



## Welcome to SportMedicine of Atlanta

We strive to provide our patients with excellent service and quality care. Our commitment to your well-being and health care is something that we at *SportsMedicine of Atlanta* take very seriously.

Your commitment to your physical therapy program is critical to your success. We will recommend treatment and set goals for you. In order to reach those goals you must do your part and your most important part is to make each and every appointment.

We will give you an appointment card to keep track for your appointments. If you should misplace this, please give us a call to review your appointment dates. We expect you to keep all your appointments; however should you need to cancel please note that we require a 24-hour notice.

If you need to cancel please call our office within 24-hours of your scheduled appointment to reschedule. Our Phone number is 770-979-1400.

If you do not show for your scheduled appointment and have not called to cancel, you may be charged \$25 for the missed appointment.

If you miss 3 consecutive appointments we may need to discontinue your treatment.

We thank you for choosing *SportsMedicine of Atlanta* and we are looking forward to working with you and helping you reach your goals.

### *The Staff at SportsMedicine of Atlanta*

I have read and understand this policy:

\_\_\_\_\_  
Patient/Guardian

\_\_\_\_\_  
Date



I, \_\_\_\_\_ hereby give my written consent that SportsMedicine of Atlanta **release** any medical or billing records, upon request, to an insurance carrier, legal office, or other medical facility. I also give SportsMedicine of Atlanta permission to **obtain** any medical or billing records from an insurance carrier, legal office, or other medical facility.

Patient Signature

Date

---

Witness Signature

Date

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**NEW PATIENT INTAKE FORM – HEALTH INSURANCE**

Today's Date \_\_\_\_\_

Patient: \_\_\_\_\_ Patient # \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ St. \_\_\_\_\_ Zip \_\_\_\_\_

Phone# \_\_\_\_\_ Alt. Phone# \_\_\_\_\_ DOB \_\_\_\_\_

PCP \_\_\_\_\_ Referring MD \_\_\_\_\_

Diagnosis \_\_\_\_\_

Insurance Co. Name \_\_\_\_\_ ID# \_\_\_\_\_

Subscriber Name \_\_\_\_\_ Telephone # \_\_\_\_\_

Subscriber DOB \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Any Previous Therapy Treatment for this injury? Yes \_\_\_\_\_ No \_\_\_\_\_

If Yes – When \_\_\_\_\_ Where \_\_\_\_\_

**Health Insurance Benefits**

Effective Date \_\_\_\_\_

Co-Pay \_\_\_\_\_ Co-Ins \_\_\_\_\_ Deductible \_\_\_\_\_  
\_\_\_\_\_

Benefits \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Date of 1<sup>st</sup> visit \_\_\_\_\_ Time \_\_\_\_\_ Therapist \_\_\_\_\_

- Patient Reminders:** Patient financial responsibility – co-pays, co-ins, etc.
- Bring script from physician
- Bring Insurance Card and all Ins information
- Wear or bring appropriate clothing – shorts, sneakers etc.
- Cx/No Show policy
- Any other information necessary to process claims.



**Patient Medical Information**

In the past, have you had?

Yes	No		
_____	_____	Fractures/Broken Bones	What area _____ When _____
_____	_____	Sprains/Strains	What area _____ When _____
_____	_____	Surgeries	What area _____ When _____
_____	_____	Medical conditions or major illness	Please Specify _____

Please provide a list of **all** medications you are currently taking. \_\_\_\_\_  
\_\_\_\_\_

Any personal history of Hypertension/Diabetes/Cancer? Explain \_\_\_\_\_

Are you pregnant? \_\_\_ yes \_\_\_ no Other important information \_\_\_\_\_

Are you currently working? \_\_\_ yes \_\_\_ no If no, is it because of this injury? \_\_\_ yes \_\_\_ no

Have you had an injury to this area before? \_\_\_ yes \_\_\_ no If yes, explain \_\_\_\_\_  
\_\_\_\_\_

What is your occupation and specific need of your job that you need help with? \_\_\_\_\_  
\_\_\_\_\_

Do you participate in any hobbies or athletics that you have difficulty doing or would like to return to? If so, what are they? \_\_\_\_\_

Name all physicians, chiropractors, specialists, physical therapists, etc. you have seen in regards to this injury.  
\_\_\_\_\_

Have you had any of the following in regards to this injury: (Circle all that apply)

Cat Scan      MRI      Bone Scan      X-Rays      Other \_\_\_\_\_

In case of emergency, who should we contact? Name: \_\_\_\_\_

Phone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Relationship \_\_\_\_\_

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date



**SPORTSMEDICINE OF ATLANTA  
MEDICAL HISTORY AND SYSTEMS REVIEW**

Date: \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_  
 Height \_\_\_\_\_ Weight \_\_\_\_\_ Occupation \_\_\_\_\_  
 Leisure Activities \_\_\_\_\_  
 Date of Injury \_\_\_\_\_ Sex \_\_\_\_\_  
 Describe the reason for your visit \_\_\_\_\_  
 \_\_\_\_\_

When was the onset of your problem \_\_\_\_\_  
 Onset (Check One) Gradual \_\_\_\_\_ Sudden \_\_\_\_\_  
 How did the problem occur? \_\_\_\_\_  
 Was the injury a CONTACT or NON-CONTACT injury? \_\_\_\_\_  
 Did you hear any NOISE associated with the onset of the injury? \_\_\_\_\_  
 Where was the pain initially felt? \_\_\_\_\_  
 Now, where is the pain? \_\_\_\_\_

Type of Pain Dull \_\_\_\_\_ Sore \_\_\_\_\_ Constant \_\_\_\_\_ Intermittent \_\_\_\_\_  
 Sharp \_\_\_\_\_ Throbbing \_\_\_\_\_ Bruised \_\_\_\_\_ Burning \_\_\_\_\_

Have you had any previous or similar problems? \_\_\_\_\_  
 Did you have SWELLING immediately? \_\_\_\_\_  
 What is the length of time your symptoms have been present? \_\_\_\_\_

Are you CURRENTLY seeing any of the following:

Medical Doctor	YES	NO
Osteopath	YES	NO
Dentist	YES	NO
Psychiatrist/Psychologist	YES	NO
Physical Therapist	YES	NO
Chiropractor	YES	NO

If you have been seen by any of the above during the past three months, please describe for what reasons (illness, medical condition, physical exam, etc): \_\_\_\_\_  
 \_\_\_\_\_

Please list any surgeries or other conditions for which you have been hospitalized, including the approximate date and reason for the surgery or hospitalization:

Date	Surgery / Hospitalization / Reason
_____	_____
_____	_____
_____	_____

Please describe any injuries for which you have been treated (including fractures, dislocations, sprains, strains) and the approximate date of injury:

Date	Injury
_____	_____
_____	_____
_____	_____



Which of the following OVER-THE-COUNTER medications have you taken in the last week:

Aspirin	YES	NO
Tylenol	YES	NO
Advil/Motrin/Ibuprofen	YES	NO
Laxatives	YES	NO
Decongestants	YES	NO
Antacids	YES	NO
Vitamins/Mineral Supplements	YES	NO
Antihistamines	YES	NO
Other	_____	

Please list any PRESCRIPTION medication that you are currently taking (including pills, injections, and/or skin patches)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

How much caffeinated coffee or other caffeine containing beverages do you drink per day? \_\_\_\_\_

How many packs of cigarettes do you smoke per day? \_\_\_\_\_

How many days per week do you drink alcohol? \_\_\_\_\_

Have you or any of your family EVER been diagnosed as having any of the following:

Cancer	YES	NO
If yes, please describe what kind:		
_____		
Heart Problems	YES	NO
High Blood Pressure	YES	NO
Asthma	YES	NO
Emphysema	YES	NO
Chemical Dependency (e.g. alcoholism)	YES	NO
Thyroid problems	YES	NO
Diabetes	YES	NO
Multiple Sclerosis	YES	NO
Rheumatoid Arthritis	YES	NO
Other Arthritic Conditions	YES	NO
Depression	YES	NO
Hepatitis	YES	NO
Tuberculosis	YES	NO
Stroke	YES	NO
Kidney Disease	YES	NO
Anemia	YES	NO
Epilepsy	YES	NO
Other	_____	

Date of last complete physical exam:

Month \_\_\_\_\_ Year \_\_\_\_\_ Physician \_\_\_\_\_



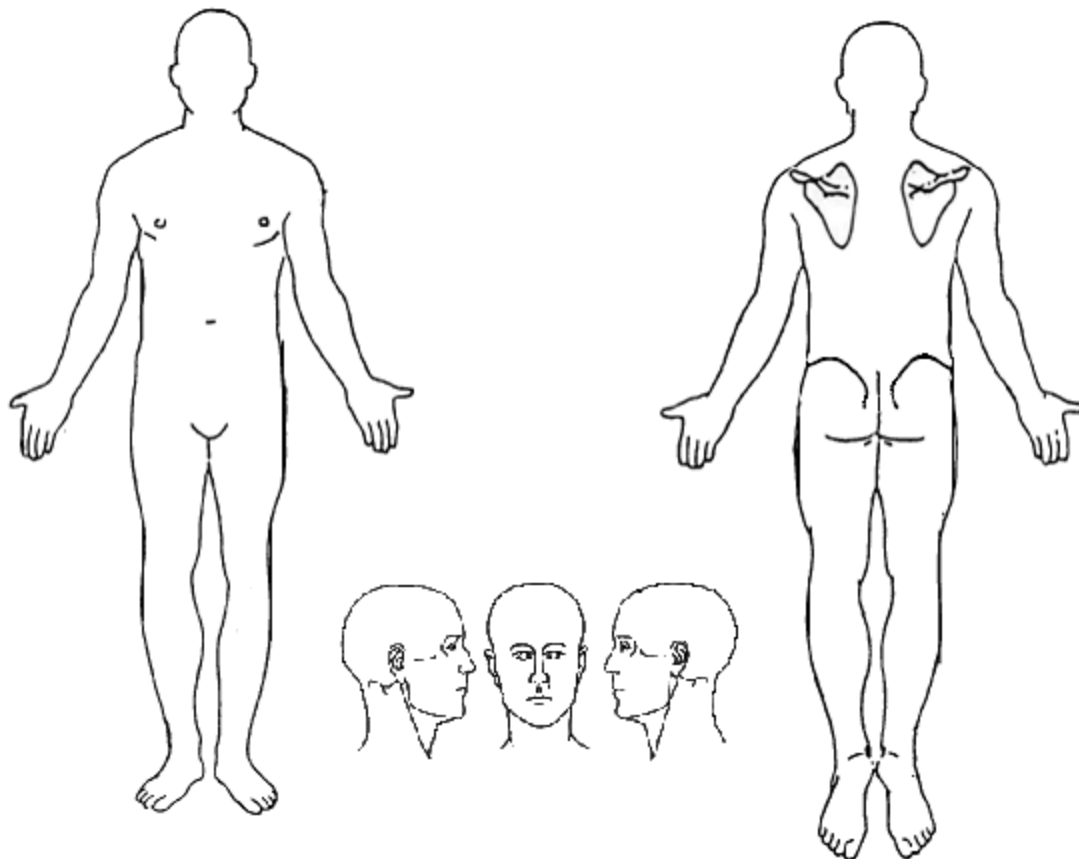
**SPORTSMEDICINE OF ATLANTA**  
**Have You Had, Or Do You Experience:**

<b>Cardiovascular System</b>	<b>YES</b>	<b>NO</b>	<b>GI System</b>	<b>YES</b>	<b>NO</b>
Elevated cholesterol	___	___	Difficulty swallowing	___	___
Sweating associated with pain	___	___	Heartburn	___	___
Palpitations	___	___	Jaundice (yellow appearance)	___	___
Swelling of extremities	___	___	Specific food intolerance	___	___
History of Smoking	___	___	Constipation	___	___
Orthopnea (difficulty breathing)	___	___	Diarrhea	___	___
			Change in color of stool	___	___
			Rectal bleeding	___	___
			Gall bladder problems	___	___
			Liver Problems	___	___
<b>G.U. System</b>	<b>YES</b>	<b>NO</b>	<b>Pulmonary System</b>	<b>YES</b>	<b>NO</b>
Dysuria (painful urination)	___	___	Dyspnea (labored breathing)	___	___
Hematuria (blood in urine)	___	___	Wheezing	___	___
Incontinence	___	___	Prolonged cough	___	___
Frequency of urination	___	___	Sputum production	___	___
Urinary urgency	___	___	amount / color: _____		
Vaginal discharge	___	___			
Dysmenorrhea (painful menstruation)	___	___			
Post menopausal vaginal bleeding	___	___	<b>Endocrine System</b>	<b>YES</b>	<b>NO</b>
Painful intercourse	___	___	Excessive thirst	___	___
Infertility	___	___	Excessive hunger	___	___
Hx of STD	___	___	Polyuria (large volume of urine)	___	___
Date of Last Period	___ / ___	___ / ___	Excessive sweating	___	___
			Fatigue	___	___
			Weakness	___	___
			Thyroid problems	___	___
<b>Neurological System</b>	<b>YES</b>	<b>NO</b>	<b>Other Systems</b>	<b>YES</b>	<b>NO</b>
Ataxia (poor muscular coordination)	___	___	ENT (ears, nose, throat)	___	___
Memory lapses	___	___	Integumentary (skin)	___	___
Confusion	___	___	Lymphatic	___	___
Head Trauma	___	___	Psychiatric	___	___
Neurological disorder	___	___	Musculoskeletal	___	___
Tremors	___	___			
Slurred speech patterns	___	___			
Hearing/Visual disturbances	___	___			



## Where is your pain?

Please mark on the drawings below the areas where you feel your pain.



Please mark an **X** upon the line in the area which best indicates your current pain level:



# OSWESTRY LOW BACK PAIN AND DISABILITY QUESTIONNAIRE

Fairbank et al (1980)

**Instructions:** For each of the next 10 statements, place a check mark or X in the box next to the response which best reflects how you are feeling right now.

<p><b>1. Pain Intensity</b></p> <p><input type="checkbox"/> I can tolerate the pain I have without having to use painkillers.</p> <p><input type="checkbox"/> The pain is bad, but I can manage without painkillers.</p> <p><input type="checkbox"/> Painkillers give complete relief from pain.</p> <p><input type="checkbox"/> Painkillers give moderate relief from pain.</p> <p><input type="checkbox"/> Painkillers give very little relief from pain.</p> <p><input type="checkbox"/> Painkillers have no effect on the pain and I do not use them.</p>	<p><b>2. Personal Care (Washing, Dressing, Etc.)</b></p> <p><input type="checkbox"/> I can look after myself normally without causing extra pain.</p> <p><input type="checkbox"/> I can look after myself normally, but it causes extra pain.</p> <p><input type="checkbox"/> It is painful to look after myself, and I am slow and careful.</p> <p><input type="checkbox"/> I need some help to manage most of my personal care.</p> <p><input type="checkbox"/> I need help every day in most aspects of self-care.</p> <p><input type="checkbox"/> I do not get dressed. I wash with difficulty and stay in bed.</p>
<p><b>3. Lifting</b></p> <p><input type="checkbox"/> I can lift heavy objects without extra pain.</p> <p><input type="checkbox"/> I can lift heavy objects, but it gives extra pain.</p> <p><input type="checkbox"/> I can't lift heavy objects from off of the floor, but if they are conveniently positioned (e.g. on a table), I can manage.</p> <p><input type="checkbox"/> I can't lift heavy objects, but I can manage light to medium ones.</p> <p><input type="checkbox"/> I can only lift very light weights.</p> <p><input type="checkbox"/> I cannot lift or carry anything at all.</p>	<p><b>4. Walking</b></p> <p><input type="checkbox"/> Pain does not prevent me from walking any distance.</p> <p><input type="checkbox"/> Pain prevents me from walking more than 1 mile.</p> <p><input type="checkbox"/> Pain prevents me from walking more than ½ mile.</p> <p><input type="checkbox"/> Pain prevents me from walking more than ¼ mile.</p> <p><input type="checkbox"/> I can only walk using a stick or crutches.</p> <p><input type="checkbox"/> I am in bed most of the time and have to crawl to the toilet.</p>
<p><b>5. Sitting</b></p> <p><input type="checkbox"/> I can sit in any chair as long as I like.</p> <p><input type="checkbox"/> I can sit in my favorite chair as long as I like.</p> <p><input type="checkbox"/> Pain prevents me from sitting more than 1 hour.</p> <p><input type="checkbox"/> Pain prevents me from sitting more than 30 minutes.</p> <p><input type="checkbox"/> Pain prevents me from sitting more than 10 minutes.</p> <p><input type="checkbox"/> Pain prevents me from sitting at all.</p>	<p><b>6. Standing</b></p> <p><input type="checkbox"/> I can stand as long as I want without extra pain.</p> <p><input type="checkbox"/> I can stand as long as I want, but it gives extra pain.</p> <p><input type="checkbox"/> Pain prevents me from standing for more than 1 hour.</p> <p><input type="checkbox"/> Pain prevents me from standing for more than 30 minutes.</p> <p><input type="checkbox"/> Pain prevents me from standing for more than 10 minutes.</p> <p><input type="checkbox"/> Pain prevents me from standing at all.</p>
<p><b>7. Sleeping</b></p> <p><input type="checkbox"/> Pain does not prevent me from sleeping well.</p> <p><input type="checkbox"/> I can sleep well only by using tablets.</p> <p><input type="checkbox"/> Even when I take tablets, I have less than 6 hours of sleep.</p> <p><input type="checkbox"/> Even when I take tablets, I have less than 4 hours of sleep.</p> <p><input type="checkbox"/> Even when I take tablets, I have less than two hours of sleep.</p> <p><input type="checkbox"/> Pain prevents me from sleeping at all.</p>	<p><b>8. Sex Life</b></p> <p><input type="checkbox"/> My sex life is normal and causes no extra pain.</p> <p><input type="checkbox"/> My sex life is normal, but causes some extra pain.</p> <p><input type="checkbox"/> My sex life is nearly normal, but is very painful.</p> <p><input type="checkbox"/> My sex life is severely restricted because of pain.</p> <p><input type="checkbox"/> My sex life is nearly absent because of pain.</p> <p><input type="checkbox"/> Pain prevents any sex life at all.</p>
<p><b>9. Social Life</b></p> <p><input type="checkbox"/> My social life is normal and gives me no extra pain.</p> <p><input type="checkbox"/> My social life is normal, but increases the degree of pain.</p> <p><input type="checkbox"/> I can't participate in more energetic activities (e.g. tennis).</p> <p><input type="checkbox"/> Pain restricts my social life, and I don't go out as often.</p> <p><input type="checkbox"/> Pain restricts my social life to home.</p> <p><input type="checkbox"/> I have no social life because of pain.</p>	<p><b>10. Traveling</b></p> <p><input type="checkbox"/> I can travel anywhere without pain.</p> <p><input type="checkbox"/> I can travel anywhere, but it gives me extra pain.</p> <p><input type="checkbox"/> Pain is bad when I travel, but I manage journeys over 2 hours.</p> <p><input type="checkbox"/> Pain restricts me to journeys of less than 1 hour.</p> <p><input type="checkbox"/> Pain restricts me to short, necessary journeys of less than 30 minutes.</p> <p><input type="checkbox"/> Pain prevents me from traveling (except to my health practitioner).</p>
<p><b>11. Changing Degree of Pain</b></p> <p><input type="checkbox"/> My pain is rapidly getting better.</p> <p><input type="checkbox"/> My pain fluctuates, but is definitely getting better.</p> <p><input type="checkbox"/> My pain seems to be getting better, but improvement is slow.</p> <p><input type="checkbox"/> My pain is neither getting better nor worse.</p> <p><input type="checkbox"/> My pain is gradually worsening.</p> <p><input type="checkbox"/> My pain is rapidly worsening.</p>	



### Functional Interference Estimate

For each question below, please circle the appropriate number according to the following scale:

0	1	2	3	4	5
Pain usually or severely interferes		Pain occasionally interferes			Pain rarely interferes

Rate your ability to stand or sit	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
Rate your ability to engage in social activities (clubs, visiting relatives, etc).	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
Rate your ability to walk.	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
Rate your ability to participate in recreational activities (dancing, etc).	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
Rate your ability to perform work.	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>

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Reprinted with permission. Toomey TC, Mann D, Hernandez JT, Abashian SW. Psychometric Characteristics of a Brief Measure of Pain-Related Functional Impairment. *Arch Phys Med Rehabil* 1993; 74:1305-1308.



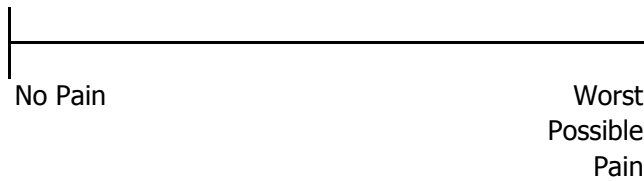
## Short-Form McGill Pain Questionnaire

Patient's Name: \_\_\_\_\_ Date \_\_\_\_\_

	NONE	MILD	MODERATE	SEVERE
Throbbing	_____	_____	_____	_____
Shooting	_____	_____	_____	_____
Stabbing	_____	_____	_____	_____
Sharp	_____	_____	_____	_____
Cramping	_____	_____	_____	_____
Gnawing	_____	_____	_____	_____
Hot - Burning	_____	_____	_____	_____
Aching	_____	_____	_____	_____
Heavy	_____	_____	_____	_____
Tender	_____	_____	_____	_____
Splitting	_____	_____	_____	_____
Tiring - Exhausting	_____	_____	_____	_____
Sickening	_____	_____	_____	_____
Fearful	_____	_____	_____	_____
Punishing - Cruel	_____	_____	_____	_____

**PPI**

- 0      No Pain
- 1      Mild
- 2      Discomforting
- 3      Distressing
- 4      Horrible
- 5      Excruciating



Reprinted with permission. Melzack R. The Short-Form McGill Pain Questionnaire. *Pain* 1987; 30:191-197.



Please describe the pain you have these days:

**For each group of words, choose the ONE that best applies.**

If there are groups of words that do not apply, you may omit them.

**1.**

Flickering  
Quivering  
Pulsing  
Throbbing  
Beating  
Pounding

**2.**

Jumping  
Flashing  
Shooting

**3.**

Pricking  
Boring  
Drilling  
Stabbing

**4.**

Sharp  
Cutting  
Lacerating

**5.**

Pinching  
Pressing  
Gnawing  
Cramping  
Crushing

**6.**

Tugging  
Pulling  
Wrenching

**7.**

Hot  
Burning  
Scalding  
Searing

**8.**

Tingling  
Itchy  
Smarting  
Stinging

**9.**

Dull  
Sore  
Hurting  
Aching  
Heavy

**10.**

Tender  
Taut  
Rasping  
Splitting

**11.**

Tiring  
Exhausting

**12.**

Sickening  
Suffocating

**13.**

Fearful  
Frightful  
Terrifying

**14.**

Punishing  
Grueling  
Cruel  
Vicious  
Killing

**15.**

Wretched  
Blinding

**16.**

Annoying  
Troublesome  
Miserable  
Intense  
Unbearable

**17.**

Spreading  
Radiating  
Penetrating  
Piercing

**18.**

Tight  
Numb  
Drawing  
Squeezing  
Tearing

**19.**

Cool  
Cold  
Freezing

**20.**

Nagging  
Nauseating  
Agonizing  
Dreadful  
Torturing