OVAL PHYSICAL THERAPY & SPORTS MEDICINE
(818)-643-0517
Ovalphysicaltherapy@gmail.com

Date: _______________

Name: ____ Date of Birth: _______

Gender Identity: ☐ Male ☐ Female ☐ Non-Binary ☐ I prefer not to say

Address: ____

City: _________________________ State:_____ Zip Code: __________

Phone Number: ___________________ Email Address: _______________________

Preferred Contact: ☐ Phone ☐ Email ☐ Text

Occupation:_______________________________

Emergency Contact

Name: ___________________________________ Relationship: ________________

Phone Number: _______________________________

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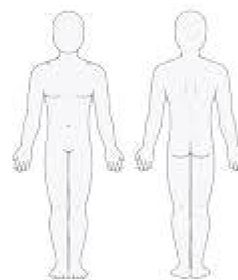
Medical History Questionnaire

Name: ____ Primary Language: ___________________________

Describe your current problem and how it began:____
____
____

Onset Date: ____________________________ Surgery Date: _____________________________

How often do your symptoms occur?
☐ Constantly (76-100% of the day) ☐ Occasionally (26-50% of the day)
☐ Frequently (51-75% of the day) ☐ Intermittently (0-25% of the day)

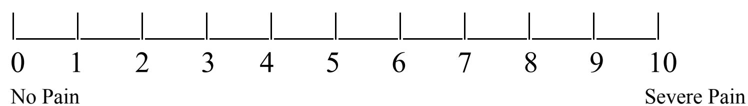


Describe the nature of your symptoms:
☐ Sharp ☐ Dull Ache ☐ Numb
☐ Shooting ☐ Burning ☐ Tingling

How is your condition changing?
☐ Improving ☐ No Change ☐ Getting Worse

Please indicate above where you have pain or other symptoms

Current Pain Scale (How you feel today):



|____|____|____|____|____|____|____|____|____|____|
0 1 2 3 4 5 6 7 8 9 10
No Pain Severe Pain

Who have you seen for your current condition before today?
☐ Medical Doctor ☐ Massage Therapist ☐ Chiropractor ☐ Physical Therapist ☐ Acupuncturist
☐ Occupational Therapist ☐ Athletic Trainer ☐ No One ☐ Other _________________________________

What treatment did you receive and when? ____
____

Have you had any of the following for your area(s) of complaint? ☐ X-rays ☐ MRI ☐ CT Scan

Date(s) Taken: ___________________________ Which areas were taken? ____________________________

Check if you have any difficulty with: ☐ Seeing ☐ Hearing ☐ Swallowing ☐ Speaking ☐ Memory

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Medical History Questionnaire

Please check all of the following that apply to you

- [ ] Pain
- [ ] Numbness/Tingling
- [ ] Osteoarthritis
- [ ] Rheumatoid Arthritis
- [ ] Other Arthritic Conditions
- [ ] Dizziness/Fainting
- [ ] Recent Fever
- [ ] Diabetes
- [ ] Osteoporosis
- [ ] High Blood Pressure
- [ ] High Cholesterol
- [ ] Circulation Problems
- [ ] Stroke/CVA (Date)_______
- [ ] Blood Clots
- [ ] Asthma
- [ ] Emphysema/Bronchitis
- [ ] Tuberculosis
- [ ] Ehlers-Danlos Syndrome
- [ ] Epilepsy
- [ ] MRSA
- [ ] Depression
- [ ] Alcohol/Drug Dependence
- [ ] Hepatitis
- [ ] Stomach Ulcers
- [ ] Multiple Sclerosis

- [ ] Cancer If yes, describe what kind & treatment: ____

- [ ] Heart Problems If yes, describe what kind & treatment: ______________________________________

- [ ] Kidney Problems If yes, describe what kind & treatment: _____________________________________

How much caffeinated coffee or other caffeinated beverages do you drink per day? _______

How many days a week do you drink alcohol? _______
If one drink equals one beer or a glass of wine, how much do you drink at an average sitting? _______

Are you now, or have you ever been, a smoker? **YES/NO**
If so, how many packs of cigarettes do you smoke a day? _______

Have you ever taken an anticoagulant? **YES/NO**

Do you have a pacemaker? **YES/NO**

Have you ever taken steroid medications for any reason? **YES/NO**

During the past month, have you been feeling down, depressed, or hopeless? **YES/NO**

During the past month, have you been bothered by having little interest or pleasure in doing things? **YES/NO**

Do you ever feel unsafe at home, or has anyone hit you or tried to injure you in any way? **YES/NO**

Are you pregnant or do you think you might be? **YES/NO**

Estimated due date? __________

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CURRENT MEDICATIONS

Please list ALL medications (INCLUDING prescription, over-the-counter, herbal, vitamin/mineral/dietary supplements, injections and/or skin patches) that you are currently taking. For each medication, please provide the name, dosage, frequency, and route of administration (oral, inhaled, intravenous, topical, etc.). If you have your own medication list, you may attach it.

Current Medications

Medication:__________________________
Dosage:_______ Frequency:________
Route:___________________________________

Medication:__________________________
Dosage:_______ Frequency:________
Route:___________________________________

Medication:__________________________
Dosage:_______ Frequency:________
Route:___________________________________

Medication:__________________________
Dosage:_______ Frequency:________
Route:___________________________________

Medication:__________________________
Dosage:_______ Frequency:________
Route:___________________________________

Medication:__________________________
Dosage:_______ Frequency:________
Route:___________________________________

Medication:__________________________
Dosage:_______ Frequency:________
Route:___________________________________

Medication:__________________________
Dosage:_______ Frequency:________
Route:___________________________________

Medication:__________________________
Dosage:_______ Frequency:________
Route:___________________________________

Medication:__________________________
Dosage:_______ Frequency:________
Route:___________________________________

Medication:__________________________
Dosage:_______ Frequency:________
Route:___________________________________

Medication:__________________________
Dosage:_______ Frequency:________
Route:___________________________________

****During the course of your physiotherapy, if there are any changes (type or dosage) to your medications or supplements, it is important to inform your therapist!****

I certify, to the best of my knowledge and belief, that the above information is complete and accurate. If the health plan information is inaccurate, or if I do not qualify to receive health care benefits through this provider/professional, I understand that I am responsible for all charges for services rendered and agree to promptly notify this provider/professional of any changes in my health status or health plan coverage in the future. I understand that this provider/professional may need to contact my physician if my condition requires joint care. Therefore, I authorize this provider/professional to contact my physician, if necessary.

Patient/Responsible Party Signature:______________________________________ Date:______________

Reviewed with the Patient: ____ Date:______________

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Patient's Name:________________________________ Date of Birth:_____________

Daytime Phone Number:_____________________________

Please send my medical records to the following institution:
Name:____
Address:____
Telephone Number:____________________________ Fax Number:__________________________

This authorization is:
☐ Unlimited (all records, excluding substance abuse, mental health, HIV diagnosis/treatment)
☐ Limited to the following medical information:____

- Please note that our X-rays and MRI/CT scan films should not be mailed to a third party. If you wish to have them sent elsewhere, please return them to us with the proper mailing instructions
- In addition, X-rays and MRI/CT scan films are on LOAN ONLY for 30 days. If the films are not returned to us by the due date, you will be charged the full price.
- You, as the patient, are fully responsible for your films.

______ I have read and fully understand the above information concerning my medical records. (Initial)
______The release of your medical records, test results or other related information to anyone outside of *Oval Physical Therapy & Sports Medicine* can only be made with your specific written consent. I, the undersigned, hereby authorize you to RELEASE the above medical information to the above facility. Patient's Signature:____________________________________ Date:____________________
_____ I understand that my medical records, test request, test results or other related information will be filed in my medical records chart and will only be available for the purpose of my medical care within *Oval Physical Therapy & Sports Medicine*. I, the undersigned, hereby authorize you to RELEASE the above medical information for the above facility. Patient's Signature:____________________________________ Date:____________________

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Cancellation Policy

We are dedicated to providing you with the best possible healthcare services and ensuring your overall experience with our practice is as smooth and efficient as possible. We are implementing a cancellation fee of **$25** if we are notified of your appointment cancellation within **24 hours** of the scheduled time. This change is designed to improve the scheduling process for all patients.

Notice of Privacy Practices

Your information. Your rights. Our responsibility.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **We will not share your information for marketing purposes or sell your information.** Please review it carefully.

Your Rights

You have the right to:

- Obtain a copy of your medical records.
- Request corrections to your record.
- Request confidential communications.
- Request that we limit the information we share.
- Get a list of the people with whom we have shared your information.
- Obtain a copy of this privacy notice.
- Appoint someone to act on your behalf.
- File a complaint if you believe your rights have been violated.

Our Uses and Disclosures

We may use and share your information to:

- Provide medical attention and coordinate your care.
- Bill for services and receive payment.
- Manage and improve our practice.
- Comply with legal requirements.
- Prevent and address health and safety issues.
- Respond to requests from the authorities.

Our Responsibilities

- By law, we are required to maintain the privacy and security of your health information.
- We will notify you promptly if a breach occurs that may have compromised the privacy or security of your information.
- We will not use or share your information except as described in this notice.
- We will follow the duties and privacy practices described in this notice.

This **Notice of Privacy Practices** complies with the Health Insurance Portability and Accountability Act (HIPAA) and applies to all services provided by **Oval Physical Therapy & Sports Medicine.**

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Consent and Acknowledgments

If you have any questions regarding this notice or our health information privacy policies, please contact our office.

I hereby acknowledge that I have read and understood the "Cancellation Policy" and the "Notice of Privacy Practices".

Please read and initial next to each statement to confirm receipt:

______ I understand the financial policies of this practice.

______ I authorize the release of medical information to my insurance company for billing purposes.

______ I acknowledge having received the Notice of Privacy Practices (HIPAA).

______ I have read and understand the cancellation policy and acknowledge that I will be charged a **$25** fee for missed or late-canceled appointments.

Print Name:____

Signature:____ Date:__________