Patient Name: ____ **DOB:** _________ **Date:** _________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND NONDISCRIMINATION & PROPGRAM ACCESIBILITY.

_____ (Initial Here) I acknowledge that I have been offered a copy of the Notice of Privacy Practices and Notice of Nondiscrimination & Program Accessibility. I hereby consent to receive physical therapy and related services at Lonestar Physical Therapy & Sports Performance, LLC, commencing on this acknowledgement date and terminating when determined by myself, my physician, or my Physical Therapist.

ACKNOWLEDGEMENT OF CONSENT TO TREAT NOTICE

_____ (Initial Here) I have read the Consent to Treat Notice and hereby consent to receive physical therapy and related services at Lonestar Physical Therapy & Sports Performance, LLC, commencing on this acknowledgement date and terminating when determined by myself, my physician, or my Physical Therapist.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PATIENT RESPONSIBILITIES

_____ (Initial Here) I have been offered and understand the Notice of Patient Responsibilities. I understand that Cancellations within 24 hours and no shows will be subject to a $30 fee.

NOTICE OF PATIENT COMMUNICATION PRACTICES

_____ (Initial Here) In caring for our patients, it may be necessary for our practice to contact you to leave a message or text. When you are not available to speak to directly, we like to leave messages when possible. I consent to receive communication from Lonestar Physical Therapy & Sports Performance, LLC via phone call, voicemail, text message, and electronic mail. If you have any questions, please call the clinic.

I have the option to update and/or change my preferred phone number or electronic mail address by notifying the clinic of your request in writing and submitting it to the clinic.

I have read (or have had read to me) the above information and understand the content.

____ ____

Signature of Patient or Personal Representative Date

____

Signature of Parent or Legal Guardian, if applicable

For Staff Only. If patient or personal representative refuses to acknowledge receipt of any item herein referenced, provide an explanation here: ____

____

____

Signature of Employee _______________________________________ Date _______________

Patient Name: ____ DOB: _________ Date: _________

AUTHORIZATION FOR PHI USE AND DISCLOSURE

By signing below, I hereby authorize the use or disclosure of the above-named patient's individually identifiable and protected health information ("PHI") by Lonestar Physical Therapy & Sports Performance, LLC. If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drugs/alcohol abuse, or sexually transmitted diseases, you are hereby authorizing disclosure of this information.

☐ Self
☐ Person/Entity ____
Address ____
City, State, Zip ____

- I understand if I do not specify an expiration date, event, or condition in the above, this authorization will expire in sixty (60) days (or in the case of PHI concerning mental health services, one hundred and eighty (180) days) from the date of this authorization is signed by the above listed patient or personal representative.
- I understand that the PHI used or disclosed may be subject to re-disclosure by the person/entity receiving it and no longer protected.
- I understand that my signature on this authorization is voluntary and my refusal to sign will not affect my ability to receive treatment from the practice. I understand I have the above-listed practice address, but the revocation will not apply to; (1) PHI that has already been released in reliance on this authorization, or (2) PHI created by the practice expressly for disclosure to the above-listed person/entity.
- I understand that if I have any questions regarding the use or disclosure of my PHI, I can contact the office at any time.

I have read (or have had read to me) the above information and understand the content.

____ ____
Signature of Patient or Personal Representative Date

____
Signature of Parent or Legal Guardian, if applicable

HEALTH HISTORY for LONESTAR PHYSICAL THERAPY & SPORTS PERFORMANCE

Patient Name: ____DOB: ___/___/_____ Date: ___/___/____

Who is your Primary Care Physician (PCP)? ____

Height: __________ Weight: __________ Hand Dominance: ☐Right ☐Left T-Shirt Size: ________

Occupation: ____ Last Date Worked: ___/___/_____

How did you hear about us? ☐ Health Care Referral ☐ Family/Friend ☐Online ☐ Other ____________________

Current Condition / Chief Complaint

What is the reason for your visit today? ____

____

What was the mechanism of injury? ____

When did the symptoms begin? ____

How have your symptoms evolved since onset? ☐Better ☐Worse ☐Same

Have you had this problem before? ☐Yes ☐No

What did you do for the problem previously? ____

Have you seen a health care provider and/or had any treatments for this problem? If yes, please explain.

____

____

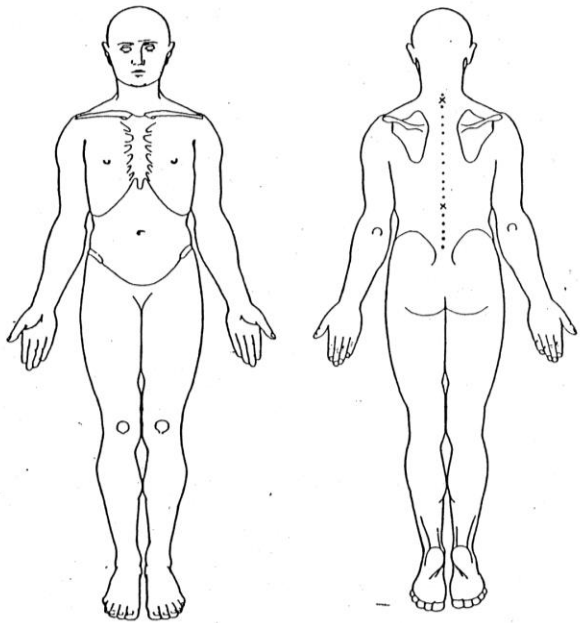
Have you had any imaging or other clinical testing performed for this condition? ☐Yes ☐No

If yes, please explain. ____

Did you have **SURGERY** for this condition? ☐Yes ☐No Date of Surgery: ___/___/_____

If yes, please explain. ____

Please mark on the diagram where you are having your symptoms.



Please indicate your level of pain on a scale from 0 to 10 (0 pain free, 10 worst imaginable pain).

Current: ____ / 10

Pain at Best: ____ / 10

Pain at Worst: ____ / 10

WOMEN ONLY

Currently or possibly pregnant? ☐Yes ☐No

Any OBGYN difficulties? ☐Yes ☐No

Women's health surgery? ☐Yes ☐No

MEN ONLY

Prostate disease? ☐Yes ☐No

Have you had any falls in the past year? ☐Yes ☐No If yes, how many falls? ___________________

Patient Name: ____**DOB:** ___/___/_____ **Date:** ___/___/____

Do you currently have any of the following symptoms? Please answer each question individually.

Lightheadedness	☐Yes	☐No	Impaired coordination	☐Yes	☐No
Night sweats	☐Yes	☐No	Loss of balance	☐Yes	☐No
Night pain	☐Yes	☐No	Clumsiness of hands	☐Yes	☐No
Easy bruising	☐Yes	☐No	Unintentional weight changes	☐Yes	☐No
Vision changes	☐Yes	☐No	Hearing problems	☐Yes	☐No
Balance deficits	☐Yes	☐No	Difficulty walking	☐Yes	☐No
Clicking/Catching/Popping	☐Yes	☐No	Difficulty sleeping	☐Yes	☐No
Buckling	☐Yes	☐No	Difficulty swallowing	☐Yes	☐No
Numbness/Tingling	☐Yes	☐No	Bowel dysfunction	☐Yes	☐No
Chest pain	☐Yes	☐No	Bladder dysfunction	☐Yes	☐No
Shortness of breath	☐Yes	☐No	Sexual dysfunction	☐Yes	☐No
Headaches	☐Yes	☐No	Unexplained weakness	☐Yes	☐No

Have you been diagnosed with any Medical Conditions? Select all that apply.

- ☐ Cancer
- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ High Cholesterol
- ☐ Fibromyalgia
- ☐ Osteoporosis
- ☐ Broken Bones/Fracture
- ☐ Obesity
- ☐ Heart Disease
- ☐ Circulation/Vascular Problem
- ☐ Systemic Arthritis (e.g. RA, Lupus, AS)
- ☐ Thyroid Dysfunction
- ☐ Hypoglycemia/Low Blood Sugar
- ☐ Depression
- ☐ Movement Coordination Disorder (e.g. Parkinson's, MS, Dystonia)
- ☐ Stomach/GI Problems (e.g. GERD, Ulcers, Gallstones)
- ☐ Anxiety
- ☐ Stroke
- ☐ Lung Problems (e.g. COPD, Asthma)
- ☐ Skin Disease
- ☐ Kidney Problems (e.g. Kidney Stones, Renal Disease)
- ☐ Developmental or Growth Problems
- ☐ Seizures/Epilepsy
- ☐ Infectious Disease (e.g. TB, hepatitis, COVID19)
- ☐ Allergies
- ☐ Latex Allergy
- ☐ NONE
- ☐ Other:____

<u>Over the last 2 weeks, how often have you been bothered by the following problems?</u>

1. Feeling nervous, anxious, or on edge?

   ☐ Not at all ☐ Several Days ☐ More than half days ☐ Nearly every day
2. Not being able to stop or control worrying?

   ☐ Not at all ☐ Several Days ☐ More than half days ☐ Nearly every day

<u>Over the last 2 weeks, how often have you been bothered by the following problems?</u>

1. Littler interest or pleasure in doing things

   ☐ Not at all ☐ Several Days ☐ More than half days ☐ Nearly every day
2. Feeling down, depressed, or hopeless

   ☐ Not at all ☐ Several Days ☐ More than half days ☐ Nearly every day

Patient Name: ____**DOB:** ___/___/_____ **Date:** ___/___/____

Surgical History. Please list any surgeries, including approximate dates:

1.____
Date ___/___/_____
Reason for Surgery: ____________________________

2.____
Date ___/___/_____
Reason for Surgery: ____________________________

3.____
Date ___/___/_____
Reason for Surgery: ____________________________

4.____
Date ___/___/_____
Reason for Surgery: ____________________________

Social History. Smoking Currently: ☐Yes ☐No

Alcohol Consumption: ☐Yes ☐No

Do you exercise beyond normal daily activities and chores? ☐Yes ☐No

If yes, please explain. ____

Medications/Vitamins/Minerals/Dietary Supplements: Additional Cont'd Med List page available at request.

Medication Name	Dosage	Frequency	Prescribing MD

EMERGENCY CONTACT. Please list the individual you would like us to contact in case of emergency.

Name: _______________________________ Phone: _______________________ Relation: _________________

I understand the content of this form and attest that I have completed this form truthfully and completely.

____
Signature of Patient or Personal Representative

____
Date

____
Signature of Parent or Legal Guardian, if applicable