1809 E. Dyer Rd. #313 Santa Ana, CA 92705
Phone: (949) 975-1900 Fax (949) 975-0070

PERSONAL INJURY INTAKE SHEET

Referring physician:	Today's date: / /
Patient name:	DOB: / / Age:
Address:	
Phone #: ( ) Social Security #:	Gender: M / F

EMPLOYER INFORMATION

Employer (where injury occurred):	
Employer's address:	
What is your occupation?	Are you presently employed? Y / N

ATTORNEY INFORMATION

Attorney's name:	Phone #: ( )
Attorney's address:	

EMERGENCY NOTIFICATION

Name:
Phone #: ( )
Relationship:

MEDICAL HISTORY

Have you or any of your immediate family members ever been told by your medical doctor that you have:

Me	Family member		Me	Family member		Me	Family member	
☐	☐	Heart	☐	☐	Pacemaker/defibrillator	☐	☐	Smoking
☐	☐	Diabetes	☐	☐	High blood pressure	☐	☐	Leg/ankle swelling
☐	☐	Lung	☐	☐	Gastro-intestinal	☐	☐	Currently pregnant
☐	☐	Anemia	☐	☐	Metal implants	☐	☐	Bladder
☐	☐	Kidney	☐	☐	Cancer	☐	☐	Osteoporosis
☐	☐	Seizures	☐	☐	Infection (last few weeks)	☐	Other:	________________

Please list any medication that you are currently taking or have recently used for any of the above medical conditions. ____

____

____

Please list any known allergies: ____

____

HISTORY OF ACCIDENT/INCIDENT

Date of accident/incident:_____________________Was the police notified?____Yes____No

How did the accident/incident occur? ____

____

____

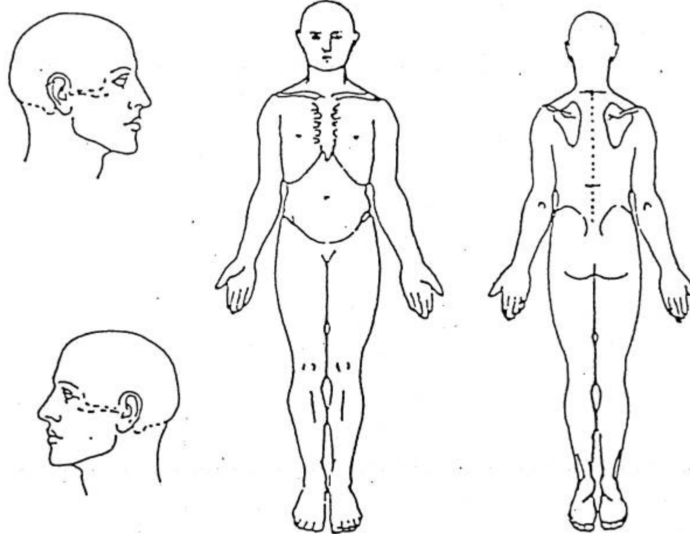
Was hospitalization required? ____Yes____No If yes, how long were you hospitalized________

Are you taking pain medications? Please list them: ___________________________________

Please place a checkmark next to any of the following symptoms:

☐ Fever	☐ Sweats	☐ Shortness of breath	☐ Diarrhea
☐ Skin rash	☐ Problems with vision	☐ Cough	☐ Constipation
☐ Weakness	☐ Dizziness	☐ Hoarseness	☐ Change in bowel/bladder
☐ Tingling	☐ Nausea/vomiting	☐ Difficulty swallowing	☐ Involuntary weight loss/gain
☐ Numbness	☐ Heart palpitations	☐ Painful swallowing	☐ Bleeding of any kind
☐ Joint pain	☐ Difficulty breathing	☐ Other: ___________________	

Please indicate the location of your pain on the picture below:



http://www.continuingedcourses.net/active/courses/images/course016-body.jpg

On the scale below, circle your pain level today:

(pain free) 0 1 2 3 4 5 6 7 8 9 10 (worse possible pain)

Please circle all that apply to describe your pain: sharp, stabbing, throbbing, aching, shooting, burning, tingling, heaviness, discomfort, dull, intermittent, constant

If constant, do you have the pain right now? Y / N

Are the symptoms getting: ☐worse ☐better ☐staying the same

Aggravating factors: ____

Relieving factors: ____

Have you had this problem before the injury? Y / N

Please give the name and dates of the surgeries you have had as a result of your injury: ______

____

Southern California Sports Rehabilitation
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Patient/Provider Arbitration Agreement

1. Agreement to Arbitrate. The undersigned agree that, except as provided in this agreement, any dispute arising by and between Patient (as identified below) and Southern California Sports Rehab ("Provider") will be decided and resolved through arbitration by the Orange County, California, offices of J.A.M.S/Endispute's or its successor, and not by lawsuit or resort to court process except California law provides for judicial review of arbitration proceedings. The parties to this agreement, by entering into it, are knowingly giving up their constitutional rights to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. Except as provided otherwise herein or as may be applicable to California law as it relates to arbitrations involving health care providers, all arbitrations shall be conducted in accordance with the provisions of JAMS/Endispute's Streamlined Arbitration Rules and Procedures in effect at share of the expenses and fees of the arbitration. The parties hereto agree that the arbitrator may not award punitive damages. The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper party in a court action and upon such intervention and joinder any existing court action by, against or otherwise involving such additional person or entity shall be stayed pending arbitration. The parties hereto agree that provisions of California law applicable to health care providers shall apply to disputes with this arbitration agreement including but not limited to, Code of Civil Procedure sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitration a Discovery shall be conducted pursuant to Code of Civil Procedure Section 1238.5; however, depositions may be taken without prior approval of the neutral arbitrator. A Claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

In lieu of arbitration, Provider, at Provider's sole discretion, may file one or more actions in the Superior Courts (or Small Claims Court for matters within that Courts' jurisdiction) for the County of Orange, State of California to collect any fees owing the Patient to Provider. Such filings shall not waive Providers right to compel arbitration of any other claim.
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2. ***Miscellaneous.*** If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. By my signature below, I acknowledge receipt of a copy of this agreement. The parties hereto intend that this agreement binds all parties, their spouses, heirs and successors in interests. This agreement is governed by California Law.

BY SIGNING THIS AGREEMENT I UNDERSTAND THAT I AM VOLUNTARILY AGREEING TO HAVE ANY MALPRACTICE AND OTHER DISPUTES DECIDED THROUGH ARBITRATION AND THAT I AM GIVING UP MY RIGHT TO A JURY OR COURT TRIAL, THAT I HAVE NOT RELIED ON ANY ORAL REPRESENTATIONS RELATIVE TO ARBITRATIONS THAT ARE NOT IN WRITING AND INCLUDED IN THIS AGREEMENT, AND, FURTHER, I ACKNOWLEDGE RECEIPT OF A COPY OF THIS AGREEMENT.

Provider: Southern California Sports Rehabilitation:	**Patient:**	**Parent/Guardian** (if pt is a minor)
______________________ Signature Date	______________________ Signature: Date	______________________ Signature Date
______________________ Printed name and title	______________________ Printed Name	______________________ Printed Name

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(This form is to be utilized by all aquatic therapy patients.)

In consideration for the pool owner's (the "Owner") grant of the use of the aquatic facilities (the "Premises") for aquatic/physical therapy, and SOUTHERN CALIFORNIA SPORTS REHABILITATION, LLC's (the "Company") making aquatic/physical therapy services ("Physical Therapy") available to the undersigned (the "Patient"), Patient, jointly and severally, hereby releases Owner, Company, and their respective employees (whether or not such employees are leased), members, shareholders, partners, owners, directors, tenants, lessors, employers and agents and their successors and assigns (collectively, the "Indemnified Persons") from all liability for injuries or damages of any nature that Patient may sustain as a result of his or her participation in the Physical Therapy or while in, at or about the Premises.

Patient hereby expressly waives and relinquishes all rights and benefits under California Civil Code section 1542 which reads in substantial part: *A general release does not extend to claims which the creditor does not know or suspect to exist in his favor at the time of executing the release, which if know by him must have materially affected his settlement with the debtor.*

Patient agrees to indemnify and hold harmless the Indemnified Persons from all claims and demands whatsoever, which may be made in respect to injuries or damages of any nature sustained by Patient, in, at or about the Premises. Patient covenants not to sue Owner, the Company or any Indemnified Persons for any injuries as a result of his participation in the Physical Therapy or while in, at or about the Premises.

Patient is allowed in the pool only during the scheduled appointment, while a licensed physical therapist or a physical therapist assistant is present. If the patient enters the pool at any other time, it is at the patient's own risk. Patient shall comply with the rules and regulations pertaining to participation in the aquatic physical therapy, including but not limited to rules set by the owners of the pool and facilities.

If any term of this instrument is void, invalid or unenforceable for any reason, such term or provision shall be severed from this instrument and the remaining terms and provisions shall remain in force and effect.

I read and fully understand the terms of this release and acknowledge that this release is binding upon Patient, and his or her successors, assigns and estate.

Patient: ______________________________ ______________________________
Signature Date

______________________________ ______________________________
Printed Name Date of Birth

REQUEST FOR RELEASE
OF
MEDICAL RECORDS

To:____

Physician's Name

Address:__________________________City:_________________State:_____Zip Code:___________

I hereby request that my medical records
Be released to:

____

Physicians' Name

Address:__________________________City:_________________State:_____Zip Code:___________

Date:______________________________

Patient's Signature:____________________________________

Print Name of Patient:_____________________ _________ ____

Date of Birth:____________________Social Securtiy Number:________________________________

Treatment authorization: I authorize the treatment by Southern California Sports Rehabilitation.
I have read, understand, and agree to all information presented to me today.

____ ______________________________

Signature of Patient/Guardian Date

OF-011 Rev. 10/03

Authorization of Direct Payment and Doctor's Lien

Provider: Southern California Sports Rehabilitations______

Attorney's Namee:___________________________________

Attorney's Address:________________________________

____

Phone/Fax Number:_________________________________

I do hereby authorize Southern California Sports Rehabilitation (SCSR) to furnish you a full report of Initial evaluation, re-evaluation, progress notes and treatment documentation of myself in regard to the accident in which I was involved

I hereby authorize and direct you , my attorney, to pay directly to SCSR such sums as may be due and owing SCSR for therapy services rendered me both by reason of this accident and by reason of any bills that are due to SCSR and to withhold such sums form any settlement, judgment or verdict as may be necessary to adequately protect SCSR. And I hereby further give a lien on my case to SCSR against any and all proceeds of any settlement, judgment or verdict which may be paid to you, my attorney, or myself as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am direct and fully responsible to SCSR for all medical bills submitted by SCSR for therapy services rendered me and that this agreement is made solely for said SCSR's additional protection and in consideration of SCSR awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

______________________________ ______________________________

Patient's Signature Date

______________________________ ______________________________

Print patient's full name Witness

____

Patient's address

______________________________ ______________________________

Treating office location Date of injury

The undersigned being attorney of record for the above patient does hereby agree to observe all terms of the above and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect SCSR.

______________________________ ______________________________

Attorney's Signature Date

Mr. Attorney: Please date, sign and return one copy to above SCSR office. Thank you.
Keep one copy of your records.