VIRGINIA CENTER FOR SPINE & SPORTS THERAPY

2820 Waterford Lake Drive, Suite 103 Midlothian, VA 23112 PHONE: 804-249-8277 FAX: 804-249-9690

Name: _____ DOB: _____ / _____ / _____

Email: _____ How do you prefer to be contacted? ☐ Phone ☐ Text ☐ Email

Why did you choose Virginia Center for Spine & Sports Therapy?

☐ Referring Physician _____ ☐ Friend _____

☐ Family Member _____ ☐ Public Outreach _____

☐ Google Review ☐ Internet Search ☐ Facebook ☐ Instagram ☐ Twitter ☐ Snapchat

☐ YouTube ☐ Other _____

Height: _____ ft _____ inches Weight: _____ lbs

Symptoms began on: _____ / _____ / _____

How did symptoms start? _____

_____

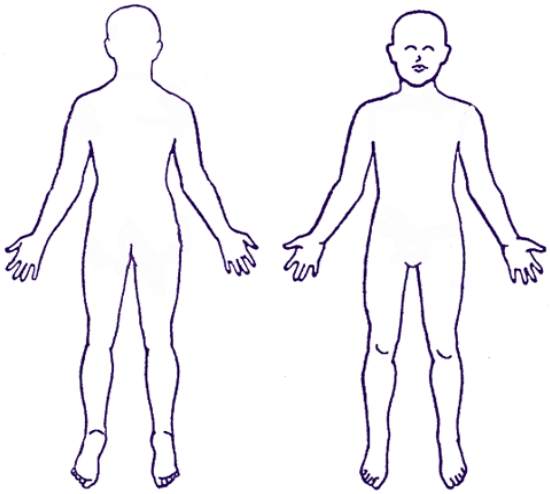
Describe how these symptoms affect your ability to function compared to before onset: _____

_____

Average Pain Intensity

Last 24 hours: No Pain 1 2 3 4 5 6 7 8 9 10 Worst Pain

Past week: No Pain 1 2 3 4 5 6 7 8 9 10 Worst Pain



Indicate where you have symptoms

How often do you experience your symptoms?

☐ Constantly ☐ Frequently (51%-74%) ☐ Occasionally (26%-50%) ☐ Intermittently (0%-25%)

How much have your symptoms interfered with your usual daily activities?

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

In general, how would you say your overall health is right now? ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

To better identify how we can best help you; what are your expectations or goals from physical therapy?

1) _____
2) _____

Do you have or have you ever had any of the following?

Chest Pain	☐ Yes ☐ No	Hypertension	☐ Yes ☐ No	Emotional problems	☐ Yes ☐ No
Shortness of breath	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No	Depression	☐ Yes ☐ No
Heart attack	☐ Yes ☐ No	Pins / metal implants	☐ Yes ☐ No	Infectious diseases	☐ Yes ☐ No
Other heart trouble	☐ Yes ☐ No	Arthritis	☐ Yes ☐ No	Joint replacement	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Numbness / tingling	☐ Yes ☐ No	Latex allergy	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Bowel / bladder issues	☐ Yes ☐ No	Do you smoke?	☐ Yes ☐ No
Unintended weight loss	☐ Yes ☐ No	Headaches	☐ Yes ☐ No	Are you pregnant?	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Sleeping problems	☐ Yes ☐ No	Allergies _____	

Please explain any previous "Yes" answers or describe any medical problems that would limit your ability to participate in a physical program?

_____

_____

_____

Please provide a list **or** list below all medications that you currently take. Include those prescribed by a physician as well as any over-the-counter medications such as vitamins, herbals, Tylenol, et. Please use a separate page to continue if necessary.

NAME OF MEDICATION	DOSAGE (mg, etc.)	FREQUENCY (HOW OFTEN)	ROUTE (HOW TAKEN)
			☐ Oral ☐ Other
			☐ Oral ☐ Other
			☐ Oral ☐ Other
			☐ Oral ☐ Other
			☐ Oral ☐ Other
			☐ Oral ☐ Other
			☐ Oral ☐ Other
			☐ Oral ☐ Other

We ask that you notify us one appointment prior to when you are returning to your doctor for a follow-up visit. This will allow us to provide your doctor with a progress note regarding your care.

CANCELLATION / NO-SHOW POLICY

We are committed to adhering to the prescription or plan of care your physician has prescribed and expect the same of you. We understand that while emergencies occur, we must require a 24hr. cancellation notice. There will be a $15.00 charge for all no show or no call visits. These charges are not covered by insurance.

I understand and agree to abide by the clinic's cancellation policy. *****_____ INITIALS REQUIRED***

HIPAA POLICY

Virginia Center for Spine & Sports Therapy uses your personal and health information for treatment, obtaining payment for treatment, conducting internal administrative activities, and assessing the quality of the care we are proud to provide. We have prepared a detailed NOTICE OF PRIVACY PRACTICES which is available to you at any time and is posted in our office & on our website. **I acknowledge that VCSST's NOTICE OF PRIVACY POLICY was made available to me. *** _____ INITIALS REQUIRED *****

Patient /Responsible Party (Signature): _____ **Date:** _____