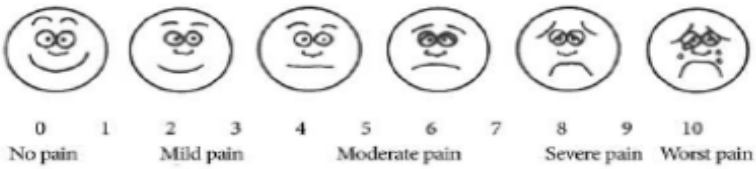
Injury/primary complaint: _____

Date of injury/onset of pain: _____ Cause: _____

What is the pain rating for your current condition using a scale of 0 – 10?



0 1 2 3 4 5 6 7 8 9 10

No pain Mild pain Moderate pain Severe pain Worst pain

When do you feel your pain the most ☐ Constantly ☐ Morning ☐ Mid day ☐ Evening/Night ☐ Activity Dependent

Your pain is aggravated by: ☐ Sitting ☐ Standing ☐ Walking ☐ Kneeling ☐ Up/Down Stairs ☐ Running/hopping ☐ Twisting ☐ Reaching overhead/behind ☐ Bending ☐ Lifting/carrying ☐ Lying on your back/stomach/side ☐ Other: _____

Your pain is eased by: ☐ Rest ☐ Heat ☐ Ice ☐ Meds ☐ Massage ☐ Movement ☐ Other: _____

What is your current stress level? (Circle one) Mild Moderate Severe

Do you currently or have you ever had any of the following?

Yes	No	Exercise induced light headedness, chest pain, or difficulty breathing	Yes	No	Asthma or other respiratory disorder
Yes	No	Musculoskeletal Disorders	Yes	No	Headaches
Yes	No	Numbness and/or tingling	Yes	No	Infection of any kind
Yes	No	Heart Disease or chest pain	Yes	No	Grinding of teeth and/or clenching jaw
Yes	No	Stroke	Yes	No	Diabetes
Yes	No	Osteoporosis or Osteopenia	Yes	No	Epilepsy or seizures
Yes	No	Fall(s) or stumbling in the last year	Yes	No	Vision Impairment or blurred vision
Yes	No	Cancer	Yes	No	Hearing Impairment
Yes	No	Depression and/or anxiety	Yes	No	Tinnitis (ringing in the ears)
Yes	No	High or low blood pressure	Yes	No	Skin allergies
Yes	No	Dizziness, fainting, and/or vertigo	Yes	No	HIV or AIDS
			Yes	No	Other _____

Explain if circled "Yes" for any of the above: _____

_____

Have you ever sprained, strained, dislocated, tore or fractured any of the following:	Date of Injury:	Treatment received:
Neck/Head (including concussion)		
Trunk (ribs, vertebrae, sternum)		
Upper/Mid Back		
Low Back		
Upper Extremity (shoulder, arm, elbow, wrist)		
Lower Extremity (hip, leg, knee, ankle, foot)		

List all orthopedic/non-orthopedic surgeries you've had in the past or have scheduled for the near future:

Surgery:	Date:	Doctor:

Please list all prescription and non-prescription medication(s) presently taking:

Medication:	Purpose:	Medication:	Purpose:

Women: Are you currently pregnant? Yes No **Have you had previous pregnancies?** Yes No

What recreational activities/sports do you practice? _____

_____

Have you ever had PT in the past? Yes No If so, for what injury, date(s), location of treatment?

_____

I agree that the above information accurately describes my medical history and that I will notify my PT immediately should any changes occur.

Name_____ Signature _____ Date_____

GOLDEN GATE PHYSICAL THERAPY

Referring Physician _____

Secondary Referral Source _____

PATIENT INFORMATION

Date _____

Name _____
(First) (Last) (Middle Initial)

Address _____ APT # _____

City _____ State _____ ZIP _____

Home Phone _____ Cell Phone _____

E-Mail _____ Work Phone _____

Social Security # _____ **Sex** M ☐ F ☐ **Birth Date** _____

Marital Status M ☐ S ☐ W ☐ D ☐ SO ☐ Spouse's Name _____

Appointment reminder preference: **Voice call** ☐ **Text** ☐ **Email** ☐ **No reminder** ☐

EMERGENCY CONTACT:

Name _____ Phone # _____ Relationship _____

Do you attend physical therapy elsewhere? Yes ☐ Where? _____ No ☐

Have you been treated at Golden Gate Physical Therapy before? Yes ☐ No ☐

How did you hear about us? _____

EMPLOYMENT INFORMATION

Employer/School _____ Occupation _____

Dept. _____ Address _____

Status: ☐ Full-Time ☐ Part-Time ☐ Retired ☐ Disability ☐ Unemployed

MEDICAL INFORMATION

Treating Physician(s) _____ Phone _____

Address _____ Fax _____

Date of Injury/ Surgery onset _____

Auto Accident Yes ☐ No ☐

Workers Comp Yes ☐ No ☐ Employer _____

Lawsuit Yes ☐ No ☐ Attorney's Name _____ Phone _____

For office use: ☐OA ☐DX ☐PN ☐Chart ☐INS

GOLDEN GATE PHYSICAL THERAPY

1801 Bush Street
Lower Level, Ste 200
@ Bush and Octavia St
San Francisco, CA 94109

phone 415-776-1646
fax 415-776-1964
admin@ggatept.com
www.ggatept.com

TREATMENT AUTHORIZATION

Your signature is required below to authorize treatment. Your signature also authorizes the release of medical information needed to process your claim, allowing an assignment of benefits where a claim has been filed, and acknowledging your understanding of the above office policies. An additional treatment authorization signature is required by a parent/ legal guardian for all minors.

_____ _____
Patient Signature Date

_____ / _____ _____
Parent or Guardian Signature / Print Full Name Date

NOTICE OF PRIVACY PRACTICE (form available upon request)

Effective April 14, 2003, I, _____, hereby acknowledge receipt of Golden Gate Physical Therapy's Notice of Privacy Practices. Golden Gate Physical Therapy will use or disclose my PHI for the purposes of carrying out treatment, payment, and health care operations. The Notice of Privacy Practices provides detailed information about how the practice may use and disclose my confidential information.

I understand Golden Gate Physical Therapy has reserved the right to change its privacy practices that are described in the Notice. I also understand a copy of any Revised Notice will be provided to me or made available at my next office visit.

I give my consent to Golden Gate Physical Therapy to notify me of new facilities or services. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to Golden Gate Physical Therapy.

_____ _____
Patient Signature Date

_____ / _____ _____
Parent or Guardian Signature / Print Full Name Date

If you are not the patient, please specify your relationship to the patient _____

GOLDEN GATE PHYSICAL THERAPY

WE KINDLY REQUEST A 24 HOUR ADVANCED NOTICE FOR ANY APPOINTMENT CANCELLATIONS OR RESCHEDULING

A **$100** charge will be applied as
patient responsibility
for appointments missed or cancelled
less than 24 hours prior to appointment time
(insurance does not get billed for missed appointments)

PLEASE BE TIMELY FOR APPOINTMENTS
Arriving more than 15 minutes late shortens your treatment time and may require a reschedule of your appointment.

WHEN ABLE, PLEASE SCHEDULE YOUR FOLLOW UP APPOINTMENTS AT LEAST ONE WEEK IN ADVANCE TO SECURE THE TIMES THAT YOU NEED
Appointment times given do not automatically follow through to the subsequent weeks

NO SHOW POLICY

If you do not show up to an appointment **a total of 3 times**, your future appointments will be automatically removed. To schedule you must call the office on the same day you would like to be seen.

Patient Signature **Date**