Sports Medicine & Training Center

Patient Information

Patient Name: _____
Date of Injury: _____
Next Doctor Appointment: _____

Check the following which apply to your injury:

□ work related injury □ motor vehicle accident □ recurrence of previous injury
□ fall □ athletic / recreational injury □ cause unknown □ surgery
□ Other: _____

Have you had any orthopedic surgeries? NO _____ YES _____ If yes, list procedures and dates:_____

_____

_____

Check any of the following medical conditions you have that may interfere with your treatment:

□ No known conditions that will affect treatment
□ Osteoarthritis □ Diabetes Mellitus Type 1
□ Cardiovascular Disease □ Diabetes Mellitus Type 2
□ Allergies (please list) _____
□ Other (please list) _____

Are you currently taking medications, either prescribed or OTC? NO _____ YES ____
If yes, please list: _____

_____

Other than your referring physician, have you been treated by any other medical professional for this injury? NO ____ YES ____
If yes, circle one: physical therapist chiropractor massage other:_____

Type of Pain (circle):
Sharp Dull Ache Tingling Numbness
Other: _____

Please list any recreational activities/hobbies that you participate in and how often and for what duration you perform them: _____

_____

_____

Please list goals you would like to achieve during your course of treatment:_____

_____

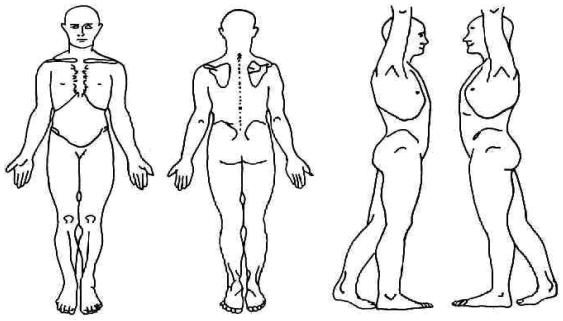
_____

_____

Rate the intensity of the pain

At Worst:	0	1	2	3	4	5	6	7	8	9	10
Current:	0	1	2	3	4	5	6	7	8	9	10
At Best:	0	1	2	3	4	5	6	7	8	9	10

Please indicate location of symptoms



_____ _____ _____
Signature Relationship to Patient Date

Which of the following represents the reason you chose SMTC? (Circle all that apply)

I have been a patient or exercise client here before
A family member, friend or co-worker has been a patient or exercise client before
My physician recommended SMTC My school trainer recommended SMTC School: _____
Case manager Attorney recommended SMTC Workers' Compensation
Online What Site: _____ Drive by/Live Close By Insurance Plan Website
I have participated in dance activities at the SMTC studio or was attracted by the Dance Medicine Program
I was a participant or spectator at an athletic event where SMTC was providing medical services
Other: _____

PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle Initial:_____
Street Address: _____ City: _____
State: _____ Zip: _____ Date of Birth: _____/_____/_____ SSN: _____/_____/_____
Home Phone: _____ Alternate/cell phone: _____
Sex: Male Female Marital Status (circle one): Single Married Domestic Partnership Widowed
Occupation or School: _____ Full-Time Part-Time
Duty Level: Full Light Other _____ Out of Work Since: _____ Return to Work: _____
Emergency Contact Name: _____
Relationship to Patient: _____ Phone Number: _____
May we contact you via email with company updates, patient surveys and/or company newsletters?
YES ____ NO____ Email Address: _____

INSURANCE AND GUARANTOR INFORMATION

Policy Holder: _____ Date of Birth: _____/_____/_____ SSN: _____/____/____
Relationship to patient: (circle one) Self Spouse Parent/Guardian
Secondary Insurance Policy Holder: _____ Date of Birth: _____/_____/_____
Relationship to patient: (circle one) Self Spouse Parent/Guardian
Who should be billed for any balance due (after insurance)?: _____
Is guarantor's address different than patient?: YES____ NO____ If yes, please provide below:
_____

LEGAL INFORMATION

Is this a Worker's Compensation case?: NO ____ YES ____ Company: _____
Contact/Case Manager: _____ Phone Number: _____
Employer: _____
Employer Street Address: _____ City: _____
State: _____ Zip Code: _____ Employer Phone Number: _____

Is this a Litigation case?: NO ___ YES ___ Attorney's Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Attorney Phone Number: _____ Contact Person: _____

Is this an auto accident?: NO ____ YES _____ Claim# _____
Adjuster's Name: _____ Adjuster's Phone Number: _____

I know that weight training and cardiovascular exercise are potentially hazardous activities. I should not enter unless I am medically able and take into account any pre-existing medical conditions and in consultation with my physician. I assume any and all risks associated with this activity. I agree to comply with all SMTC policies and rules, including but not limited to all SMTC policies, guidelines, signage, and instructions.

Because SMTC is open for use by other individuals, I recognize that I am at higher risk of contracting COVID-19. SMTC has put in place preventative measures to reduce the spread of COVID-19; however, SMTC cannot guarantee that clients will not become infected with COVID-19. By signing this agreement, I acknowledge the contagious nature of COVID-19 and voluntarily assume the risk that I may be exposed to or infected by COVID-19 by attending SMTC, and that such exposure or infection may result in personal injury, illness, permanent disability, and death. I voluntarily agree to assume all of the foregoing risks and accept with full awareness and appreciation of the risks having read this waiver and knowing these facts, and in consideration of your providing services for me, I for myself and anyone entitled to act on my behalf, waive and release the Sports Medicine & Training Center, its employees and all other persons connected with this facility. They are not held liable or responsible for any injuries or illnesses which I may suffer while training or as a result thereof. In this connection, I hereby waive any claim for damages to my person or property. I grant full permission for use of photographs, videotape or motion pictures of me, and/or quotations from me in legitimate accounts and promotions of this facility.

_____ _____ _____
Signature Relationship to patient Date