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

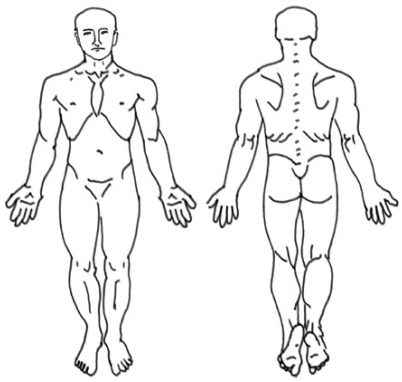
**Pain rating: Indicate your level of pain by circling the appropriate number on the scale:**

**Worst 0 1 2 3 4 5 6 7 8 9 10**
mild moderate extreme agony
**Current 0 1 2 3 4 5 6 7 8 9 10**
mild moderate extreme agony
**Best 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 |
|---|---|---|---|
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**Towson Sports Medicine Fall Risk Screening**

**As part of our required documentation, we need to ask our patients the following questions. Please answer all of the questions.**

**Thank You**

1. **Have you fallen in the past year? Yes No**
2. **How many times have you fallen in the past year? _____**
3. **Please describe any injuries you have sustained from a fall**

   **_____**

   **_____**

   **_____**
4. **Please describe the circumstances of your last fall**

   **_____**

   **_____**

   **_____**

   **_____**

**Date:_____ Initial:_____**

***Instructions:*** Mark the answer that best describes how you felt over the past week.

| | | Yes | No |
|---|---|---|---|
| **1.** | Are you basically satisfied with your life? | ☐ | ☐ |
| **2.** | Have you dropped many of your activities and interests? | ☐ | ☐ |
| **3.** | Do you feel that your life is empty? | ☐ | ☐ |
| **4.** | Do you often get bored? | ☐ | ☐ |
| **5.** | Are you in good spirits most of the time? | ☐ | ☐ |
| **6.** | Are you afraid that something bad is going to happen to you? | ☐ | ☐ |
| **7.** | Do you feel happy most of the time? | ☐ | ☐ |
| **8.** | Do you often feel helpless? | ☐ | ☐ |
| **9.** | Do you prefer to stay at home, rather than going out and doing things? | ☐ | ☐ |
| **10.** | Do you feel that you have more problems with memory than most? | ☐ | ☐ |
| **11.** | Do you think it is wonderful to be alive now? | ☐ | ☐ |
| **12.** | Do you feel worthless the way you are now? | ☐ | ☐ |
| **13.** | Do you feel full of energy? | ☐ | ☐ |
| **14.** | Do you feel that your situation is hopeless? | ☐ | ☐ |
| **15.** | Do you think that most people are better off than you are? | ☐ | ☐ |

***Total Score*** _____

**Name:**_____ **Date:**_____

| | | |
|---|---|---|
| 1) Have you relied on people for any of the following: bathing, dressing, shopping, banking, or meals? | YES | NO |
| 2) Has anyone prevented you from getting food, clothes, medication, glasses, hearing aides or medical care, or from being with people you wanted to be with? | YES | NO |
| 3) Have you been upset because someone talked to you in a way that made you feel shamed or threatened? | YES | NO |
| 4) Has anyone tried to force you to sign papers or to use your money against your will? | YES | NO |
| 5) Has anyone made you afraid, touched you in ways that you did not want, or hurt you physically? | YES | NO |