THE OHIO STATE UNIVERSITY MEDICAL CENTER
PATIENT ACCESS SERVICES - REGISTRATION FORM

DATE: _____ **MEDICAL RECORD #** _____

PATIENT INFORMATION

BIRTHDATE: _____ / _____ / _____ SEX: (CIRCLE ONE) M / F SSN: _____ /_____ / _____

NAME: _____
(LAST) (FIRST) (MI)

ADDRESS: _____ ZIP: _____

CITY: _____ STATE: _____ COUNTRY (IF OTHER THAN USA): _____

HOME PHONE: ( ) _____ - _____ OTHER PHONE: ( ) _____ - _____

MARITAL STATUS: _____ MAIDEN NAME: _____

EMPLOYER NAME:_____

ADDRESS: _____ ZIP: _____

CITY: _____ STATE: _____ COUNTRY: _____

PHONE: ( ) _____ - _____ EXT. _____

Welcome to The Ohio State University Medical Center! We care about each of our patients. We also want to help the community that we serve. One way we can do this is to allow our patients to tell us about their background. We use this information to make sure that no one is denied access to medical care and research based on ethnicity or race. This form helps us collect this information. We will put all the answers we get together. Your answers will not affect the care you receive at The Ohio State University Medical Center. Your participation is voluntary. Thanks for helping to make our hospital and your community one of the best in the country. Please check below:

1. ARE YOU HISPANIC OR LATINO? ----------

IF YES, CHOOSE ONE OF THE FOLLOWING:

- ☐ MEXICAN, MEXICAN-AMERICAN, CHICANO
- ☐ PUERTO RICAN
- ☐ CUBAN
- ☐ OTHER HISPANIC OR LATINO
- ☐ DO NOT CARE TO RESPOND

OR ELSE, CHOOSE ONE OF THE FOLLOWING:

- ☐ NO, I AM NOT HISPANIC OR LATINO
- ☐ DO NOT KNOW
- ☐ DO NOT CARE TO RESPOND

2. WHAT IS YOUR RACE? ----------

- ☐ BLACK, AFRICAN-AMERICAN
- ☐ WHITE
- ☐ AMERICAN INDIAN OR ALASKAN NATIVE
- ☐ ASIAN CAMBODIAN
- ☐ ASIAN CHINESE
- ☐ ASIAN INDIAN OR PAKISTANI
- ☐ ASIAN JAPANESE
- ☐ ASIAN KOREAN
- ☐ ASIAN LAOTIAN
- ☐ ASIAN VIETNAMESE
- ☐ ASIAN OTHER
- ☐ SOMALI
- ☐ AFRICAN OTHER
- ☐ MIDDLE EASTERN
- ☐ NATIVE HAWAIIAN OR PACIFIC ISLANDER
- ☐ OTHER
- ☐ MORE THAN ONE RACE
- ☐ DO NOT CARE TO RESPOND

EMERGENCY CONTACT / NEXT OF KIN INFORMATION

RELATIONSHIP TO PATIENT: _____

NAME: _____ NAME SFX:_____
(LAST) (FIRST) (MI)

ADDRESS: _____ ZIP: _____ -- _____

CITY: _____ STATE: _____ COUNTRY: _____

PHONE: ( ) _____ - _____ OTHER PHONE: ( ) _____ - _____ EXT. _____

Patient Data Form

Name: _____ Date of Birth: _____ Appointment Date: _____

Date of last: Physical _____ Eye exam _____ Dental exam _____ Tetanus shot _____
Pneumonia shot _____Cholesterol test _____ Flexible sigmoidoscopy _____

Past Medical History:

Have you had or do you currently have any of the following? (Y=yes, N=no)

Chicken pox	Y N	Tuberculosis	Y N	High blood pressure	Y N	Stroke	Y N
Rheumatic fever	Y N	COPD / emphysema	Y N	High cholesterol	Y N	Epilepsy / seizures	Y N
Mumps	Y N	Asthma	Y N	Osteoporosis	Y N	Glaucoma	Y N
Measles	Y N	Pneumonia	Y N	Kidney disease	Y N	Anemia	Y N
German measles	Y N	MI / heart attack	Y N	Thyroid disease	Y N	Arthritis	Y N
Scarlet fever	Y N	Diabetes	Y N	Cancer:	Y N	HIV	Y N
Shingles	Y N	Stomach ulcers	Y N	Depression	Y N	Hepatitis A, B or C	Y N

List all hospitalizations and surgeries:	List all current medications / vitamins / herbs:
1.	1.
2.	2.
3.	3.
4.	4.
List all known allergies (drugs, food, environmental):	5.
1.	6.
2.	7.
3.	8.

Family History: Does anyone in your family have any of the following?

___ Diabetes ___ Heart Disease ___ Cancer ___ Mental Illness/Alcoholism

Mother: Age___A D* Health problems: _____
Father: Age___A D* Health problems: _____
Sibling: Age___A D* Health problems: _____
Age___A D* Health problems: _____
Age___A D* Health problems: _____

* (A=Alive, D=Deceased – circle one)

Social History:

Occupation: _____ # Persons in household ____ Stress: (circle one) work, home, both, none

Do you use tobacco products? __ No __ Yes: What kind and how much? _____

Have you used recreational substances within the last 2 years? __ No __ Yes

Do you drink alcohol? __ No __ Yes: # drinks per day/week/month) _____

Caffeine: # drinks per day _____ Exercise (type, # days per week): _____ Sleep (hours/day): _____

Review of Systems:

Are you currently having problems with any of the following?

Fever	Y N	Chest pain	Y N	Constipation	Y N	Convulsions	Y N
Blurred or double vision	Y N	Palpitations	Y N	Nausea or vomiting	Y N	Headaches	Y N
Loss of vision	Y N	Shortness of breath	Y N	Abdominal pain	Y N	Depression	Y N
Problem swallowing, food stuck in throat	Y N	Persistent cough	Y N	Blood in stools or black stools	Y N	Joint pain	Y N
Sore throat	Y N	Coughing up blood	Y N	Painful urination	Y N	Muscle pain	Y N
Earache	Y N	Diarrhea	Y N	Blood in urine	Y N	Hives or skin rash	Y N

Form completed by: _____ Date: _____

Reviewed by: _____DO/MD/NP Date: _____

REASON FOR VISIT

DIAGNOSIS/SYMPTOMS:_____

If Test/Symptoms are due to an accident (other then the BWC information listed above), please check one reason below and enter the date of the accident:

_____AUTO ACCIDENT DATE_____
_____OTHER ACCIDENT DATE_____

If visit is not due to an accident, when did symptoms begin? _____/_____/_____

DAY MONTH YEAR

PHYSICIAN INFORMATION

REFERRING PHYSICIAN FULL NAME: _____

ADDRESS: _____

CITY: _____ STATE _____ ZIP CODE: _____

PHONE: ( ) _____ - _____ EXT. _____

FAMILY PHYSICIAN AND/OR CLINIC FULL NAME: _____

ADDRESS: _____

CITY: _____STATE _____ ZIP CODE: _____

PHONE: ( ) _____ - _____ EXT. _____

Date _____ **Please answer the following questions to the best of your ability.**

1. Describe your problem:

2. When did it start? _____ When did you see your doctor? _____

Did you have x-rays and/or MRI? ❑ Yes ❑ No Did you have surgery? ❑ Yes ❑ No Date of surgery _____

3. If you have pain, what activity makes the pain worse?

4. Rate your pain on the scale below:

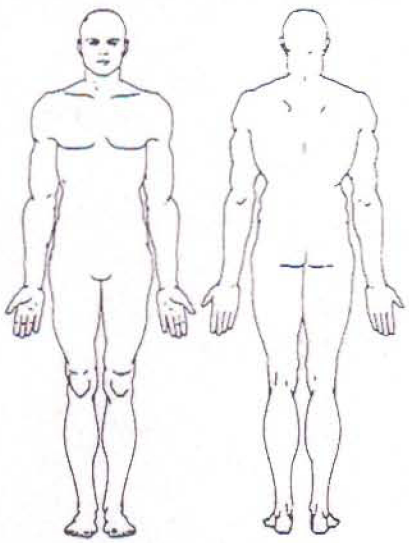
0	1 2 3	4 5 6	7 8 9	10
No pain	Minimal	Moderate	Severe	Excruciating

5. Are you working? ❑ Yes ❑ No If yes, place and description of employment:

Are you playing sports? ❑ Yes ❑ No If yes, type and description of sport:

Does your job/sport cause your pain to worsen? ❑ Yes ❑ No If so, how and when:

Shade in the painful areas on the following figure:



6. Has the pain or injury had any effect in the following areas: ❑ household chores ❑ driving ❑ sports ❑ self-care ❑ other _____

Your goals for physical therapy/sports chiropractic are:

Please check any medical problems that apply to you:

❑ high blood pressure	❑ diabetes	❑ stroke	❑ heart disease
❑ cardiac pacemaker	❑ cancer	❑ arthritis	❑ pregnant
❑ phlebitis	❑ seizures	❑ metal implants	❑ respiratory problems
❑ artificial joints	❑ impaired sensation	❑ circulation problems	

Is there any other information we should know?

Patient's Signature:

PN0061

THE OHIO STATE UNIVERSITY HEALTH SYSTEM

SPORTS MEDICINE PATIENT HISTORY

Patient Name:

Medical Record Number:

Date of Birth:

MC 201810 (02/06)

PROGRESS NOTES

INSURANCE ☐ **CARD COPY ATTACHED** *CARD GIVEN TO SERVICE AREA STAFF MEMBER TO BE COPIED

☐ **NO COPY OF INSURANCE CARD** (IF INSURANCE INFORMATION IS NOT ON FILE, ACCOUNT WILL BE CODED AS SELF PAY)

☐ **SELF PAY**

INSURANCE SUBSCRIBER INFORMATION -*IF SELF, PLEASE CHECK HERE* ☐ **AND SKIP THIS SECTION!**

- IF PT IS A MINOR CHILD, PLEASE COMPLETE THIS SECTION WITH THE INFORMATION OF THE PARENT WHOSE INSURANCE THE CHILD IS UNDER

NAME: _____ NAME SFX:_____
(LAST) (FIRST) (MI)

RELATIONSHIP TO PATIENT: _____

BIRTHDATE: ____ / ____ / _____ SEX: M / F SSN: _____ / _____ / _____

ADDRESS: _____ ZIP: _____ -- _____

CITY: _____ STATE: _____ COUNTRY: _____

PHONE: ( ) _____ - _____ OTHER PHONE: ( ) _____ - _____ EXT. _____

OTHER PHONE TYPE: _____

EMPLOYER NAME: _____

ADDRESS: _____ ZIP: _____ -- _____

CITY: _____ STATE: _____ COUNTRY: _____

PHONE: ( ) _____ - _____ EXT. _____

BWC ☐ **WORKER'S COMPENSATION (BWC)** *IF TODAY'S VISIT IS DUE TO A WORK RELATED INCIDENT, PLEASE COMPLETE THE FOLLOWING:

NAME OF EMPLOYER WHEN BWC WAS FILED: _____

COMPANY ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: ( ) _____ - _____

WHAT WAS YOUR OCCUPATION AT THAT COMPANY:_____

WHAT WAS THE BWC INJURY: (EX: CUT RIGHT HAND, FRACTURE LEFT LEG) _____

DATE OF BWC INJURY:_____ BWC CLAIM NUMBER:_____

Summary Notice and Acknowledgment

PLEASE SIGN THIS FORM TO ACKNOWLEDGE THAT WE HAVE PROVIDED YOU WITH A COPY OF THE OHIO STATE UNIVERSITY HEALTH SYSTEM'S NOTICE OF PRIVACY PRACTICES

The Notice of Privacy Practices describes your rights in regard to your health information, the possible uses of your health information, and how we must protect the confidentiality of your health information.

THIS IS NOT A CONSENT
BY SIGNING THIS DOCUMENT YOU ARE ONLY STATING THAT WE HAVE PROVIDED YOU WITH A COPY OF OUR NOTICE OF PRIVACY PRACTICES. IF YOU WISH TO RECEIVE A COPY OF THIS FORM, ASK THE REGISTRATION/ADMITTING STAFF MEMBER WHO IS ASSISTING YOU.

We encourage you to carefully read the full Notice. You may also access our Notice of Privacy Practices on our website, www.osumedcenter.edu. This website is also listed on the Notice.

I have been given The Ohio State University Health System Notice of Privacy Practices:

Signature:_____ Date:_____

_____ _____
Authorized Agent Relationship to Patient

Documentation of Attempt:

SUMMARY OF THE NOTICE OF PRIVACY PRACTICES

NOTE: THIS INFORMATION IS DESCRIBED IN DETAIL IN THE NOTICE OF PRIVACY PRACTICES

Your rights include:
- A right to inspect and copy your medical information
- A right to amend your health information
- A right to request restrictions on what information we use or how we disclose your health information
- A right to receive an accounting of certain disclosures we have made of your health information
- A right to receive a paper copy of our Notice of Privacy Practices

These rights do have special restrictions, so it is important to read the full Notice.

Possible uses of your health information and/or records:
- Plan for your care
- Help your health care providers communicate and work together to care for you
- Submit bills to pay for your care
- Help health care payors make sure services were actually provided
- Help improve the quality of health care. For example, if you are admitted to our facility, a Hospital Representative may visit you during your stay to see how you are doing. Or, after your visit, we may contact you to see how you are doing and to find out how you felt about our service.
- Disclose information to certain officials or organizations where we may, or are required to do so by law.

The Ohio State University Health System is an academic and research institution. Researchers who are working to find new treatments and cures, or important information to improve your health care and the health care of the general public may use or access your information. Your information could possibly be used to assist in the training and education of health care professionals. In every instance, every person who accesses your information is bound by our confidentiality requirements, as outlined in our Notice of Privacy Practices.

Medical Center

General Activity Total:	/40
Dance Specific Total:	/50
Total Score:	/90
Percentage:	%

Dance Functional Outcome System

Please answer every section, and mark in each section the one statement which most applies to you. We realize that two statements in any one section may relate to you, but just mark the one, which most closely describes your level now. These questions are based only on what you can do at this time. Do not compare yourself to other dancers. If a section is not applicable, please skip it.

GENERAL ACTIVITY

1. Overall Activity Level (10)

____ I have no limitations. I am able to do everything, including strenuous dancing and exercise.
____I can dance, but at a lower level. I must guard myself and limit the amount of heavy dancing.
____Light dancing is possible with occasional problems. I must avoid certain movements.
____No dancing is possible. Daily activities are possible with occasional problems.
____Daily activities cause moderate problems.
____Daily activities cause severe problems.

2. Movement Quality (10)

____ I feel confident that I can perform at the same level and quality as prior to my injury. I am able to articulate my limbs with 100% certainty or clarity.
____ I feel confident that I am almost at the same level and quality of performance as prior to my injury. I am able to articulate my limbs with 80% certainty or clarity.
____ I am improving but have a ways to go before I am back to the level and quality I was prior to my injury. I am able to articulate my limbs with 60% certainty or clarity.
____ I am improving but can only control my movement quality some of the time. I am able to articulate my limbs with 40% certainty or clarity.
____ I am improving but only beginning to focus on movement quality. I am able to articulate my limbs 20% of the time.
____ I am improving but am working on basics and not able to focus on quality at this time.

3. Walking (5)

____ Normal and unlimited, including hills.
____ Slight problems, relatively unlimited distances.
____ Mild problems, most surfaces, up to half a mile or 10 blocks.
____ Moderate problems, flat surfaces, no more than ¼ mile or 5 blocks.
____ Severe problems, only 1/8 mile or 2-3 blocks.
____Severe problems, need cane or crutches.

4. Stairs (5)

____ Normal, unlimited up and down stairs.
____ Slight problems, need to be careful, particularly (circle one) up/down stairs.
____ Mild problems, have to go slowly, particularly (circle one) up/down stairs.
____ Moderate problems, only 10-15 steps possible, particularly (circle one) up/down stairs.
____ Severe problems, require a banister for support particularly (circle one) up/down stairs.
____ Severe problems, only 0-5 steps with support, especially (circle one) up/down stairs.

5. Stability and Symptoms (5)

____ I can do everything without symptoms of giving out, locking, catching, grinding or feeling weak.
____ I only have symptoms (of giving out, locking, catching, grinding or feeling weak) with strenuous dancing or exercise.
____ I only have symptoms (of giving out, locking, catching, grinding or feeling weak) with moderate dancing; it limits my vigorous activity.
____ Because I have symptoms (of giving out, locking, catching, grinding or feeling weak) with light dancing, it limits almost all of my dancing. I occasionally have symptoms with walking or light household work.
____ I have symptoms frequently with simple activities such as walking. I must guard my injury at all times.
____ I have severe problems with symptoms (of giving out, locking, catching, grinding or feeling weak). I can't do much of anything without having symptoms.

6. Pain (5)

____ I have no pain.
____ I have occasional pain with strenuous dance or exercise. I don't think that things are entirely back to normal. Limitations are mild and tolerable, if I am careful.
____ There is occasional pain with moderate dancing or light exercise.
____ I have pain with any dancing, exercise, or light recreational activities. Occasional pain is brought on by daily activities.
____ Pain is a significant problem with activities as simple as walking. The pain is relieved by rest. I can't participate in dancing or exercise.
____ I have pain at all times, even during walking, standing, or light household work.

DANCE TECHNIQUE SPECIFIC

7. Plié (5)

____ Able to fully perform grand plié in all positions, including 4th and 5th.

____ Able to perform grand plié in 1st and 2nd only.

____ Able to perform grand plié in 2nd position only.

____ Cannot grand plié, but can demi-plié in all positions.

____ Have some difficulty with demi-plié.

____ Cannot demi-plié

8. Développé (5)

____ I am able to fully perform all parts of développé to the front or side without a problem.

____ I have slight problems performing développé to the front or side.

____ I have mild problems fully extending my leg in développé to the front or side, and must développé at a lower height.

____ I have moderate problems fully extending my leg in développé to the front or side and must mark it, but I can fully passé.

____ I do not développé to the front or side at all, but can do a full passé.

____ I cannot perform a full passé

9. Relevé Balance (If you do pointe work, indicate whether you can perform the indicated level on pointe.) (5)

____ Able to attain and maintain my balance in relevé/pointe on the involved side without a problem.

____ Able to attain and maintain my balance in relevé /pointe on the involved side with only slight problems.

____ Able to attain and maintain my balance in relevé /pointe on the involved side with moderate difficulty.

____ Able to relevé but can't maintain the balance on the involved side without barre assistance.

____ Able to maintain my balance on flat foot, but cannot balance on relevé.

____ Cannot relevé or maintain my balance on the involved side on flat foot.

10. Rond de jambe (5)

____ Able to fully perform as much and as often as required, at 90°: grand rond de jambe en l'aire a la seconde (rotational movements of the leg in the air).

____ Able to perform at reduced speed: rond de jambe en l'aire a la seconde.

____ Able to perform with mild problems such as reduced number and speed: rond de jambe en l'aire a la seconde.

____ Able to perform with moderate problems such as reduced number, speed, and height (at 45°): rond de jambe en l'aire a la seconde.

____ I mark or avoid all rond de jambe en l'aire type movements.

____ I am unable to perform rond de jambe en l'aire a la seconde at all.

11. Kneeling/Floorwork (5)

____ Able to fully perform floorwork or kneeling activities without limitations.

____ Able to perform floorwork or kneeling activities with mild limitations.

____ Able to perform floorwork or kneeling activities, with more moderate limitations: may require less repetitions or slight modification.

____ Severe problems, require support or modification.

____ Severe problems, unable to do.

12. Turning (5)

____ Able to fully perform unlimited multiple turns of all kinds, on either leg (to the extent you were prior to your injury).

____ Able to perform, but not quite fully, turns of all kinds, on either leg (to the extent you were prior to your injury).

____ Able to perform with slight problems, turns of most kinds, on either leg. I have to be careful about placement.

____ I have moderate problems with turning. I am able to do single inside and outside turns on the involved side.

____ Severe problems, no turning. I only do turn preparation and balance in relevé on the involved side.

____ Severe problems, unable to balance on the involved side.

13. Jumping (10)

____ Able to fully perform everything: all grand and petit allegro combinations, including beats(to the extent you were able prior to your injury). Take off power is normal and unlimited. Able to maintain my balance when landing from a jump or hop.

____ Able to perform, but not quite full, grand and petit allegro combinations (to the extent you were able prior to your injury). Take off power and ability to maintain my balance when landing is pretty good.

____ Able to perform with slight problems and some guarding: grand and petit allegro, and balance when landing from jumps or hops. I avoid most difficult jumps. Unable to do repeated jumps.

____ I have moderate problems with jumping. I am only doing simple jumps in the center.

____ Severe problems, affects all jumping in center floor. Can do simple jumps at the barre.

____ Severe problems, no jumping activity possible

14. Grand Allegro/Across the Floor/Traveling/Running (10)

____ Able to fully perform all traveling combinations (change of direction, pivots, quick stops and starts, or run) at full speed.

____ Able to perform, bit not quite fully, all traveling combinations (change of direction, pivots, quick stops and starts, or run).

____ Able to perform, with slight problems, traveling combinations (change of direction, pivots, quick stops and starts, or run) at reduced speed.

____ I have moderate problems, and must move slowly and carefully in traveling combinations (change of direction, pivots, quick stops and starts, or run).

____ I have severe problems, and must avoid most traveling combinations. I stick to barre and adagio.

____ I avoid all traveling combinations.

Compared to before my injury, if I had to give my dancing performance a grade from 0 to 100, with 0 being the worst and 100 being the best, I would give myself a

_____

Bronner, S., (2007). Dance Functional Outcome System. Journal of Orthopaedic & Sports Physical Therapy, v37/9, 539-540

1. CONSENT FOR MEDICAL CARE AND TREATMENT: Permission is hereby granted to The Ohio State University Health System and members of its medical staff to perform such diagnostic and therapeutic procedures as they consider advisable for my care and treatment. If I am unable to give consent because I am a minor, I am unable to comprehend or I am otherwise unable to personally give consent at the time of treatment, the person signing below represents that they are my authorized agent.

2. PATIENT RIGHTS AND RESPONSIBILITIES: I understand that the rules of The Ohio State University Health System are for the patient's benefit and as I am made aware of these rules, I agree to comply with them.

3. PERSONAL VALUABLES: I understand that I should leave my valuables or any other property that I do not need while at the health system at home or with my family or place this property in the Office of Patient Property/Department of Security.

4. MEDICARE AND/OR STATE ASSISTANCE RECIPIENTS:
   MEDICARE: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I have been given a written statement of my rights and responsibilities as a Medicare patient which includes the right to request a review of my medical records to determine my liability for payment if I am informed that Medicare will no longer cover my stay.

   MEDICAID, DISABILITY: My signature below is my consent authorizing a representative of The Ohio State University Health System to act on my behalf in requesting a state hearing or obtaining information contained in my file from the Ohio Department of Human Services should the need arise.

5. ASSIGNMENT OF BENEFITS/PATIENT RESPONSIBILITY: I request and assign direct payment to The Ohio State University Health System and members of its medical staff who render service, of any and all charges payable under the terms and provisions of my policy. I understand that I am responsible for and will pay any unpaid amount due for services performed by The Ohio State University Health System and members of its medical staff.

6. RELEASE OF INFORMATION: I agree to release information about my physical or mental condition, dates of service, diagnosis, procedures, consults, social work notes, surgeries or treatment. I agree to let The Ohio State University Health System and/or members of its medical staff release this information to my doctor, referring doctors and other health care providers and agencies. Any insurance company or organization that helps pay my bill and agents hired to collect or obtain payment may also have this information. The Ohio State University Health System and/or its medical staff may also give my information to any government agency and its representative to which I have applied for aid.

   _____ I am aware that the information released may include information regarding HIV or AIDS, alcohol or drug abuse and psychiatric treatment (signer to indicate approval).

   By signing my name below, I certify that I have read and agree to the above.

PATIENT	WITNESS (Optional)	DATE
AUTHORIZED AGENT	RELATIONSHIP TO PATIENT	

7. REFUSAL TO RELEASE INFORMATION TO INSURERS: I do not authorize the release of information concerning my medical care and treatment to my insurance company. I understand that I am responsible for all charges incurred and agree to pay The Ohio State University Health System and the doctors that treat me for all charges.

PATIENT	DATE

FS0001

THE OHIO STATE UNIVERSITY HEALTH SYSTEM

CONSENT FOR MEDICAL CARE AND TREATMENT

Patient Name:

Medical Record Number:

Date of Birth: