VIRGINIA CENTER FOR SPINE & SPORTS THERAPY
2820 Waterford Lake Drive, Suite 103 Midlothian, VA 23112 PHONE: 804-249-8277 FAX: 804-249-9690

Patient Name: ______________________________ DOB: _____ / _____ / _____

Patient's Preferred Pronouns (optional):______________________________

Emergency Contact Name: ______________________________ Emergency Contact PH#______________________

Symptoms began on: _____ / _____ / _______

Surgery Date: _____ / _____ / ________

How did symptoms start? ______________________________

____

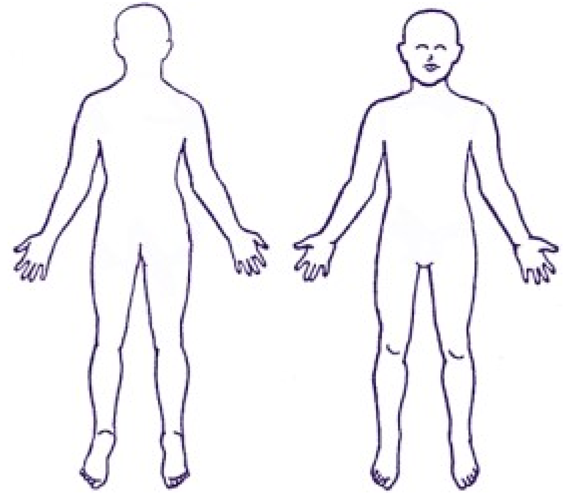
Describe how these symptoms affect your ability to function compared to before onset: ______________________________

____

Average Pain Intensity

Last 24 hours: No Pain 1 2 3 4 5 6 7 8 9 10 Worst Pain

Past week: No Pain 1 2 3 4 5 6 7 8 9 10 Worst Pain



Indicate where you have symptoms

How often do you experience your symptoms?

☐ Constantly ☐ Frequently (51%-74%) ☐ Occasionally (26%-50%) ☐ Intermittently (0%-25%)

Describe your pain: ☐ Sharp ☐ Dull Ache ☐ Numb ☐ Shooting ☐ Burning ☐ Tingling

How much have your symptoms interfered with your usual daily activities?

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

In general, how would you say your overall health is right now? ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

Please identify 3 important activities that you are unable to do or are having difficulty doing. Please score them with a number based on the following scale:

Unable to perform activity	0	1	2	3	4	5	6	7	8	9	10	Able to perform at the same level as before injury

ACTIVITY Please write the activity below (ex. Raise arms overhead to wash hair, bend over to put on shoes, carry a bag of groceries)	**SCORE** Please write the number that corresponds with your ability to perform the task

Please provide a list **or** list below all medications that you currently take. Include those prescribed by a physician as well as any over-the-counter medications such as vitamins, herbals, Tylenol, et. Please use a separate page to continue if necessary.

NAME OF MEDICATION	DOSAGE (mg, etc.)	FREQUENCY (HOW OFTEN)	ROUTE (HOW TAKEN)
			☐ Oral ☐ Other
			☐ Oral ☐ Other
			☐ Oral ☐ Other
			☐ Oral ☐ Other

We ask that you notify us one appointment prior to when you are returning to your doctor for a follow-up visit. This will allow us to provide your doctor with a progress note regarding your care.

CANCELLATION / NO-SHOW POLICY

We are committed to adhering to the prescription or plan of care your physician has prescribed and expect the same of you. It is very important that keep your scheduled appointments and arrive on time. As a courtesy and convenience for you, we offer text message and/or email reminders in advance of your appointment time. Please call the clinic at least 24 hours in advance if you are unable to attend your appointment. Available appointments are in high demand and your early cancellation will give another patient the possibility to have access to timely rehabilitative care.

If you do not cancel or reschedule your appointment with at least a 24-hour notice, we will assess a **$45 Late Cancellation** charge to your account. If you **No-Show** for your appointment, we will assess a **$45 No-Show** charge to your account. These fees are not covered by your insurance, and you will be responsible for payment in full.

I understand that I can provide credit card information to be retained in a secure file and any late cancellation / no-show fees will be charged to my account.

I understand and agree to abide by the clinic's cancellation policy. ***____________ INITIALS REQUIRED***

NOTICE OF PRIVACY PRACTICES (NPP)

I acknowledge that I have been shown the posted Notice of Information Practices by H2 Health and its affiliates. This notice explains how H2 Heath and its affiliates may use and disclose my personal health information. Upon request, I will be provided a copy so I may read it in full or I can download the latest version from the company's website, www.h2health.com. By initialing below, I acknowledge the presentation/availability of the NPP. If I have questions regarding this NNP, I can contact the Privacy Officer at PrivacyOfficer@h2health.com .

I acknowledge that VCSST's NOTICE OF PRIVACY POLICY was made available to me. * ________________ INITIALS REQUIRED *****

If you are eligible for Medicare benefits, please complete this section.

Please check all applicable boxes below if you are receiving any of the following benefits.

☐ Black Lung Benefits
☐ Government benefits (i.e. Research Grant)
☐ Department of Veteran's Affairs
☐ Group Health Plan Coverage
☐ Medicare due to disability
☐ Medicare due to ESRD kidney benefits
☐ HMO or Group Health plan
☐ Medicare while employed or spouse employed
☐ Medicare due to age

Patient /Responsible Party (Signature): ____ **Date:** ______________________

VIRGINIA CENTER FOR SPINE & SPORTS THERAPY

ASSOCIATED HEALTH CONDITIONS
(REQUIRED BY INSURANCE)

Patient Name: ___________________________________ **Date of Birth:** _____________________

Height: _______ ft ______ inches Weight: ________ lbs
Do you live alone? Yes / No
Do you rely on others for transportation? Yes / No
Do you feel that you have a good social support system? Yes / No
Do you have to use stairs to navigate in/out or around your home? Yes / No
Do you worry about having adequate housing, food, or affordable medications? Yes / No

Do you have or have you ever had any of the following? Please check all that apply and circle specific conditions.

- ○ Diabetes, Pre-diabetes
- ○ Respiratory Disorders (asthma, COPD, pulmonary fibrosis, sarcoidosis, oxygen-dependency)
- ○ Musculoskeletal disorder (rheumatoid arthritis, contracture, fracture, osteoarthritis, other)
- ○ Cognitive impairment (brain injury, intellectual disability, concussion, language delay, memory impairment)
- ○ Active major medical treatment (radiation, chemotherapy, hemodialysis)
- ○ Neurological condition (prior stroke, Parkinson's, MS, spasticity, seizures, cerebral palsy, tremors)
- ○ Medical devices (PEG tube, catheter, shunt, tracheostomy)
- ○ Psychological / Emotional disorder (bipolar, ADHD, anxiety, depression, panic attacks, PTSD, other)
- ○ Pregnancy or recently post-partum (within last 6 months)
- ○ Non-developmental impairment (uncorrected hearing or vision loss)
- ○ Sensory processing disorder (apraxia, hemi-sensory loss, vertigo, balance)
- ○ Heart or lung transplant
- ○ Coronary artery disease (heart attack, angina, chest pain, other heart trouble, pacemaker)
- ○ Complications from COVID
- ○ Amputation
- ○ Genetic disorder (Down's syndrome, other)
- ○ Shortness of breath
- ○ Cancer
- ○ Unintended weight loss
- ○ Anemia
- ○ Hypertension / High blood pressure
- ○ Osteoporosis
- ○ Pins / Metal implants
- ○ Numbness / Tingling
- ○ Bowel / Bladder problems
- ○ Headaches
- ○ Sleeping problems
- ○ Infectious diseases
- ○ Joint replacement
- ○ Latex allergy
- ○ Do you smoke?
- ○ Allergies: ____

Patient / Responsible Party Signature: ______________________________________ **Date:** _____________________