Peak Performance Sports & Spine

PATIENT INFORMATION		
Last Name:	First Name:	
DOB:	SSN:	Cell Phone:
How do you prefer to receive appointment reminders?	☐ Text to cell phone	☐ Receive automated voice call on primary #

Emergency Contact Person	
Last Name:	First Name:
Relation to patient:	Phone #:

ACKNOWLEDGEMENT OF
***Notice of Privacy* PRACTICES**

I have been informed - either in writing or verbally by a staff member- of the "Notice of Privacy" practices *(HIPAA regulation)* of Peak Performance Sports & Spine.

Signature: _____ Date: _____

ATTENDANCE POLICY

All appointments cancelled with less than a 24 hour notice, and appointments missed with no notice, will be subject to **a $50.00 fee**. I have read, understand and agree to this policy.

Signature: _____ Date: _____

NON-MEDICARE LIFETIME AUTHORIZATION, Assignment and Release: I hereby authorize payment directly to my provider for all insurance benefits otherwise payable to me for medical services rendered. I understand that I am financially responsible for all charges, whether or not allowed or paid by my insurance, and for all services rendered on behalf of my dependents. I also understand that it is my responsibility to know when my maximum insurance benefits have been met and I agree to pay for services at full fee thereafter. I authorize my provider to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I have read, understand and agree to the above.

_____ _____
Date Signature of Guarantor

MEDICARE
LIFETIME AUTHORIZATION

I request that payment of authorized MEDICARE benefits to be made to my attending Provider, for any services furnished me by the Provider. I agree to be held personally responsible for services provided to me that are not authorized by MEDICARE. I authorize any holder of medical information about me to release to the HEALTH CARE FINANCING ADMINISTRATION, aka CMS and its agents any information to determine these benefits or the benefits payable for related services.

_____ _____
Date Signature of Guarantor

Peak Performance Sports & Spine

AUTHORIZATION FOR RELEASE
OF MEDICAL RECORDS

I authorize Peak Performance Sports & Spine to obtain copies of my past and current medical records from your office.

(Please mark any of the following tests related to this condition / injury you had)

MRI ☐
CT scan ☐
X-ray ☐

☐ **alley Imaging** ☐ **Memorial Hospital** ☐ **Regional Hospital**

Other: _____

Please fax indicated records to 509-453-7330, or mail to:
2505 Racquet Ln, Yakima, WA 98902.

Thank you for your prompt response.

To: _____

Regarding: _____

Patient Name:_____

Patient Signature: _____

Date: _____

PEAK PERFORMANCE
SPORTS & SPINE ◆ PHYSICAL THERAPY

Patient Health History Questionnaire

Patient Name _____ **Date of Birth** _____ **Today's Date** _____

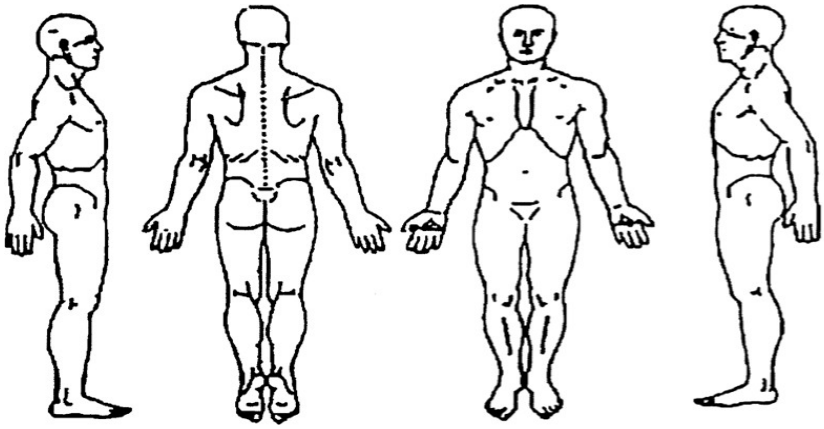
Date of Injury/ Onset: _____ **Duration of Symptoms**: _____

Are you currently experiencing pain? ☐ Yes ☐ No

Indicate the areas of pain on the following diagram:

Describe the pain:

- ☐ Sharp
- ☐ Burning
- ☐ Pain
- ☐ Numbness
- ☐ Pulsating



Please circle the number that indicates your worst level of pain when doing activity today.

NO Pain — 0 1 2 3 4 5 6 7 8 9 10 — Worst Pain imaginable

Diagnostic tests related to the current condition:

- ☐ Bone scan
- ☐ CT scan
- ☐ Labs
- ☐ MRI
- ☐ NCV/EMG
- ☐ Ultrasound
- ☐ X-ray
- ☐ Other: _____

Are you experiencing any of these conditions related to your current problem/complaint? ☐ Yes ☐ No

If yes, please specify:

- ☐ Chest pain or pressure
- ☐ Bowel/bladder function difficulties
- ☐ Dizziness/fainting
- ☐ Fever/chills
- ☐ Headaches
- ☐ Nausea/vomiting
- ☐ Night sweats/night pain
- ☐ Numbness in the genital/ anal area
- ☐ Pregnant? # of weeks ___
- ☐ Problems with vision, hearing and speech.
- ☐ Under doctor's care
- ☐ Unexplained shortness of breath
- ☐ Unexplained weakness
- ☐ Unexplained weight change
- ☐ Other: _____

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Fall Assessment: Have you had two (2) or more falls in the last 12 months? ☐Yes ☐No

Have you had **any** falls in the past 12 months? ☐Yes ☐No

Allergies: Are you allergic/sensitive to latex or adhesive? ☐Yes ☐No

Do you have any other allergies? ☐Yes ☐No

If yes, please list: _____

Please indicate any previous surgeries or medical conditions:

Condition/Surgery:	**Description**
☐ Cancer	
☐ Cardiac	☐ High Blood Pressure ☐ Heart Attack ☐ Congestive Heart Disease
☐ Endocrine	☐ Diabetes ☐ Thyroid condition
☐ Genitourinary	
☐ Infection	
☐ Neurological	☐ Stroke ☐ Seizures ☐ Multiple sclerosis
☐ Orthopedic	☐ Osteoporosis
☐ Pulmonary	
☐ Reproductive	
☐ Implanted devices	☐ Pacemaker ☐ Nerve stimulator ☐ Pumping device ☐ Deep Brain Stimulator
☐ Other	

Home environment:

☐ Indoor stairs with railing? *How many?* ___

☐ Indoor stairs without railing? *How many?* ____

☐ Outdoor stairs with railing? *How many?* ___

☐ Outdoor stairs without railing? *How many?* __

Employment status: Occupation, if applicable:_____ Hours/Week: _____

☐ Full time Part time

☐ Part Time

- ☐ *Work without restrictions*
- ☐ *Working same job with restrictions*
- ☐ *Working different job with restrictions*

☐ Retired

☐ Disabled

☐ Unemployed

- ☐ *Unable to work due to current condition*

Social History: Tobacco Use: ☐ Never ☐ Previously, but quit ☐ Yes, # per day: _____

Alcohol Use: ☐ Never ☐ Previously, but quit ☐ Yes, # per day: _____

Drug Use: ☐ Never ☐ Previously, but quit ☐ Yes, # per day: _____

By signing your name below, you agree that the information provided is true to the best of your knowledge.

Patient Signature: _____ **Date:** _____

For office use only

Form reviewed by (PT initials): _____ **Date:** _____