SIERRA PHYSICAL THERAPY
Marilyn Nishi-Gormely, RPT
Indian Rock Professional Center
14520 Mono Way, Suite 130
Sonora, CA 95370
(209)533-1273

PATIENT INFORMATION SHEET
(Please Print)

DATE_______________ DATE OF ILLNESS/ INJURY_______________

NAME____
FIRST LAST MIDDLE

MAILING ADDRESS_______________________________________

STREET ADDRESS_______________________________________

HOME PHONE_____________ WORK_____________ CELL_____________

BIRTH DATE_____________ AGE_____________ SEX_____________

SOCIAL SECURITY #_______________ DRIVERS LICENSE #_______________

MARITAL STATUS_______________ OCCUPATION_______________

EMPLOYER'S NAME_______________________________________

EMPLOYER'S ADDRESS_______________________________________

EMPLOYER'S PHONE NUMBER_______________________________________

CONTACT IN EMERGENCY_______________ PHONE #_______________

INSURANCE COMPANY_______________________________________

SUBSCRIBER_____________ S.S.#_____________ BIRTH DATE_____________

EMPLOYER_______________________________________

ADDRESS_______________________________________

HOW WERE YOU REFERRED TO OUR OFFICE? ☐ Union Democrat ☐ Twain Harte Times

☐ Yellow Pages ☐ Friend:_______________ ☐ Doctor:_______________

RELEASE OF INFORMATION: The provider may disclose all or part of the patient's record to any person or corporation which is or may be liable under contract to the provider or to the patient, family member, or the employer of the patient or the family member for all or part of the provider's charge, including but not limited to, medical service companies, workman's compensation carriers, welfare funds, or the patient's employer. I further authorize my employer to release employment information to the provider or the provider's agents.

Signature_______________________________ Date_______________

SIERRA PHYSICAL THERAPY

NAME:____________________DATE:__________OCCUPATION:____________________

HISTORY OF PRESENT EPISODE:____

____

PREVIOUS HISTORY:____

____

DIAGNOSTIC TESTS: Have you had: X-RAYS:______MRI:______CTSCAN:______OTHER:______

SURGERY:____DATE:________

CASTED: yes___no___HOW LONG:__________DESCRIBE PAIN____________________

Medications you are taking:____

CURRENT PAIN LEVEL: No pain -1 -2 -3 -4 -5 -6 -7 -8 -9 -10 - Worst possible pain

What aggravates the pain?:____

What eases the pain?:____

CIRCLE ANY THAT MAY APPLY:

Pain is worse with: sitting - rising - standing - walking - am - pm - lying - daily activities - work

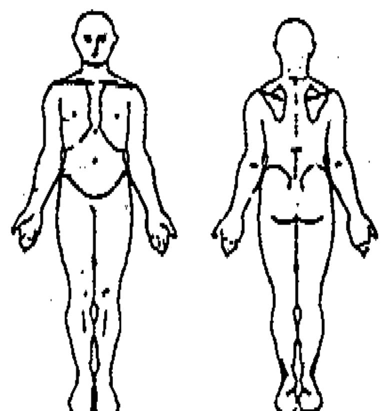
Pain decreases with: sitting - rising - standing - walking - am - pm - lying - daily activities - work

Have you had prior medical treatment for this problem?________What?________________

CHECK SYMPTOMS YOU HAVE NOTICED SINCE INJURY:

( ) Headaches
( ) Neck Pain
( ) Back Pain
( ) Numbness in Toes
( ) Dizziness
( ) Pins and needles in Arms
( ) Pins and needles in Legs
( ) Numbness in Fingers
( ) Sleeping Problems
( ) Irritability
( ) Shortness of Breath
( ) Chest Pain

MARK ON THE BODY CHART ALL AREAS WHERE YOU FEEL PAIN:



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PATIENT'S PAST MEDICAL HISTORY

HEART DISEASE:

Yes___ No___ Congestive Heart Failure
Yes___ No___ High Blood Pressure
Yes___ No___ Heart Attack
Yes___ No___ Atherosclerotic Disease
Yes___ No___ Angioplasty
Yes___ No___ Valvular Disease
Yes___ No___ Stents
Yes___ No___ Arrhythmia
Yes___ No___ Coronary Artery Bypass Graft
Yes___ No___ Angina

OTHER DISORDERS:

LUNG DISEASE

Yes___ No___ Chronic Obstructive Pulmonary Disease
Yes___ No___ Asthma
Yes___ No___ Emphysema
Yes___ No___ Recent Pneumonia

VASCULAR DISEASE

Yes___ No___ Peripheral Arterial Disease
Yes___ No___ Acquired Respiratory Distress Syndrome (ARDS)
Yes___ No___ Diabetes
Yes___ No___ Taking Blood Pressure Meds
Yes___ No___ Stroke/TIA
Yes___ No___ Chronic Bronchitis
Yes___ No___ Hypertension

GENERAL MEDICAL CONDITIONS

Yes___ No___ Arthritis (rheumatoid/osteoarthritis)
Yes___ No___ Allergies
Yes___ No___ Neurological Disease (e.g. MS or Parkinson's)
Yes___ No___ Headaches
Yes___ No___ Gastrointestinal Disease (ulcer, hernia, reflux, Bowel, liver, gall bladder)
Yes___ No___ Visual Impairment (cataracts, glaucoma, Macular degeneration)
Yes___ No___ Back Pain (neck pain, low back pain, degenerative disc disease, spinal stenosis)
Yes___ No___ Hepatitis/AIDS
Yes___ No___ Prior Surgery(s)

Yes___ No___ Osteoporosis
Yes___ No___ Anxiety or Panic Disorders
Yes___ No___ Depression
Yes___ No___ Previous Accidents
Yes___ No___ Kidney, Bladder, Prostrate or Urination Problems
Yes___ No___ Incontinence
Yes___ No___ Hearing Impairment
Yes___ No___ Sleep dysfunction
Yes___ No___ Prosthesis/ Implants
Yes___ No___ Cancer

Please explain any "yes" marked above:____

____

____

______________________ ______________________ ______________________
Patient Signature | Printed Patient Name | Date

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Consent to the use and disclosure of health information for treatment, payment, or Healthcare operations

Name________________**Birth date**____________ **S.S.#**______________

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment.

I understand that this information serves as:

- **A basis for planning my care and treatment.**
- **A means of communication among the many healthcare professionals who contribute to my care.**
- **A source of information for applying my diagnosis and surgical information to my bill.**
- **A means by which a third-party payer can verify that services billed were actually provided.**
- **A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.**

I understand that I have the right:

- **To object to the use of my health information for directory purposes.**
- **To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations – and that the organization is not required to agree to the restrictions requested.**
- **To revoke this consent in writing, except to the extent that the organization has already taken action to reliance thereon.**

___ I request the following restrictions to the use or disclosure of my health information:

____

____

____

Patient:

___________________________	________	________________
Signature of Patient or Legal Representative	**Date**	**Witness Signature**

OFFICE USE ONLY:

____**Accepted**	____________________	____________	________
____**Denied**	**Signature**	**Title**	**Date**

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SIERRA PHYSICAL THERAPY ATTENDANCE AND FINANCIAL AGREEMENT

We at Sierra Physical Therapy will do our best to provide you with professional care and treatment that will enable you to return to your normal daily activities. In order to fulfill this commitment, we need your full cooperation which includes consistent attendance as prescribed by your physician. **After 3 cancellations or 2 "No Shows," you will be discharged from therapy and a report will be sent to your physician and/or work comp adjuster regarding non-compliance**. A $25.00 fee will be charged if 24 hour notice is not given. We realize sickness and unforeseen emergencies do come up and this will be taken into consideration.

As a service to our patients, we will bill primary and secondary insurance's. This is based on the information provided by you, please make sure this information is current and complete. You are responsible for knowing your co-pay amount and deductibles. **Any balance left unpaid after 30 days from your last treatment will become your responsibility and a monthly interest fee will be added until paid in full. Failure to make payments on your account will result in your file being sent to Transwestern Systems, Inc.**

I authorize Sierra Physical Therapy to release information to my insurance company as necessary in the course of billing for services rendered. I further authorize for direct payment to be made to Sierra Physical Therapy.

I understand that even though I may have insurance coverage, I am fully responsible for payment of services rendered by Sierra Physical Therapy. I further understand that it is my responsibility to insure that Sierra Physical Therapy is provider for my insurance company, for co-payments due and deductibles still owing.

I HAVE READ THE ABOVE AND UNDERSTAND THIS AGREEMENT.

Patient Signature:___________________________________Date:________________
(If under age 18, responsible party signature)