

## Patient Health and Sport Questionnaire

Name of Patient/Athlete: _____	Age: _____	DOB: _____
School: _____	Grade: _____	
Sports/Teams: _____		
Coaches Names/Contact Info: _____		
How did you hear about our clinic? Check all that apply:		
<input type="checkbox"/> Physician <input type="checkbox"/> NCS event <input type="checkbox"/> School Athletic Trainer <input type="checkbox"/> Media/TV            Other: _____		

Date of injury: \_\_\_\_\_ Date of surgery: \_\_\_\_\_

Please describe your injury: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Regarding this injury, have you had an:  
 X-RAY   
 MRI   
 CT Scan   
 EMG

If yes, what are the results? \_\_\_\_\_  
 \_\_\_\_\_

What treatment have you done for this injury previously (if any)?  
 \_\_\_\_\_  
 \_\_\_\_\_

How has this injury limited your sport/activity? \_\_\_\_\_  
 \_\_\_\_\_

Do you currently have, or have had in the past, any of the following conditions?

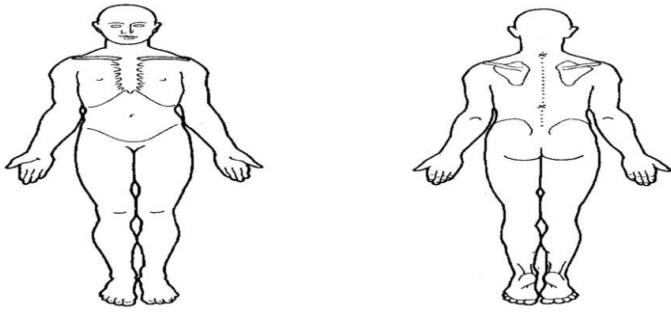
yes  no Diabetes  
 yes  no Unexplained weight loss  
 yes  no Bowel / Bladder  
 yes  no Seizures  
 yes  no Hernia  
 yes  no Rheumatoid Arthritis  
 yes  no Allergies \_\_\_\_\_  
 yes  no Dietary concerns \_\_\_\_\_  
 yes  no Asthma \_\_\_\_\_  
 yes  no Previous Surgery \_\_\_\_\_  
 yes  no Immunizations up to date

Additional comments (medical or general health issues, any barriers to learning or communication?):  
 \_\_\_\_\_  
 \_\_\_\_\_

Please list all medications you are currently taking:  
 \_\_\_\_\_  
 \_\_\_\_\_

Please mark where you feel your pain/symptoms and describe them:  
 (circle all that apply)

Constant (always present) / Intermittent (comes and goes)  
 Sharp / Achy / Dull  
 Numb/Tingling /Shooting / Burning



Please circle the number that best describes your pain:  
 (NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 (WORSE POSSIBLE)

What makes your pain / symptoms better? \_\_\_\_\_  
 \_\_\_\_\_

What makes your pain / symptoms worse? \_\_\_\_\_  
 \_\_\_\_\_

What would you like to achieve with your rehabilitation program (sport goals, pain control, etc.)?  
 \_\_\_\_\_

Are you interested in a post-rehabilitation / sport specific training and conditioning program? Y / N

Email: \_\_\_\_\_

***Thank you for filling out this form. This will assist us in providing you with comprehensive care for your present injury.***

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of **parent / guardian** (if patient is under 17): \_\_\_\_\_ Date: \_\_\_\_\_

**Office use only:**  
 Clinician has reviewed and discussed with patient/caregiver: \_\_\_\_\_ Date: \_\_\_\_\_



NEW PATIENT INTAKE FORM

Patient Information

Date of Birth: \_\_\_/\_\_\_/\_\_\_ Sex: M/F
Last Name: \_\_\_ First Name: \_\_\_ Middle: \_\_\_
Address: \_\_\_
City: \_\_\_ State: \_\_\_ Zip: \_\_\_

Please circle the best phone number for calls and messages: Home / Cell / Other
Home: (\_\_\_) \_\_\_-\_\_\_-\_\_\_ Cell: (\_\_\_) \_\_\_-\_\_\_-\_\_\_ Other: (\_\_\_) \_\_\_-\_\_\_-\_\_\_
School Name: \_\_\_ Address: \_\_\_

Financial Information

Name of Responsible Party/ Guarantor: \_\_\_
Social Security: \_\_\_-\_\_\_-\_\_\_ DOB: \_\_\_ Primary Phone: \_\_\_
Address: \_\_\_
City: \_\_\_ State: \_\_\_ Zip: \_\_\_
Insurance Carrier: \_\_\_ Policy or ID: \_\_\_

Other Information

Referred to this office by: \_\_\_ Primary Care Physician: \_\_\_
Emergency Contact: \_\_\_ Day Phone: \_\_\_ Evening Phone: \_\_\_
Emergency Contact: \_\_\_ Day Phone: \_\_\_ Evening Phone: \_\_\_

Office Policies

- 1. Patients should provide 24-hour advance notice of any need to cancel an appointment.
2. The patient must provide active proof of insurance at sign in.
3. Co-payment must be paid when the patient presents for services.
4. If payment is fully or partially denied, the patient understands they will be billed directly for the services rendered...
5. If the patient or services are not covered by the health insurance, payment is expected at the time of service.
6. We currently participate in a number of insurance plans and will bill these companies for our patients.

Policies are subject to change without notice.

I have received and read a copy of the Office Policies and authorize Sports Medicine Center for Young Athletes (SMC) to bill my insurance company for me. I hereby request the direct payment of medical benefits to be made by SMC for any services. I hereby authorize the release of any and all information acquired in the course of examination and treatment to patient's insurance company.

Signature (parent or Guardian) \_\_\_\_\_ Date \_\_\_\_\_

# Sports Medicine Center for Young Athletes

100 N. Wiget Lane, Suite 200  
Walnut Creek, CA 94598  
925-988-0100

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Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

## CONDITIONS OF SERVICE

### 1. AGREEMENT TO BE TREATED:

I consent to the performance of ambulatory medical treatment and procedures deemed necessary by the attending physician or physical therapist of said patient. I further agree to release all pertinent information relative to facilitating good patient care. Parents, or other legally authorized representative of a minor, and competent adults have the right to refuse any recommended treatment, except where State or Federal law may preclude any refusal of treatment needed by a minor. If the patient, his/her parents or other representative wants to refuse any particular treatment, he/she should tell the patient's physician about this immediately.

### 2. FINANCIAL AGREEMENT:

I assign insurance benefits to be paid directly to Children's Orthopaedic Associates Medical Group, Inc., owner of the Sports Medicine Center for Young Athletes, for all sports medicine related services performed at 100 N. Wiget Lane, Suite 200, Walnut Creek, CA 94598. I also accept financial responsibility for all charges not covered by insurance, including a co-payment or co-insurance. In the event insurance is not applicable or otherwise available, I guarantee payment to Children's Orthopaedic Associates Medical Group, Inc. for all services rendered.

### 3. RELEASE OF INFORMATION:

Children's Orthopaedic Associates Medical Group, Inc. or the Sports Medicine Center for Young Athletes is allowed, by law, to disclose any information contained in the patient's medical record for treatment purposes, e.g. to your child's pediatrician, and to anyone who is or may be legally obligated to pay for all or part of the cost of the rendered services, e.g. insurance company. Please see the practice's Notice of Privacy Practices for additional information on the uses and disclosure of your child's medical information.

### 4. NOTICE OF PRIVACY PRACTICES:

\_\_\_\_\_ Patient, parent or representative has received a copy of the Children's Orthopaedic Associates Medical Group, Inc.'s Notice of Privacy Practices (patient/parent/representative initial to acknowledge receipt).

\_\_\_\_\_ Patient, parent or representative declined a copy of the Children's Orthopaedic Associates Medical Group, Inc.'s Notice of Privacy Practices (patient/parent/representative initial to acknowledge decision to decline a copy). Reason: \_\_\_\_\_

The undersigned certifies that he/she has read the foregoing, has received a copy of this form, if so desired, and is the patient, the patient's parent, or is duly authorized by the patient as a general agent, to sign this agreement and accept its terms.

\_\_\_\_\_  
Parent or Patient Representative

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Date and Time of Signing

\_\_\_\_\_  
Witness



**Sports Medicine Center For Young Athletes**  
**100 N. Wiget Lane, Suite 200**  
**Walnut Creek, CA 94598**  
**Phone: 925-988-0100 • Fax: 925-988-0122**

RELEASE OF INFORMATION

PATIENT NAME: \_\_\_\_\_

DOB: \_\_\_\_\_

Please forward copies of the above referenced patient's orthopaedic surgery and/or sports medicine/physical therapy records (for all dates of service) to:

Sports Medicine Center for Young Athletes  
100 N. Wiget Lane, Suite 200  
Walnut Creek, CA 94598  
Fax: 925-988-0122

Thank you for your attention to this matter.

\_\_\_\_\_  
Parent/Guardian

\_\_\_\_\_  
Date