sign below.

1. This payment will not excuse my indebtedness to **SPECIALIZED ORTHOPEDIC SOLUTIONS**

2. I understand that my insurance will on average be billed weekly. I agree that if my insurance does not pay within 60 days of being billed that it will then be my responsibility to make payment on any outstanding balance due.

3. I agree that any balance of said charges over and above those which have been paid by my insurance will be paid by me.

4. I agree that charges that are past due over 90 days will incur a finance charge of 5% of the unpaid balance. I understand and agree that balances past 120 days will be turned over to a collection, and any additional collection fees and finance charges will be paid by me.

5. I understand that there is a $25 fee for cancellations made on day of my set appointments. I also understand that there is a $25 fee for failure to show for any scheduled appointments. I acknowledge that this $25 fee, if accrued, is to be paid by me, separate from charges made by my insurance.

Date:_____ Patients Signature: _____

SPECIALIZED ORTHOPEDIC SOLUTIONS

Physical Therapy

CONSENT TO TREAT

I, _____, hereby consent to routine Physical Therapy services as provided by **SPECIALIZED ORTHOPEDIC SOLUTIONS** and his staff under his supervision. This will be done according to the general instructions of the referring physician (if applicable). I acknowledge that the treatment may include any number of modalities and/or procedures that will be rendered according to the general guidelines of my physician (if applicable) and the physical therapist.

Date:_____ Patients Signature:_____