

**LAKE CONROE SPORTS MEDICIN & REHABILITATION PATIENT DATA SHEET**

**DO NOT EMAIL** The electronic form is provided for your convenience. With respect to responding to this form, please do not send via email. Please populate, print and sign a hardcopy that may be faxed, mailed or hand delivered to the clinic.

**First:** \_\_\_\_\_ **MI:** \_\_\_\_\_ **Last:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Gender:** Male  Female

**Physical Address:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
**Mailing Address:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

<b>Phone Numbers:</b>	<b>OK To Call</b>	<b>Best Time To Call</b>
Home: _____	<input type="checkbox"/>	_____
Work: _____	<input type="checkbox"/>	_____
Cell: _____	<input type="checkbox"/>	_____

**May we send you text messages for your appointment reminders to the number(s) listed above? By marking "Yes" below, you understand that text messages may NOT be secure, with a risk of unauthorized access to your information.**  
 Yes  No

**May we send you emails relating to your care with us?**  Yes  No  
**By providing your email address below, you understand that email communications may NOT be secure, with a risk of unauthorized access to your information.**  
Email: \_\_\_\_\_

**Preferred language:** \_\_\_\_\_ **Interpreter required?**  Yes

**Date of Injury:** \_\_\_\_\_ **Referring Physician:** \_\_\_\_\_  
**Injury Area:** \_\_\_\_\_ **Auto or Work Accident:**  Auto  Work  N/A  
**Are you currently receiving or have you received Home Health Services (including any therapy, nursing, bathing & dressing, etc) in the last 60 days?**  Yes  No  
**Are you currently receiving or have you received other therapy services in the last 60 days?**  Yes  No

**Marital Status:**  
 Married  Single  Divorced  Widowed  Separated  Unknown

**Student Status:**  
 Full-Time  Part-Time  None

**EMPLOYMENT STATUS**

**Employment Status:**

Active Military    Full-Time    None    Part-Time    Retired    Self Employed

**Employer:** \_\_\_\_\_ **Occupation:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

**Employer:** \_\_\_\_\_ **Occupation:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

**INSURANCE INFORMATION**

**Primary Insurance:** \_\_\_\_\_

**Policy Holder's Name:** \_\_\_\_\_ **Holder's Birth Date:** \_\_\_\_\_

**Policy or Certificate #:** \_\_\_\_\_ **Group #:** \_\_\_\_\_

**Policy Holder's Employer:** \_\_\_\_\_

**Secondary Insurance:** \_\_\_\_\_

**Policy Holder's Name:** \_\_\_\_\_ **Holder's Birth Date:** \_\_\_\_\_

**Policy or Certificate #:** \_\_\_\_\_ **Group #:** \_\_\_\_\_

**Policy Holder's Employer:** \_\_\_\_\_

**How did you hear about us?**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Physician      | <input type="checkbox"/> Hospital               | <input type="checkbox"/> Marketing Ad - Print               |
| <input type="checkbox"/> Employer       | <input type="checkbox"/> Cross Referral         | <input type="checkbox"/> Marketing Ad - TV                  |
| <input type="checkbox"/> Case Manager   | <input type="checkbox"/> Friend - Word of Mouth | <input type="checkbox"/> Marketing Ad - Billboard           |
| <input type="checkbox"/> Former Patient | <input type="checkbox"/> Attorney               | <input type="checkbox"/> Marketing Ad - Direct Mail - Email |
| <input type="checkbox"/> Adjustor       | <input type="checkbox"/> Self                   | <input type="checkbox"/> Marketing Ad - Facebook            |
| <input type="checkbox"/> School         | <input type="checkbox"/> Screens - Open Houses  | <input type="checkbox"/> Marketing Ad - Other _____         |

Specify if other : \_\_\_\_\_

**Note: Please provide us with the most updated information below.**

**EMERGENCY AND OTHER CONTACTS**

Name	Phone	Work	Cell	Fax	Type

**DISCLOSURE OF MEDICAL RECORDS**

I authorize the following individuals to have access to my medical and billing records:

\_\_\_\_\_  
Name Relationship

\_\_\_\_\_  
Name Relationship

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date



## LAKE CONROE SPORTS MEDICIN &amp; REHABILITATION MEDICAL HISTORY FORM

PATIENT NAME: \_\_\_\_\_ TODAY'S DATE: \_\_\_\_\_  
 REFERRING PHYSICIAN'S NAME: \_\_\_\_\_ DATE OF INJURY OR ONSET: \_\_\_\_\_  
 PRIMARY CARE PHYSICIAN'S NAME: \_\_\_\_\_ ARE YOU PRESENTLY WORKING? YES NO  
 CAUSE OF INJURY OR ONSET: \_\_\_\_\_ DATE OF NEXT MD APPT: \_\_\_\_\_

DO YOU CURRENTLY HAVE ANY "FLU TYPE" SYMPTOMS (I.E. FEVER, COUGHING)? YES NO  
 IF YES, WHAT SYMPTOMS: \_\_\_\_\_

DO YOU HAVE ANY OPEN CUTS, LESIONS OR WOUNDS? YES NO IF YES, WHERE: \_\_\_\_\_

HAVE YOU FALLEN IN THE PAST YEAR? (circle one) YES NO IF YES, HOW MANY TIMES: \_\_\_\_\_

IF YES TO FALLING, DID YOU SUSTAIN AN INJURY AS RESULT OF THE FALL? YES NO \_\_\_\_\_

WHAT IS YOUR REASON FOR ATTENDING THERAPY: \_\_\_\_\_

BECAUSE OF YOUR PROBLEM, WHAT SPECIFIC ACTIVITIES ARE YOU HAVING DIFFICULTY WITH?

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

WHAT ARE YOUR PERSONAL GOALS/OUTCOMES YOU HOPE TO ACHIEVE FROM THERAPY?

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

DESCRIBE YOUR GENERAL HEALTH: (circle one) EXCELLENT GOOD FAIR POOR

DO YOU USE TOBACCO? (circle one) YES NO, IF YES, HOW MUCH? \_\_\_\_\_ WEAR GLASSES / CONTACTS?: YES NO

HAVE YOU RECENTLY BEEN HOSPITALIZED OR HAD SURGERY? YES NO IF YES, WHEN \_\_\_\_\_  
 AND WHY \_\_\_\_\_

HAVE YOU HAD PRIOR PHYSICAL/OCCUPATIONAL THERAPY FOR THIS CONDITION? (circle one) YES NO  
 WHAT WAS DONE? / WHAT WERE THE RESULTS?: \_\_\_\_\_

HAVE YOU HAD PRIOR PHYSICAL/OCCUPATIONAL THERAPY THIS CALENDAR YEAR? (circle one) YES NO  
 WAS IT RECEIVED AT: (circle one) HOSPITAL OUT PATIENT CENTER HOME HEALTH  
 FOR HOW LONG? \_\_\_\_\_

CURRENT MEDICATIONS: \_\_\_\_\_

ALLERGIES: Medication \_\_\_\_\_ Reaction \_\_\_\_\_ Other \_\_\_\_\_ Reaction \_\_\_\_\_

ARE YOU ALLERGIC TO LATEX? (circle one) YES NO If yes what is the Reaction \_\_\_\_\_

Are you Allergic to Dexamethasone? YES NO If yes what is the Reaction \_\_\_\_\_

DO YOU CURRENTLY HAVE OR HAVE A HISTORY OF ANY OF THE FOLLOWING CONDITIONS? (check all that apply)

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> ANEMIA  | <input type="checkbox"/> DIABETES <input type="checkbox"/> controlled <input type="checkbox"/> uncontrolled | <input type="checkbox"/> RESPIRATORY PROBLEMS   |
| <input type="checkbox"/> ARTHRITIS   | <input type="checkbox"/> DEPRESSION   | <input type="checkbox"/> ASTHMA <input type="checkbox"/> controlled <input type="checkbox"/> uncontrolled   |
| <input type="checkbox"/> CANCER  | <input type="checkbox"/> DIZZINESS/FAINTING   | <input type="checkbox"/> COPD <input type="checkbox"/> controlled <input type="checkbox"/> uncontrolled     |
| <input type="checkbox"/> CARDIOVASCULAR PROBLEMS   | <input type="checkbox"/> FRACTURES  | <input type="checkbox"/> Other  |
| <input type="checkbox"/> HOLTER MONITOR - currently wearing?   | <input type="checkbox"/> HEADACHES  | <input type="checkbox"/> SEIZURES <input type="checkbox"/> controlled <input type="checkbox"/> uncontrolled |
| <input type="checkbox"/> PACEMAKER   | <input type="checkbox"/> HEPATITIS/HIV  | <input type="checkbox"/> THYROID PROBLEMS   |
| <input type="checkbox"/> HIGH BLOOD PRESSURE <input type="checkbox"/> controlled <input type="checkbox"/> uncontrolled | <input type="checkbox"/> KIDNEY PROBLEMS  | <input type="checkbox"/> BLOOD THINNERS (Anticoagulants)  |
| <input type="checkbox"/> LOW BLOOD PRESSURE  | <input type="checkbox"/> MRSA (Methicillin Resistant Staphylococcus Aureus)                                 |   |
| <input type="checkbox"/> CURRENTLY PREGNANT  | <input type="checkbox"/> OSTEOPOROSIS   |   |

If checked any above, explain: \_\_\_\_\_

ANY OTHER MEDICAL PROBLEMS: \_\_\_\_\_

SIGNATURE OF PATIENT: \_\_\_\_\_ REVIEWED BY Therapist: \_\_\_\_\_ Date \_\_\_\_\_

This form constitutes proprietary information and cannot be used, reproduced or duplicated, in whole or in part, absent written consent of LAKE CONROE SPORTS MEDICIN & REHABILITATION. This form must be completed in its entirety and must be provided to LAKE CONROE SPORTS MEDICIN & REHABILITATION prior to initiation of therapy services. **Revised**

**CONSENT TO USE OF LIKENESS AND  
TESTIMONIAL AND RELEASE**

I, \_\_\_\_\_, hereby consent to LAKE CONROE SPORTS MEDICIN & REHABILITATION allow and its employees, agents, partners, and affiliates (collectively "Clinic"), to use my name, photograph, videotape/ audiotape recording, and/or written testimonial ("marketing materials") in Clinic's marketing brochures, publications, and/or on their website and social media accounts, including but not limited to Facebook and Twitter, to promote the services offered by Clinic. I understand and agree that these marketing materials are owned by Clinic and will not be returned to me.

I hereby release, hold harmless, and forever discharge the Clinic from any and all claims, demands, and causes of action which I have or may have by reason of this authorization.

Further, I hereby affirm that I have read this Consent to Likeness and Release, and I fully understand the content, meaning, and impact of this agreement. This agreement shall be binding upon me and my heirs, legal representatives and assigns.

\_\_\_\_\_  
Participant Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Legal Guardian (If Participant is a Minor)

**HIPAA AUTHORIZATION FOR DISCLOSURE OF PHI**

I, \_\_\_\_\_, hereby consent and authorize LAKE CONROE SPORTS MEDICIN & REHABILITATION and its employees, agents, partners, and affiliates (collectively "Clinic") to disclose my Protected Health Information ("PHI"), as that term is defined in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), for marketing purposes, as stated below. I understand that subsequent disclosures by recipients of my PHI may not be protected by the HIPAA Privacy Rule or other applicable medical record privacy laws.

Further, I authorize Clinic to disclose my PHI, in the form of written statements, photographs, and videotape/audiotape recordings, for purposes of promoting and advertising Clinic's services.

I understand that I may revoke this authorization at any time by giving written notice to Clinic, except to the extent that Clinic and its agents, employees, and representatives may have taken action in reliance on this authorization.

This authorization is effective on the date stated below for an indefinite period of time. A photocopy of this authorization form is valid and should be given the same force and effect as the original.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Participant Name

\_\_\_\_\_  
Parent/Legal Guardian (If Participant is a Minor)