Welcome to Sports + Orthopedic Leaders (SŌL) Physical Therapy + Performance Training

Move Beyond Pain + Move For Life

Thank you for returning to SOLPT!
Please complete the following pages so that we can help you get started raching your rehab goals for your new case!

Full Name	Preferred Name/Nickname	Primary Phone #

By signing below, I certify that the following information is the same since the last time I received services at SOLPT:

- Mailing Address
- Secondary Phone Number
- Emergency Contact Information
- Referring Physician Information
- Primary Care Physician Information
- Insurance Carrier
- Insurance Member ID #

If any of the above information has changed since your last case, please notify a front desk coordinator immediately.

CONDITIONS & CONSENT FOR PHYSICAL THERAPY

This page must be read and signed before we can see you for physical therapy services.

Informed consent for treatment:
The term "informed consent" means that the potential risks, benefits, and alternatives of physical therapy treatment have been explained to me. The therapist provides a wide range of services and I understand that I will receive information at the initial visit concerning the treatment and options available for my condition.

Please read below for an explanation of potential risks, potential benefits, and alternatives to treatment:

Potential benefits may include an improvement in my symptoms and an increase in my ability to perform my daily activities. I may experience increased strength, awareness, flexibility and endurance in my movements. I may experience decreased pain and discomfort. I should gain a greater knowledge about managing my condition and the resources available to me.

Potential risks: I understand I may experience an increase in my current level of pain or discomfort, or an aggravation of my existing injury. This discomfort is usually temporary; if it does not subside in 24 hours, I agree to contact my physical therapist.

No warranty: I understand that my physical therapist at SŌLPT, Inc. cannot make any promises or guarantees regarding a cure for or improvement in my condition. I understand that my physical therapist will share with me her opinions regarding potential results of physical therapy treatment for my condition and will discuss treatment options with me before I consent to treatment.

Alternatives: If I do not wish to participate in the therapy program, I will discuss my medical, surgical or pharmacological alternatives with my physician or primary care provider.

I have read the above information and I consent to physical therapy evaluation and treatment. By signing below, I acknowledge that I have read, understood and will abide by the conditions and policies noted on this consent form.

Print Name	**Patient Signature** *(If patient is a minor, this and all following signatures must be that of a legal guardian.)*	**Date**

Patient Physical Therapy Goals and Medical History

Type of Injury/Condition _____ Onset/Injury Date _____

(If Applicable) Type of Surgery _____ Surgery Date _____

What are your goals for physical therapy? _____

Please describe your physical limitations as a result of this injury or condition: _____

Please describe any activities or movements that aggravate your symptoms: _____

Please describe any previous injury or injuries that could affect care: _____

Have you had any of the following diagnostic tests in relationship to this injury? *(Circle all that apply)*

X-Ray CT Scan MRI Doppler Ultrasound

Which of the following describes your pain? *(Circle all that apply)*

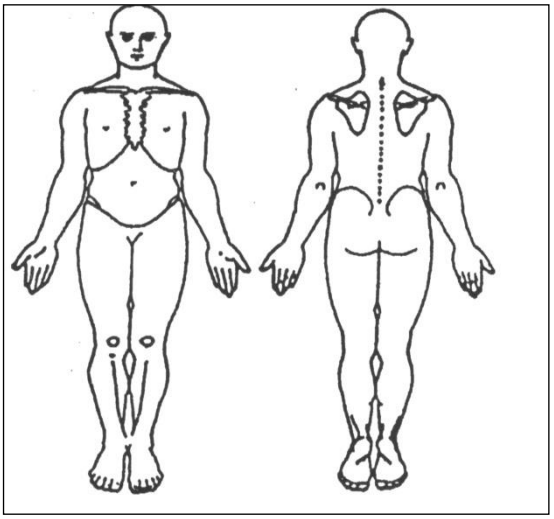
Sharp Aching Burning Tingling Numbness

Other: _____

Please Rate Your Pain (0 = None, 1=Minimal, 10 = Severe)

At Present	0	1	2	3	4	5	6	7	8	9	10
At its worst:	0	1	2	3	4	5	6	7	8	9	10
At its best:	0	1	2	3	4	5	6	7	8	9	10

Please mark the location of your symptom(s).



Are you currently taking medications? Yes No

Please List All Medications: _____

Have you recently noticed any of the following? *(Check all that apply)*

- ❒ Breathing Difficulty
- ❒ Change in Vision
- ❒ Fatigue
- ❒ Fever/Chills/Sweats
- ❒ Insomnia
- ❒ Nausea/Vomiting
- ❒ Pain at Night
- ❒ Pregnancy
- ❒ Weakness
- ❒ Weight Loss

Do you have now or have you ever had any of the following?

- ❒ Allergies/Skin Sensitivity
- ❒ Asthma/Breathing Problems
- ❒ Autoimmune Deficiency
- ❒ Cancer
- ❒ Circulation Problems
- ❒ Diabetes
- ❒ Easy Bruising/Bleeding
- ❒ Fainting
- ❒ Fractures
- ❒ Heart Problems
- ❒ Hepatitis
- ❒ High Blood Pressure
- ❒ Indigestion/Heartburn
- ❒ Kidney Disease
- ❒ Leg/Ankle Swelling
- ❒ Loss of Consciousness
- ❒ Lung Disease
- ❒ Metal Implant
- ❒ Motor Vehicle Accident
- ❒ Multiple Sclerosis
- ❒ Osteoporosis/Osteopenia
- ❒ Sprains/Strains
- ❒ Stroke
- ❒ Surgeries
- ❒ Thyroid Problems
- ❒ Urinary Problems/ Infections

Please explain and give approximate dates for any conditions marked above:

_____

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