846 W Foothill Blvd #C
Upland, CA 91786
T: (909) 985 8686
F: (909) 985-5706
rozinaandsmithpt.com

PATIENT DEMOGRAPHICS

Last Name:_______________________________________ First Name:_____________________________ MI:___

Social Security:________________________________ Date of Birth:_________________ Age:_____ Gender:___

Drivers License:_______________________________ Height:_________ Weight:________

Address:____ City:_______________ State:_____ Zip:________

Employer Name: _____________________________________ Occupation:________________________________

How did you hear about us? ____

CONTACT INFORMATION

Best Contact Number:__________________________________ ☐ Home ☐Cell
May we leave appointment, billing, or medical information on your answering machine/voice mail? ☐Yes ☐No
☐Leave detailed messages ☐Leave callback information only ☐Leave appointment reminders

Email Address:____

Emergency Contact:_____________________________ Relationship:_____________ Phone:________________
May we leave appointment, billing, or medical information on their answering machine/voice mail? ☐Yes ☐No
☐Leave detailed messages ☐Leave callback information only

MEDICAL HISTORY

Condition		Condition		Condition	
Allergies	☐Yes ☐No	High/Low Blood Pressure	☐Yes ☐No	Incontinence	☐Yes ☐No
Asthma	☐Yes ☐No	High Cholesterol	☐Yes ☐No	Parkinson's	☐Yes ☐No
Osteoarthritis	☐Yes ☐No	Cardiac Conditions	☐Yes ☐No	Multiple Sclerosis	☐Yes ☐No
Rheumatoid Arthritis	☐Yes ☐No	Cardiac Pacemaker	☐Yes ☐No	Seizures	☐Yes ☐No
Fractures	☐Yes ☐No	Circulation Problems	☐Yes ☐No	Tuberculosis	☐Yes ☐No
Osteoporosis	☐Yes ☐No	Previous Stroke	☐Yes ☐No	Hepatitis	☐Yes ☐No
Metal Implants	☐Yes ☐No	Diabetes	☐Yes ☐No	HIV/AIDS	☐Yes ☐No
Muscular Disease	☐Yes ☐No	Emphysema/Bronchitis	☐Yes ☐No	Cancer	☐Yes ☐No
Smoking	☐Yes ☐No	MRSA	☐Yes ☐No	Autoimmune Disorder	☐Yes ☐No
Chemical Dependency	☐Yes ☐No	Anemia	☐Yes ☐No	Fibromyalgia	☐Yes ☐No
Dizzy Spells	☐Yes ☐No	Gallbladder Problems	☐Yes ☐No	Hearing Impairment	☐Yes ☐No
Headaches	☐Yes ☐No	Thyroid Disease	☐Yes ☐No	Vision Problems	☐Yes ☐No
Anxiety	☐Yes ☐No	Kidney Problems	☐Yes ☐No	Speech Problems	☐Yes ☐No
Depression	☐Yes ☐No	Currently Pregnant	☐Yes ☐No		

Describe any other conditions or precautions:____

____

____

CURRENT MEDICATIONS

☐ I have provided a written list, see attached

Drug:______________________________ Dosage:________________ Reason for taking: ________________
Drug:______________________________ Dosage:________________ Reason for taking: ________________
Drug:______________________________ Dosage:________________ Reason for taking: ________________

SURGICAL HISTORY

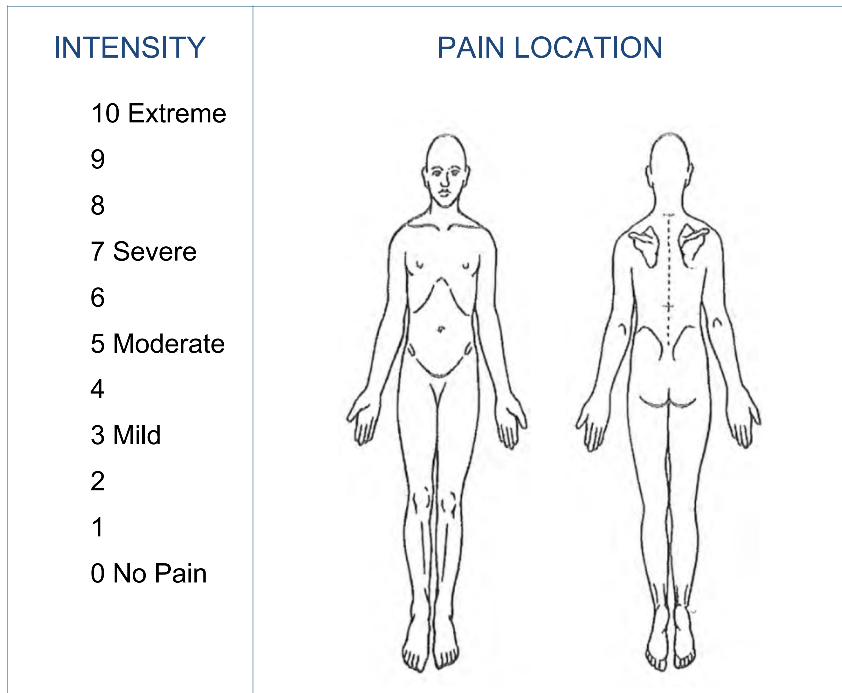
Body Region:____________________ Surgery Type:_____________________ Date of Surgery:___________
Body Region:____________________ Surgery Type:_____________________ Date of Surgery:___________

OTHER SYMPTOMS (If you have not yet seen a physician)

Check all that apply:

☐ Unexplained weight loss
☐ Fever/chills/sweats
☐ Changes in bowel/bladder function
☐ Shortness of breath
☐ Change in appetite
☐ Nausea/vomiting
☐ Difficulty swallowing
☐ Increased pain at night

1. Please circle the number on the intensity scale that best describes your current pain symptoms.
2. Circle or shade the location of your pain on the body chart below.
3. If you have any other symptoms, such as tingling or numbness, draw these as a dotted line.

INTENSITY	PAIN LOCATION
10 Extreme 9 8 7 Severe 6 5 Moderate 4 3 Mild 2 1 0 No Pain	

Please provide a brief history of your injury, such as date of injury, how it started, and any previous treatments.

ACKOWLEDGEMENT

The above information is correct to the best of my knowledge.

Patient Signature:_________________________________ Witness:______________ Date:___________

Parent/Guardian Signature (If patient is a minor):______________________________ Date:___________

Office Use Only

Patient Physical Therapy Contract

CONSENT TO TREATMENT & THERAPEUTIC PROCEDURES

I, the undersigned, hereby consent to the therapeutic procedures outlined below, to be performed by Rozina and Smith Physical Therapy, Inc. and their associates.

- I agree to be evaluated and treated for functional loss due to related nerve, muscle and skeletal dysfunctions and or pain.
- I understand that therapeutic procedures can include but are not limited to joint and soft tissue mobilization; clinic and home exercise programs; functional training including posture and body mechanics; modalities such as heat, ice, E-stim and ultrasound; and special procedures such as taping, neuromuscular E-stim and bladder training.
- I understand that I will be explained the purpose of the therapeutic procedures prior to receiving treatment and that I may refuse any therapeutic procedure or treatment at any time.
- I understand that I may consult with other therapists and/or physicians at any time regarding my condition.
- I understand that I may purchase exercise equipment from Rozina and Smith Physical Therapy, Inc. or from any other source.

ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITY AGREEMENT

I understand that Rozina and Smith Physical Therapy Inc will seek payment for my valid Workers' Compensation Claim. I understand that Rozina and Smith Physical Therapy, Inc does not accept Liens and will only accept authorization for treatment from Workers' Compensation Insurance carrier/Payer. I understand that I will not be billed for any approved/authorized services. I understand that I may be responsible for a denied claim where allowed by law. If I am made responsible for payment of the claim by the Workers' Compensation insurer or employer and my account is referred to collections, I understand that I will be required to pay collection expenses incurred.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I the undersigned acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the notice.

I certify that I have read and understand all of the above:

_________________________________ _________________________

Patient/Authorized Representative Name (Print) (Self/Parent/Legal Guardian) Relationship to Patient

____

Patient/Authorized Representative Signature

Physical Therapist's Signature: ______________________________ Date: ________________________

A signed copy of this document is to be given to the Patient. Original is to be filed in Patient's medical records. (09/27/20)

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Name:____ Date of Birth:______________________

Social Security or Drivers License #:________________________________

I request and authorize **Rozina and Smith Physical Therapy** to release my health care information to the following person(s):

☐ Referring Physician

☐ Other:

Name:____

Address:____

____

This request and authorization applies to:

☐ All healthcare information

☐ Health care information related to the following treatment, condition, or dates: __________________

____

☐ Other:____

Patient Signature:_______________________________________ Date:_______________________

Parent/Guardian Signature(if minor):____

THIS AUTHORIZATION EXPIRES 1 YEAR AFTER IT IS SIGNED.
A copy of this form will be considered as valid as the original.