nexus physical therapy
www.nexuspt.com

EL CAJON
T [619] 579-1625
F [619] 579-1611

CHULA VISTA
T [619] 420-0869
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HILLCREST
T [619] 297-4404
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T [858] 312-6444
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SAN MARCOS
T [760] 471-9953
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MISSION VALLEY
T [619] 497-2836
F [619] 497-0254

SPORTS ARENA
T[619] 226-4131
F[619] 226-4124

PATIENT INFORMATION

Last Name | First Name | Middle Name

Address | City | State | Zip

Home Phone # | Alt Phone # | Emergency Contact Name | Phone #

Social Security # | Date of Birth | Gender | Marital Status

Referring Physician | Address | City | State | Zip | Phone #

Current Occupation | Work Phone #

INSURANCE INFORMATION

Primary Insurance | Secondary Insurance

Name of Insured/Policy Holder | Relationship to Patient | Social Security # | Date of Birth

WORK INJURY

Date of Injury | Area(s) Injured

Patient's Employer | Address | City | State | Zip | Phone #

ATTORNEY WITH LIEN

Date of Injury | Area(s) Injured

Attorney's Name | Address | City | State | Zip | Phone #

MISSED APPOINTMENTS WITHOUT 24 HOURS NOTICE ARE SUBJECT TO A LATE CANCELLATION FEE OF $25

I hereby give lifetime authorization for payment of insurance benefits to be made directly to this healthcare provider and/or its affiliates for services rendered. I understand that I am financially responsible for all charges not paid by my insurance company. In the event of default, I agree to pay all costs of collection and reasonable attorneys fees. I hereby authorize this health care provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement is as valid as the original. I further authorize that my signature on this form constitutes assignment of benefits to this healthcare provider.

I consent to have this healthcare provider and/or its affiliates provide the treatment and care prescribed by my physician(s). I understand this consent may be revoked by me at any time.

SIGNATURE: _____ **DATE:** _____

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MEDICAL HISTORY FORM

What is your condition/injury? _____

Date condition/injury began: _____Date of surgery, if any: _____

How did you injure yourself? _____

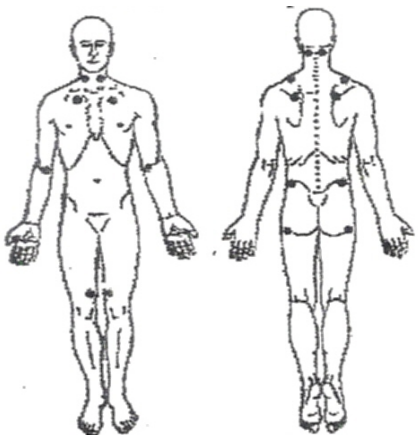
Have you had a similar problem(s) before? ☐ No ☐ Yes, What Treatment was given? _____

Please list any medications you are currently taking: _____

Have you had any tests for this problem? ☐ X-Ray ☐ MRI ☐ EMG ☐ C.T. Scan ☐ Other: _____

Are you currently receiving any other medical or health services? ☐ Chiropractor ☐ Acupuncture ☐ Massage

Please shade area of pain



What does the pain feel like (check all that apply)?

☐ Aching	☐ Pinching	☐ Pulsing	☐ Tender
☐ Burning	☐ Pins & Needles	☐ Sharp	☐ Throbbing
☐ Deep	☐ Pricking	☐ Shooting	☐ Tight
☐ Dull	☐ Pounding	☐ Sore	
☐ Knot-like	☐ Pressing	☐ Stabbing	

What makes the pain worse? _____

What makes the pain better? _____

Circle your pain on a scale of 0 to 10, 0 being no pain and 10 being the worst pain imaginable.

Pain at its **least**:	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Pain at its **worst**:	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

Medical History (check all that you have ever had):

☐ Allergies	☐ Cancer	☐ Metal Implants	☐ Seizures
☐ Arthritis	☐ Diabetes	☐ Multiple Sclerosis	☐ Stroke
☐ Asthma	☐ Head Injury	☐ Muscular Dystrophy	☐ Surgery
☐ Back Injury	☐ Heart Disease	☐ Osteoporosis	☐ Tuberculosis
☐ Bleeding Disorder	☐ High Blood Pressure	☐ Pacemaker	☐ Other: _____
☐ Fractures	☐ Kidney Problems	☐ Parkinson's Disease	☐ Other: _____

Please check any symptoms you currently have (check all that apply):

☐ Chest Pains	☐ Dizziness	☐ Numbness	☐ Visual Problems
☐ Coordination Problems	☐ Headaches	☐ Pain at Night	☐ Weakness
☐ Difficulty Sleeping	☐ Loss of Balance	☐ Swelling	☐ Other: _____

Is it possible you are pregnant? ☐ No ☐ Yes, How far along are you? _____

Have you had any physical therapy treatment before? ☐ Yes ☐ No When? _____ Where? _____

Describe the treatment you received: _____

Patient Signature: _____ **Date:** _____

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PATIENT PRIVACY NOTICE

THE FOLLOWING ABBREVIATED NOTICE BRIEFLY DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE UNUSED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

- **For Treatment:** We may use health information about you to provide you with health care treatment or services. We may disclose health information about you to personnel who are involved in taking care of you.
- **For Payment:** We may use and disclose health information about you so that the services you receive from us may be billed to insurance carriers and payment collected.
- **For Health Care Operations:** We may use and disclose health information about you for operations that are necessary to run our practice.
- **Threat to Health or Safety:** We may use and disclose health information about you when necessary to prevent a serious threat to you health and safety or the health and safety of the public or another person.
- **Military and Veterans:** If you are a member of the armed forces or separated/discharged from military services, we may release health information about you as required by military command authorities or the Department of Veterans Affairs.
- **Workers' Compensation:** We may release health information about you for workers compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.
- **Lawsuits and Disputes:** If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order, etc.
- **Law Enforcement:** We may release health information if asked to do so by a law enforcement official.

RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

- **Right to Inspect and Copy:** You have the right to inspect and copy health information that may be used to make decisions about your care.
- **Right to Amend:** If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information.
- **Right to an Accounting of Disclosures:** You have the right to request a list accounting for any disclosures of your health information we have made, except for uses and disclosures for treatment, payment, and health care operations, as previously described.
- **Right to Request Restrictions:** You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment, or health care operations.
- **Right to Request Confidential Communications:** You have the right to request that we communicate with you about health matters in a certain way or at a certain location.

I, the undersigned, have read and understand the above information.

_____

Patient signature Date