



Physical Therapy for Optimum Performance

**SPORTS + ORTHOPEDIC PHYSICAL THERPAY  
BICYCLE BIOMETRICS  
SPORTS PROFORMANCE**

**ERIK MOEN, PT  
KARI STUDLEY, PT, DPT  
SUSIE ROLEY, PT, DPT**

<b>Appointment Date</b>		<b>Time</b>		<b>Therapist</b>	
<b>Patient Information</b>					
Last Name		First Name		Nick Name	Middle Intl
Address			City	State	Zip
Home Phone		Work Phone		Other Phone (Cell)	
Date Of Birth / /	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Status S M D W	Email Address		
Referring Physician			Referring Phone Number		
<b>Emergency Contact Information</b>					
Contact Name		Contact Number		Relationship to Patient	
<b>Responsible Party</b> *Only Complete the following if policy holder is not the patient					
Last Name		First Name		Middle Intl	
Address			City	State	Zip
Relationship to patient		Date Of Birth / /		SS# - -	



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Last Name	First Name	DOB
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Have you ever or are you presently being treated for any of the following conditions?

Allergies	Yes	No
Asthma	Yes	No
Bronchitis	Yes	No
Headaches	Yes	No
Kidney Disease	Yes	No
Rheumatic Fever	Yes	No
Seizures	Yes	No
Sexually Transmitted Disease	Yes	No
Ulcers	Yes	No

Have you or an immediate family member been told you have?

	You		Family	
	Yes	No	Yes	No
Cancer	Yes	No	Yes	No
Chest Pain	Yes	No	Yes	No
Diabetes	Yes	No	Yes	No
High Blood Pressure	Yes	No	Yes	No
Osteoarthritis	Yes	No	Yes	No
Osteoporosis	Yes	No	Yes	No
Rheumatoid arthritis	Yes	No	Yes	No
Stroke	Yes	No	Yes	No

Have you experienced any of the following in the past 3 months?

Change in your health	Yes	No
Changes in bowel or bladder function	Yes	No
Depression	Yes	No
Dizziness	Yes	No
Fever/Chills/Sweats	Yes	No
Nausea/Vomiting	Yes	No
Numbness or tingling	Yes	No
Shortness of breath	Yes	No
Stress	Yes	No
Unexplained weight changes	Yes	No
Upper Respiratory Infection	Yes	No
Urinary Tract Infection	Yes	No

**Men:**

Have you ever been diagnosed with Prostate Disease? Y\_\_\_ N\_\_\_

**Women:**

Are you pregnant or think you might be pregnant? Y\_\_\_ N\_\_\_

**During the past month, have you often been bothered by feeling down, depressed, or hopeless?**

Yes No

**During the past month, have you often been bothered by little interest or pleasure in doing things?**

Yes No

**Is this something with which you would like help?** Yes Yes, not today No



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Surgeries			
Year	Reason		
Medications		Allergies	
Name of Drug/Supplement	Strength	Name	Reaction

**Health Habits**

Do you drink caffeinated beverages? Yes No  
 How many per day? \_\_\_\_\_

Do you drink alcohol? Yes No  
 How many per week? \_\_\_\_\_

Do you currently or have you previously used tobacco? Yes No  
 # of packs per day? \_\_\_\_\_

Do you exercise or participate in any hobbies or sports? Yes No  
 How many days a week? \_\_\_\_\_  
 How many minutes on average per day? \_\_\_\_\_

**TOP 3 REASONS AND GOALS FOR YOUR VISIT TODAY:**

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_



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**Certification**

I certify that all information I have provided is true and correct to the best of my knowledge. I give my permission to the practitioner to administer and perform such procedures as may be deemed necessary for proper treatment.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**No-Shows and Late Cancels**

I will reimburse Corpore Sano Physical Therapy a fee of \$50.00 if I do not arrive for my previously scheduled treatment or cancel my treatment without a 24-Hour notice. I also understand that Corpore Sano Physical Therapy may contact my physician, insurance company and/or employer if I do not arrive for my scheduled treatment.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Acknowledge of Receipt of Notice of Privacy Practices**

I acknowledge of receipt of a copy of the **Notice Privacy Practices** of Corpore Sano.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**OPTIONAL**

I authorize Corpore Sano Physical Therapy to discuss my billing and/or medical condition with the following name(d) person(s). Please include the name(s) of persons with whom we are allowed to discuss your medical condition and/or billing information.

Name	Phone	Relationship

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



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Form with fields for Last Name, First Name, and DOB.

On the scales below, please circle the number which best represents the severity of your pain.
( 0= no pain, 10= worst pain imaginable)

Average for the last 48 hours

0 1 2 3 4 5 6 7 8 9 10

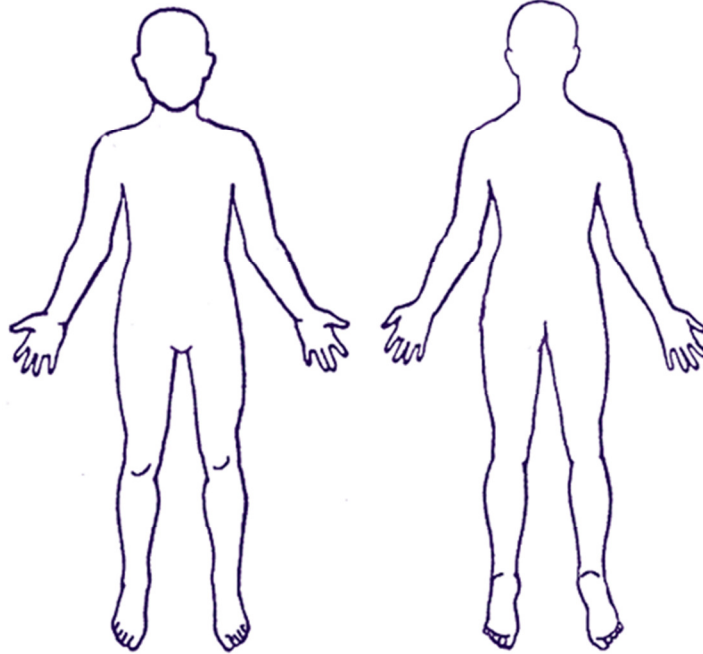
Best for the last 48 hours

0 1 2 3 4 5 6 7 8 9 10

Worst for the last 48 hours

0 1 2 3 4 5 6 7 8 9 10

Body Chart: Please mark the areas where you feel pain.



For Therapist:
+ / - Cough/Sneeze
+ / - Saddle Anesth
+ / - Bwl/BlDDR Change
+ / - Numb/Ting.

Please circle the number below which best represent your overall average level of function.
( 0= cannot do anything, 10= able to do everything)

0 1 2 3 4 5 6 7 8 9 10

What makes your symptoms better?

- 1.
2.

Aggravating Factors: Identify up to 3 important activities that you are unable to do or are having difficulty with as a results of your problem. List them below:

- 1.
2.
3.



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## **HIPAA Notice of Privacy Practices**

We understand that information about you and your health is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us, which we need to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by Corpore Sano LLC, whether made by your physical therapists or any employee of Corpore Sano LLC. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information.

### **We are required by law to:**

- Make sure that health information that identifies you is kept private.
- Give you this Notice of our legal duties and privacy practices with respect to health information about you.
- Follow the terms of the Notice that is currently in effect.

### **How we may use and disclose health information about you:**

- For treatment
- For payment
- For health care operations
- As required by law
- To avert a serious threat to health and safety
- As required by the Military or Veterans and Workers Compensation
- Public heath risks
- Health oversight activities
- Lawsuits and disputes
- Law enforcement
- Coroners, health examiners and funeral directors
- National Security and Intelligence activities
- Protective Service for the President and others

### **Your rights regarding Health Information about you:**

- Rights to inspect and copy
- Right to amend
- Right to accounting of disclosures
- Right to request restrictions
- Right to request confidential communications
- Right to a paper copy of this notice

### **Changes to this Notice:**

We reserve the right to change this notice. We will retain a copy of the current notice in our facility.

### **Complaints:**

If you believe that your privacy rights have been violated you may file a complaint with us. All complaints must be in writing. Please contact the administrator at the location or department you were treated to file a complaint.

### **Acknowledgement of Receipt of this Notice:**

We will request that you sign a separate form acknowledging you have received a copy of this notice. The acknowledgement will become part of your records.

10/17/2011