VELO Sports Rehab

New Patient Intake Form

Date:_____

First Name:_____ Last Name:_____

Preferred Name:_____ Date of Birth:_____

Address:_____City/Zip_____

Phone (cell/home):_____Email:_____

Employer/Address:_____

Occupation:_____How Long?:_____

Height: _____ Weight:_____

Marital Status: ○Single ○Married ○Other Children: ○Y ○N Ages:_____

Who may we thank for referring you to our office:_____

Medical History: check all that apply (past or present)

○Allergies
○Osteoarthritis
○Rheumatoid disease
○Inflammatory Arthritis
○Osteoporosis/Osteopenia
○Artificial bones/joints
○Asthma
○High/Low blood pressure
○Anemia
○Migraine/Headache
○Chest pain
○Shortness of breath
○Heart Attack/Stroke
○Lung Disease
○Thyroid problems
○Cancer
○Diabetes
○Other_____

○Stomach/GI disorders
○Kidney problems
○Depression/Anxiety
○Alcohol/Drug/Tobacco use
○Neurological condition (MS/ALS, etc)
○STD
○Nausea/Vomiting
○Fever/Chills/Sweats
○Weight (up/down) changes
○Numbness/Tingling
○Skin Rash
○Dizziness
○Muscle weakness
○Balance problems
○Vision changes
○Pregnancy/Birthcontrol
○HIV/Aids

Please list any serious accidents or surgeries with dates:

Family Health History:

Medications/Supplements:

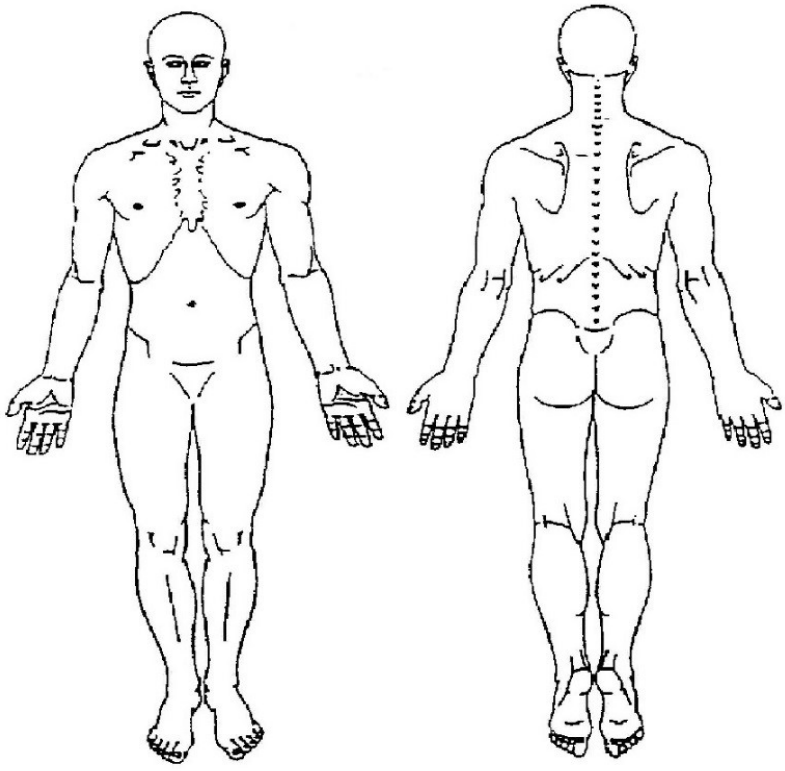
Reason for **today's** visit (work injury, auto accident, sports/training injury, etc):

Have you received any imaging (X-ray, MRI, CT, Ultrasound, etc.):

Does anything make your symptoms worse?

Better?

Please circle on the body where you are feeling symptoms:



Is there anything else about your health that you would like the doctor to know?

No Show & Cancellation Policy:

Velo Sports Rehab appreciates 24 hours prior notice when cancelling an appointment. If you cancel with less than 24 hours notice or miss your appointment, you will be charged **$50.00** for a visit with a doctor and **$85.00** for a massage. If you are more than 10 minutes late to your appointment we may ask you to reschedule. By signing below, you acknowledge that you understand and agree to the no show and cancellation policy.

_____ _____

Printed Name Signature

_____

Date

HIPAA (Privacy Practices):

I understand and acknowledge that I have received a copy of the HIPAA/Notice of Information Practices from Velo Sports Rehab and I understand it entirely.

_____ _____

Signature Date

Financial Policy:

1. We will bill your insurance company as a courtesy to you. You are ultimately responsible for your bill regardless of insurance coverage. Please keep the front desk informed about any changes to your insurance.
2. Payment for deductible, co-insurance and copays are expected at the time of visit.
3. We do offer a *time of service* discount to patients that do not have health insurance.
4. Please don't hesitate to call or email our office with any questions regarding your bill.

_____ _____

Signature Date