

NEW PATIENT INFORMATION/ PATIENT CONSENT

Please print and fill in all the information

Patient Name (Last, First, Initial): _____

Address: _____ City/State: _____ Zip: _____

Work phone: _____ Home Phone: _____ Cell: _____

Birth date: _____ Age: _____ Sex: M / F E-mail address: _____

Weight: _____ Height: _____ Social Security#: _____

Driver's Lic: _____ Employer: _____ Occupation: _____

Responsible Party(if other than patient/minor): _____

Responsible Party Phone: _____ Address: _____

Who Referred You: Family Friend Physician Web Ins. Co. Previous Patient 24hr. Fitness Yelp

Primary Insurance: _____ Name of Insured: _____

Insurance Phone: _____ Insured's Social Security#: _____

Policy/ID #: _____ Group #: _____

Secondary Insurance: _____ Name of Insured: _____

Insurance Phone: _____ Insured's Social Security#: _____

Policy/ID #: _____ Group #: _____

Emergency Contact(name/phone#): _____

The above information is correct to the best of my knowledge.

I am responsible for my medical fees, including amounts not covered by my insurance carrier.

I authorize Innovative Physical Therapy to release any medical information to my insurance company.

I authorize direct payment of medical benefits from my insurance company to Innovative Physical Therapy.

I give permission to Innovative Physical Therapy to render the proposed examination and treatment.

I acknowledge that I have read and reviewed the Notice of Privacy and the Informed Consent and I am aware that I have the right to obtain a paper copy of these notices, upon request.

I acknowledge that I have read, understand and agree to abide by Innovative Physical Therapy's Cancellation/No Show Policy.

Patient Signature: _____ Date: _____

If patient is a minor please see below:

I hereby authorize Innovative Physical Therapy, Inc. to evaluate and treat the above mentioned minor.

Print Name of Patient's Parent or Legal Guardian: _____

Patient's Parent or Legal Guardian's Signature: _____ Date: _____

Patient Health Questionnaire

Name: _____ Age: _____ Date: ____/____/____

Your therapist will review this questionnaire to better address your needs. If you do not understand a question, simply leave it unanswered.

1. Describe what you are seeking treatment for: _____

2. When did your symptoms start? _____ New injury? __ Yes __ No Old injury? __Yes __No

3. What caused your symptoms? _____

4. Did you have surgery? Yes/No Date of surgery: _____

5. How often do you experience your symptoms during the day? (check one that applies) :

- | | |
|--|--|
| <input type="checkbox"/> Constantly (76-100% of the day) | <input type="checkbox"/> Occasionally (26-50% of the day) |
| <input type="checkbox"/> Frequently (51-75% of the day) | <input type="checkbox"/> Intermittently (0-25% of the day) |

6. What symptoms are you having? (Check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Swelling | <input type="checkbox"/> Numbness/Tingling |
| <input type="checkbox"/> Loss of Motion | <input type="checkbox"/> Headaches/Migraines |
| <input type="checkbox"/> Weakness | <input type="checkbox"/> Ear/Tooth Pain |
| <input type="checkbox"/> Pain | <input type="checkbox"/> Jaw Pain/Clicking/Locking |
| <input type="checkbox"/> Stiffness | <input type="checkbox"/> Jaw Clenching/Grinding |
| <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Dizziness/Room Spinning |

7. Describe your pain (Check all that apply)

- | | |
|------------------------------------|---|
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Burning |
| <input type="checkbox"/> Dull Ache | <input type="checkbox"/> Stabbing |
| <input type="checkbox"/> Radiating | <input type="checkbox"/> Pins & Needles |

8. Are you worse in the:

- Morning Afternoon Evening Doesn't matter

9. What activities increase your symptoms? (i.e. sitting, walking, driving)

10. What eases your symptoms? (i.e. ice, rest, lying on your side)

11. Do your symptoms interrupt your sleep?

- Yes No

12. Do you wear orthotics?

- Yes No

13. Do you use a mouth appliance/night guard?

- Yes No

14. How are your symptoms changing?

- Getting Better No change Getting worse

15. Who have you seen for this injury/these symptoms?

- | | | |
|---|--|---------------------------------------|
| <input type="checkbox"/> No One | <input type="checkbox"/> Chiropractor | <input type="checkbox"/> Osteopath |
| <input type="checkbox"/> Medical Doctor | <input type="checkbox"/> Massage Therapist | <input type="checkbox"/> Natural Path |
| <input type="checkbox"/> Physical Therapist | <input type="checkbox"/> Acupuncturist | <input type="checkbox"/> Homeopath |

16. What treatment did you receive? And when?: _____

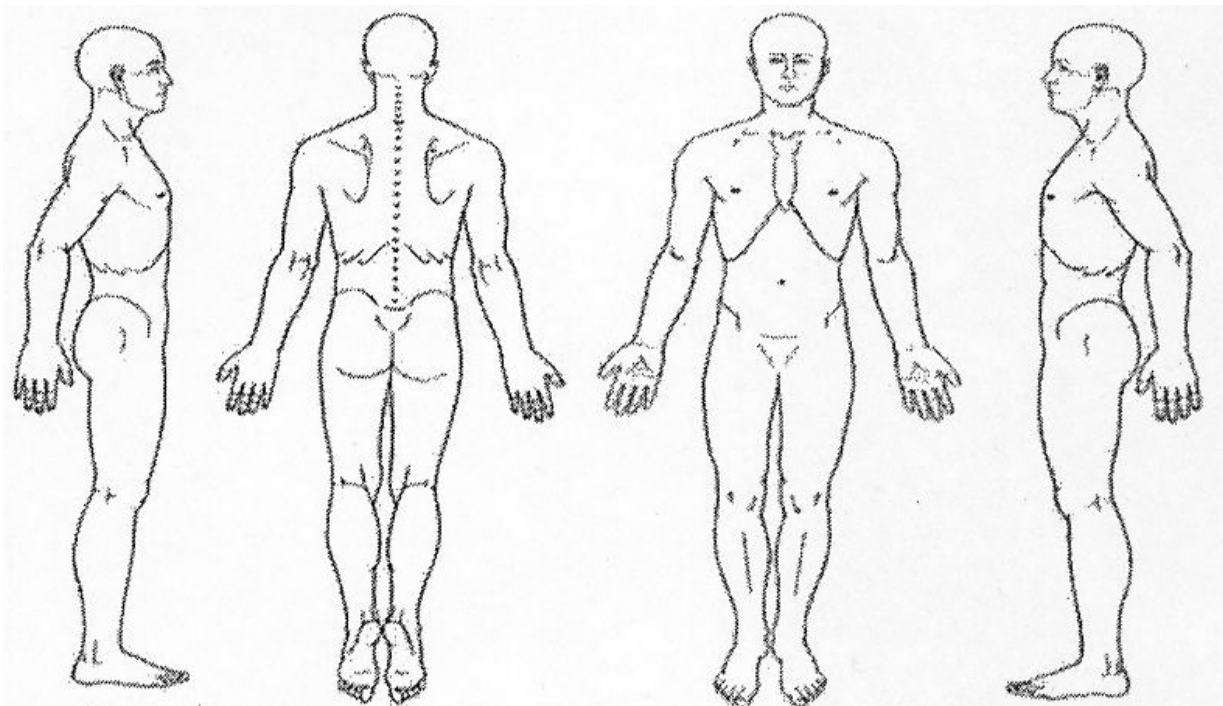
17. What diagnostic tests have you had?

- | | | | | |
|--------------------------------|------------------------------|----------------------------------|------------------------------|--------------------------------------|
| <input type="checkbox"/> Xrays | <input type="checkbox"/> MRI | <input type="checkbox"/> CT Scan | <input type="checkbox"/> EMG | <input type="checkbox"/> Other _____ |
| Date: _____ | Date: _____ | Date: _____ | Date: _____ | Date: _____ |
| Area: _____ | Area: _____ | Area: _____ | Area: _____ | Area: _____ |

Pain Assessment

Use the key below to describe your symptoms on the body diagrams.

KEY- PINS AND NEEDLES = 000 STABBING = //// BURNING = XXXX DULL ACHE = ZZZZ
 SHARP PAIN= >>> RADIATING PAIN= } } } NUMBNESS= +++



Rate your pain today: 0=None 10=Severe/Unbearable (Please circle level of pain)										
①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩	⑪

Rate your Pain overall:

- Pain at its worst: 0 1 2 3 4 5 6 7 8 9 10
- Pain at its best: 0 1 2 3 4 5 6 7 8 9 10

18. Do you have any of the following medical conditions?:

- | | | |
|--|--|---|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Osteoporosis/Osteopenia | <input type="checkbox"/> Night Sweats |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Muscle Cramps |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Cancer | <input type="checkbox"/> Circulation problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Recent weight loss/gain | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Allergies/Skin Sensitivity | <input type="checkbox"/> Pulmonary Disease | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Sensitivity to heat or cold | <input type="checkbox"/> Autoimmune disorders | <input type="checkbox"/> Bowel/Bladder Incontinence |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Anxiety/Panic Attacks |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Spleen Disorder | <input type="checkbox"/> Muscle Tenderness/Weakness |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Gall Bladder Disorder | <input type="checkbox"/> Swollen Legs or Feet |
| <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Pancreatic Disorder | <input type="checkbox"/> General Fatigue |
| <input type="checkbox"/> Stroke/CVA | <input type="checkbox"/> Kidney disorders | <input type="checkbox"/> Nausea/Vomiting |
| <input type="checkbox"/> History of falls | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Stomach Ulcers |
| <input type="checkbox"/> Balance problems | <input type="checkbox"/> Pregnant | <input type="checkbox"/> Indigestion/Heart Burn |
| <input type="checkbox"/> Vision problems | <input type="checkbox"/> Past Surgeries | <input type="checkbox"/> Other |
| <input type="checkbox"/> Hearing problems | <input type="checkbox"/> Recent Fever | <input type="checkbox"/> None |
| <input type="checkbox"/> Metal implants | <input type="checkbox"/> Shortness of Breath | |
| <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Easy Bruising | |

19. Please list and give dates of any major illness, injury, motor vehicle accident, or surgery that has occurred in the past:

20. What activities or sports are you currently involved in? (Please list activity/frequency per week) _____

21. What goals or activities do you want to achieve with Physical Therapy? _____

22. Is there anything else you would like to ask or tell your Physical Therapist? _____

Fall Assessment

Have you fallen in the past year? YES NO

Did the fall result in any injury? YES NO

If so, how many times? _____

What was the injury? _____

Why are falls occurring? _____

List all medication you are currently taking:

Medication Name	Dose (How much?)	Frequency (How often?)

*If you have more than 3 medications, please provide us with a list.

INFORMED CONSENT FOR PHYSICAL THERAPY

Your licensed therapist works by referral from your physician to provide you with rehabilitation services appropriate for the problem(s) for which you seek care. Your therapist will design a treatment program specifically for your needs and goals. S/he is not legally bound by your physician's suggestions for therapy. In fact, a licensed physical therapist is bound by law and ethics to exercise his or her own, independent, professional judgment in the treatment of each patient.

Neither we, nor any physical therapist, can guarantee a positive outcome of your therapy or make any promises as to the degree of improvement or recovery you may receive.

I. *Common Physical and Occupational Therapy Treatments*

A. **Procedures which may be utilized by your therapist:**

- Exercise to build strength, flexibility, balance, coordination and endurance.
- Joint mobilization to reduce pain and improve joint mobility.
- Soft tissue mobilization and massage to loosen muscles, tendons, ligaments and scars.
- Manual or mechanical traction; gentle forces applied to separate joint surfaces, reduce pressure on surrounding tissues.
- Functional training and postural corrections to properly perform normal daily activities, work and recreational tasks such as bending, lifting and carrying.
- Gait training to improve walking and running, help with stairs and inclines.
- Taping of joints, and taping instruction for support and re- education.
- Relaxation training for voluntary quieting of the body and improved breathing pattern.

B. **Modalities which may be used before, during or after treatment procedures:**

- Ice packs to help control swelling and pain.
- Moist heat packs, paraffin and fluidotherapy to help reduce pain and stiffness.
- Ultrasound and Diathermy to produce a deep heat for pain control and loosening soft tissues.
- Electrical Stimulation (Tens, A.R.T., Interferential) to help control pain, swelling, circulation and muscle contraction.

If you have a pacemaker, metallic implants, are currently pregnant, or have a cancerous tumor, you must notify your therapist before treatment is started; the above listed treatments may need to be avoided.

II. *Risks and/or Possible Side Effects Associated with Treatments.*

As is true with all medical care, there are potential risks and side effects of all treatments. The most common side effects of physical therapy are fatigue and temporary soreness of the muscles, tendons, joints or other tissues due to the treatment itself. These are usually transitory.

Other possible but rare side effects may include allergic reactions to products used during treatment, superficial burns, superficial blistering or bruising, or electrical shock.

The use of some electrical modalities may pose a risk to pregnant women or those with metallic implants or implanted heart or nerve stimulators.

Prior to the beginning of your treatment regimen, be sure to ask your therapist for a detailed explanation of the possible side effects of any particular treatment. Your therapist will answer any inquiries you may have about your treatment procedures. Your

health is dependent on your understanding of your treatment and its consequences. You have the right to refuse physical therapy or any part of your treatment as determined by your referring physician and your treating physical therapist. You have the right to request alternative modalities or procedures. If you choose, therapy may be limited to instruction of a home exercise program. However, your results may differ greatly from therapy recommended and provided by a licensed physical therapist.

Our office policy prohibits us from performing patient-requested therapy that differs from the physician and therapist's recommendation if such therapy can not be expected, in the therapist's judgment, to benefit the condition for which the patient seeks relief.

III. ***Safety and Health Considerations***

In consideration of the health and safety of both our patients and staff, this office enforces a policy relating to communicable diseases and conditions, including open and infected wounds.

A. We require anyone presenting with a chronic communicable (or potentially communicable) disease (e.g. TB, HIV, AIDS, hepatitis, certain skin diseases, etc.) or anyone with infected wounds or skin lesions to notify their treating therapist at their first visit.

Your therapist has a legal and ethical responsibility to notify any staff member who will be in direct physical contact with that patient with such a condition.

This allows us to take the appropriate precautions for affected parties. At the patient's request however, other non-treating staff need not be informed.

B. We reserve the right to cancel your treatment when you have an acute infection such as measles, flu, severe cold, bronchitis, etc., to help protect our staff and other patients.

C. For our patient's safety, no open wounds (infected or clean) will be treated in the whirlpool, nor will dressings covering infected wounds be changed. Sterile procedures are not available in this office.

V. ***Personal Possessions***

Innovative Physical Therapy assumes no risk for personal items lost or stolen from this facility. We encourage you to please leave your valuables at home whenever possible.

IV. ***Consent to Physical Therapy Treatment***

I have read and understand the Informed Consent declaration. I agree to accept treatment as proposed and to be bound by the health and safety requirements of Innovative Physical Therapy.



Cancellation / No Show Policy

We at Innovative Physical Therapy want to provide the best possible care for our patients and attending your scheduled appointments is a necessary part of the treatment process.

Please provide a 24 hour cancellation notice before your scheduled appointment, otherwise, a \$40.00 Cancellation/No Show fee will be charged.

This charge is not covered by your insurance company and will be collected at the time of your next scheduled appointment.

By signing below, you acknowledge that you have read, understand and agree to abide by our Cancellation/No Show Policy.

Patient Name:

Patient Signature:

Date:

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below. This Notice will take effect on 04/14/03 and will remain in effect until it is amended or replaced by us.

It is our right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

As part of your treatment you may be required to be in close proximity to other patients. Some of your personal health information may be disclosed. We will do our best to keep disclosures to a minimum.

You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer. If you have any questions regarding this form please ask to speak with our HIPPA compliance officer (Annika Soltero).

TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION

We will keep your health information confidential, using it only for the following purposes:

Treatment: We may use your health information to provide you with our professional services. We have established "minimum necessary or need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Disclosure: We may disclose and/or share your healthcare information with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.

Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities.

Required by Law: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.) We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders, including, but not limited to, voicemail messages, postcards or letters.

INSTRUCTIONS

This questionnaire asks about your symptoms as well as your ability to perform certain activities.

Please answer every question, based on your condition in the last week, by circling the appropriate number.

If you did not have the opportunity to perform an activity in the past week, please make your best estimate of which response would be the most accurate.

It doesn't matter which hand or arm you use to perform the activity; please answer based on your ability regardless of how you perform the task.

1. Please rate your pain level with activity: NO PAIN = 0 1 2 3 4 5 6 7 8 9 10 = VERY SEVERE PAIN

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. Open a tight or new jar	1	2	3	4	5
2. Do heavy household chores (e.g., wash walls, floors).	1	2	3	4	5
3. Carry a shopping bag or briefcase.	1	2	3	4	5
4. Wash your back	1	2	3	4	5
5. Use a knife to cut food.	1	2	3	4	5
6. Recreational activities in which you take some force or impact through your arm, shoulder or hand(e.g., golf, hammering, tennis, etc.).	1	2	3	4	5
	NOT AT ALL	SLIGHTLY	MODERATELY	QUITE A BIT	EXTREMELY
7. During the past week, to what extent has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbors or groups?	1	2	3	4	5
	NOT LIMITED AT ALL	SLIGHTLY LIMITED	MODERATELY LIMITED	VERY LIMITED	UNABLE
8. During the past week, were you limited in your work or other regular daily activities as a result of your arm, shoulder or hand problem?	1	2	3	4	5
Please rate the severity of the following symptoms in the last week. (circle number)	NONE	MILD	MODERATE	SEVERE	EXTREME
9. Arm, shoulder or hand pain.	1	2	3	4	5
10. Tingling (pins and needles) in your arm, shoulder or hand.	1	2	3	4	5
	NONE	MILD	MODERATE	SEVERE DIFFICULTY	SO MUCH DIFFICULTY THAT I CAN'T SLEEP
11. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand? (circle number)	1	2	3	4	5

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Therapist Use Only	
Comorbidities:	<input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart Condition <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Multiple Treatment Areas
	<input type="checkbox"/> Neurological Disorders (e.g., Parkinson's, Muscular Dystrophy, Huntington's, CVA, Alzheimer's, TBI) <input type="checkbox"/> Obesity <input type="checkbox"/> Surgery for this Problem <input type="checkbox"/> Systemic Disorders (e.g., Lupus, Rheumatoid Arthritis, Fibromyalgia)
	ICD Code: _____