CTSPORTS™
PHYSICAL THERAPY & WELLNESS
20 Glover Ave - Norwalk, CT 06850
Ph.(203) 957-8100 - Fax (203) 842-2218
www.ctsportspt.com

Today's Date: _____

Full Name: _____

Date of Birth: _____/____/____ **Age**: _____ **Sex**: ☐ Male ☐ Female **HT** _____ **WT** _____

Permanent Address: _____

City, State, Zip: _____

Home Phone: _____ Alt**. Phone**: _____

Email Address _____

Insurance _____

Primary Card Holders Name: _____ **Date of Birth** _____

In case of an emergency, please contact the following individual:

Name: _____ **Relation**: _____ **Phone** # _____

Referring MD: _____ **Primary Care MD**: _____

What is your Diagnosis (what will we be seeing you for?) _____

Whom may we thank for referring you to CTSports Physical Therapy? _____

☐ Yelp ☐ Google ☐ Facebook ☐ Ctsportspt.com ☐ Other

Please fill out the following questions so we have a better understanding of your overall health and how it will or will not pertain to your injury and your recovery. Space is provided below for explanations if necessary.

Do you have, or have you ever had any of the following:

	Yes	No		Yes	No
High or low blood pressure			Osteoporosis		
Heart problems or cardiac irregularities			Alcohol or drug problem		
Family history of cardiac problems			Neck strain		
Pacemaker or metal implants			Low back pain		
Cancer (indicate type)			Fractures		
Family history of cancer			Arthritis (indicate joint)		
Recent unexplained weight loss			Ligament sprain, muscle strain		
Respiratory ailments			Diabetes (type 1 or 2)		
Systemic disorders (i.e. RA, MS, AIDS, etc.)			Intestinal organ problems (stomach, kidneys, etc.)		
Allergies including latex or medications			Thyroid condition		

If you answered yes to anything above, please explain: _____

_____

_____

_____

Please list any medications you are taking: (if you have a list, we will make a copy)

_____

_____

Have you been to physical therapy at another facility for THIS CONDITION?

_____

Please list any surgeries including dates: _____
_____
_____

For our female patients, is there any chance you could be pregnant? _____

What brings you into our office today (chief complaint)? _____
_____
_____
_____

When did your symptoms start and how did they begin? _____
_____
_____
_____

On a scale from 0-10 (0 being none and 10 being unbearable) please select number that describes your pain when it is at its worst:

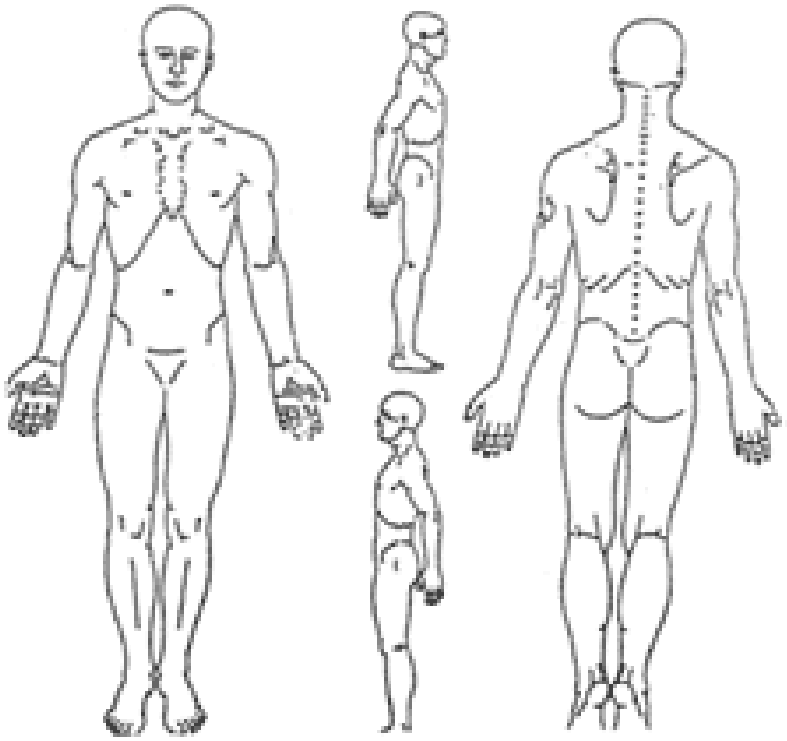
1 2 3 4 5 6 7 8 9 10

What is your pain on average?

1 2 3 4 5 6 7 8 9 10

Place an "x" where you feel pain

Please sign below to indicate you have answered all questions to the best of your knowledge.



Assumption of Risk I understand that although CTSports Physical Therapy and its staff take precautions to safeguard my health and safety, serious and potentially debilitating injuries can and do occur while participating in physical activity. I know that it is extremely important that I consider and be ever mindful of the risks that are involved in such activities as Physical Therapy and/or Personal Training/Wellness. I feel comfortable with and accept these risks and hereby release CTSports Physical Therapy and its entire staff from any and all liability.

INITIAL: _____

Consent to Receive Medical Care

I give authorization to CTSports Physical Therapy and/or its staff and agents to evaluate and treat me during my participation and the CTSports facility (this includes immediate First Aid and treatment, physical exam, follow-up care, exercise, and rehabilitation). I understand that any CTSports staff has the authority to prevent me from further participation because of an injury and/or because of any undue liability to CTSports.

INITIAL: _____

Health Insurance Portability and Accountability Act Release (HIPAA)

I have read and fully understand the Notice of Privacy Practices. I may request a copy of the Notice of Privacy Practices at any time and hereby give CTSports Physical Therapy to release my medical information for purposes of billing and medical consultation.

Patient Financial Responsibility

As a courtesy to our patients, we have enrolled in numerous managed care insurance programs. We are pleased to be able to provide this service to you, and will make every effort to verify coverage and bill your insurance company completely. Its is the responsibility of each patient to know the details of his or her insurance plan in addition to any lapses in insurance coverage. Any charges that occur as a result of insurance plan restrictions or lapses in coverage are ultimately the patient's responsibility. Unfortunately, if you do not inform us on any changes in your insurance coverage, we may bill you directly for those charges. If current insurance coverage cannot be verified prior to each appointment, payment will be due at the time of service.

Attendance Policy

I understand that I am responsible for my appointed times and will give 24 hour notice for cancellation or be subjected to a $25 cancellation fee.

BY SIGNING BELOW I ACKNOWLEDGE I HAVE READ AND UNDERSTAND THE FOLLOWING POLICIES AND I ACCEPT THE RIGHTS AND RESPONSIBILITIES OUTLINED WITHIN THEM.

- **Patient Rights Regarding Medical Records**
- **Patient Financial Responsibility**
- **Confidentiality and Privacy of Medical Records**

I hereby authorize the physician to release any and all information necessary concerning my diagnosis and treatment for the purposes of securing payment from my insurance company; and thereby authorize payment of the insurance benefits directly to the physician for any services rendered that are not paid for directly by me.

INITIAL: _____

PRINTED NAME: _____

SIGNATURE: _____ **DATE**: ___/___/___