DOB_____

Subjective:

Name:_____Date_____Age:_____
Physician:_____Diagnosis:_____
Occupation:_____ Currently working? Y N
Demands of the job? _____
Sport/Activity:_____

Please circle which body part you are seeking treatment: Left Right
Neck Mid Back Low Back Shoulder Elbow Hand/Wrist Hip Knee Ankle/foot
Other_____

Date of injury:_____ Date of Surgery:_____

What caused your injury or problem?_____
_____

What is your chief complaint?_____

Have you had similar occurrences in the past?_____
_____

Have you had previous treatment? What kind?_____ When:_____

Circle recent tests- MRI Xrays CT Scan Bone Scan EMG Other_____

Medical History (Circle) Current smoker**,** High Blood Pressure, Diabetes, Arthritis, Osteoporosis/penia, Cancer**,** Allergies, Heart condition, Pace Maker, Stroke, Pregnant, hearing loss, vision loss, memory loss, depression, anxiety**Other** (including orthopedic conditions and surgeries):_____
_____
_____
_____
_____

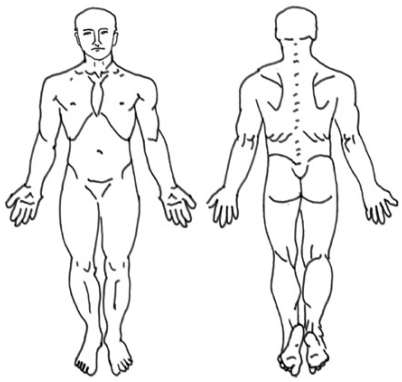
Pain rating: Indicate your level of pain by circling the appropriate number on the scale:

Least 0___1___2___3___4___5___6___7___8___9___10
mild moderate extreme agony
Usual 0___1___2___3___4___5___6___7___8___9___10
mild moderate extreme agony
Worst 0___1___2___3___4___5___6___7___8___9___10
mild moderate extreme agony

TURN PAGE OVER

Using the appropriate symbols, mark on the body diagram where you feel the following sensations:

Numbness	Pins and Needles	Burning	Stabbing	Aching
===	○○○	xxx	///	***



Does your pain?(circle) Throb Burn Stab Ache Other_____

Is your pain constant? Yes No

Does your pain radiate? Yes, where_____ No

Numbness, tingling, or weakness? Yes, where_____ No

What makes your pain worse? _____
_____

What makes your pain better?_____
_____

What is your goal for your treatment?_____

Activities you are limited with due to current injury: self-care, child care, cooking cleaning, shopping, driving, sleeping, recreation other:_____
_____

When is your next Dr. appt.?_____

Email (for receipt purposes only):_____

Patient Signature:_____ Date:_____

FOR THERAPIST USE ONLY

Height_____ Weight_____

COMMENTS:_____
_____
_____
_____
_____
_____
_____

Therapist Signature_____Date_____

CONSENT FOR CARE AND TREATMENT

I, the undersigned, having legal authority to do so, do hereby agree and give consent for Towson Sports Medicine to furnish medical care and treatment as considered necessary and proper in diagnosing or treating my/his/her physical and/or mental condition.

HIPAA

I, the undersigned, have been made aware of my rights as a patient under the "Health and Information Portability and Accountability Act" as posted in the office. I further understand that I may request a printed copy of these rights at any time.

MISSED APPOINTMENTS

Towson Sports Medicine requires that you give us **24 hours** notice of cancellations. If 24 hour advanced notice is not given, you may receive a **$25** missed appointment fee. Please contact the office ASAP to cancel appointments. This policy does not apply in situations of extreme weather. We also ask that you bring your appointment slip to each appointment. No show appointments will automatically be assessed the $25 fee

Bel Air 410-569-8587
Cockeysville 410-616-1455
Rosedale 410-616-1401
Towson- Bellona Ave 410-337-8847; York Rd 410-337-4024

FINANCIAL RESPONSIBILITY

I understand I am responsible for my account. In the event that my account is referred to a collection agency, there will be a **35% fee** added to the outstanding balance

I have read and understand the statements noted above.

Patient/Guardian/Responsible Party_____ Date_____

Please Print Your Name_____ Date_____

Towson Sports Medicine Representative_____ Date_____

Please provide a list of all your medications including prescription, over the counter, vitamins, and supplements, with dosage, frequency, and how administered (oral, injected, etc).

Medication	Dosage	Frequency	How Administered