

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

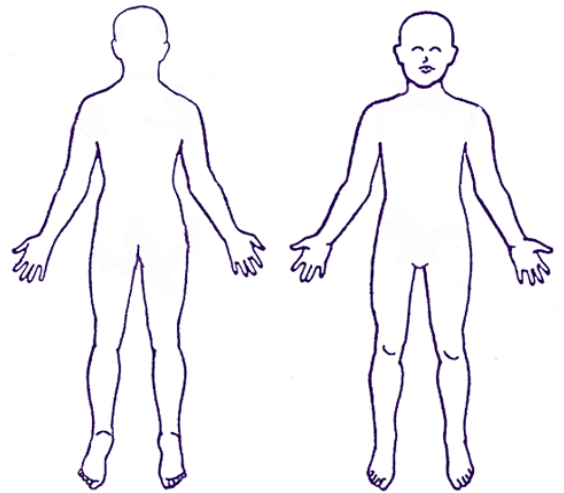
YouTube  Other \_\_\_\_\_

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: \_\_\_\_\_



Indicate where you have symptoms

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

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

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

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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)
			<input type="checkbox"/> Oral <input type="checkbox"/> Other
			<input type="checkbox"/> Oral <input type="checkbox"/> Other
			<input type="checkbox"/> Oral <input type="checkbox"/> Other
			<input type="checkbox"/> Oral <input type="checkbox"/> Other
			<input type="checkbox"/> Oral <input type="checkbox"/> Other
			<input type="checkbox"/> Oral <input type="checkbox"/> Other
			<input type="checkbox"/> Oral <input type="checkbox"/> Other
			<input type="checkbox"/> Oral <input type="checkbox"/> 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: \_\_\_\_\_