INNOVATIVE PHYSICAL THERAPY

NEW PATIENT INFORMATION / CONSENT FORM

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:_____

Referring Physician Name _____

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: _____

INNOVATIVE PHYSICAL THERAPY

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) :

- ❑ Constantly (76-100% of the day)
- ❑ Frequently (51-75% of the day)
- ❑ Occasionally (26-50% of the day)
- ❑ Intermittently (0-25% of the day)

6. What symptoms are you having? (Check <u>all</u> that apply)

- ❑ Swelling
- ❑ Loss of Motion
- ❑ Weakness
- ❑ Pain
- ❑ Stiffness
- ❑ Loss of Balance
- ❑ Numbness/Tingling
- ❑ Headaches/Migraines
- ❑ Ear/Tooth Pain
- ❑ Jaw Pain/Clicking/Locking
- ❑ Jaw Clenching/Grinding
- ❑ Dizziness/Room Spinning

7. Describe your pain (Check <u>all</u> that apply)

- ❑ Sharp
- ❑ Dull Ache
- ❑ Radiating
- ❑ Burning
- ❑ Stabbing
- ❑ 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 vou 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?

❑ No One	❑ Chiropractor	❑ Osteopath
❑ Medical Doctor	❑ Massage Therapist	❑ Natural Path
❑ Physical Therapist	❑ Acupuncturist	❑ Homeopath

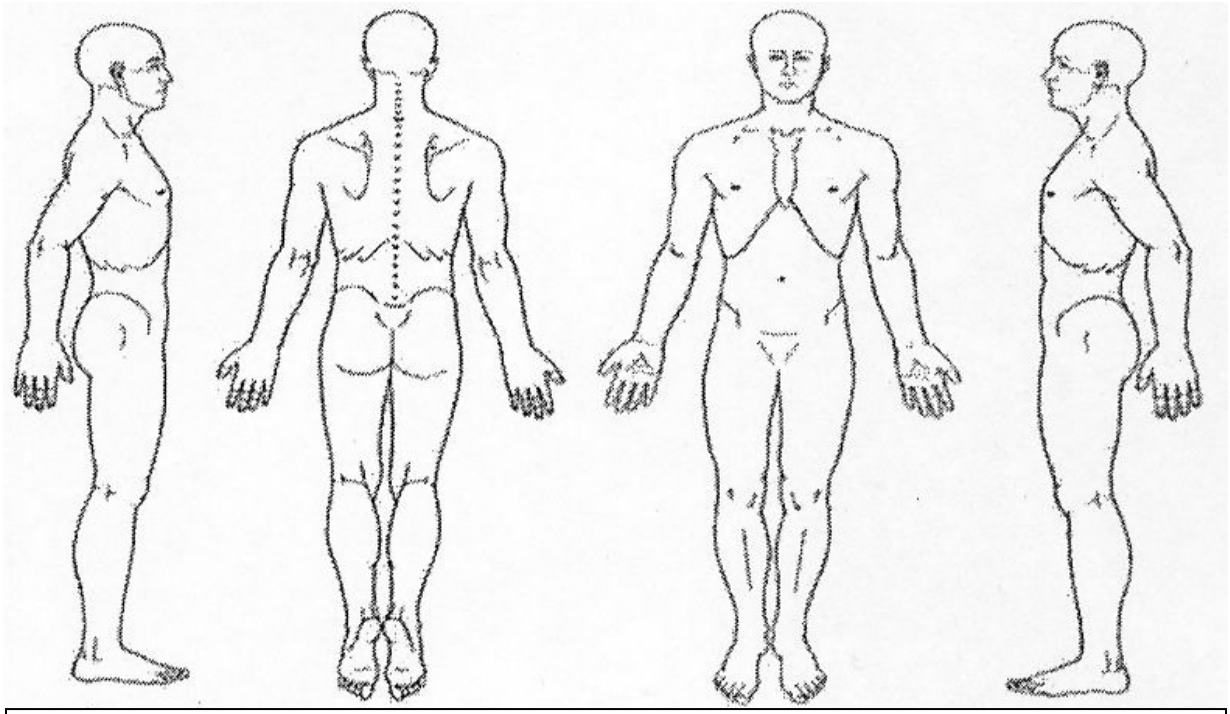
16. What treatment did you receive? And when?: _____

17. What diagnostic tests have you had?

❑ Xrays	❑ MRI	❑ CT Scan	❑ EMG	❑ 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)

⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

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?:

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

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.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSEDAND 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.

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.

INNOVATIVE PHYSICAL THERAPY, INC.
Solutions in Motion

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 $80.00 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:

5030 Camino De La Siesta · Suite 220 · San Diego, CA 92108 · 619-260-0750 · Fax: 619-260-0201

Patient Name: _____ Date: _____

The Activities-specific Balance Confidence (ABC) Scale*

Instructions to Participants: For each of the following activities, please indicate your level of confidence in doing the activity without losing your balance or becoming unsteady from choosing one of the percentage points on the scale from 0% to 100% If you do not currently do the activity in question, try and imagine how confident you would be if you had to do the activity. If you normally use a walking aid to do the activity or hold onto someone, rate your confidence as if you were using these supports.

0%	10	20	30	40	50	60	70	80	90	100%
No Confidence										Completely Confident

How confident are you that you will not lose your balance or become unsteady when you…

1. …walk around the house? _____%
2. …walk up or down stairs? _____%
3. …bend over and pick up a slipper from the front of a closet floor? _____%
4. …reach for a small can off a shelf at eye level? _____%
5. …stand on your tip toes and reach for something above your head? _____%
6. …stand on a chair and reach for something? _____%
7. …sweep the floor? _____%
8. …walk outside the house to a car parked in the driveway? _____%
9. …get into or out of a car? _____%
10. …walk across a parking lot to the mall? _____%
11. …walk up or down a ramp? _____%
12. …walk in a crowded mall where people rapidly walk past you? _____%
13. …are bumped into by people as you walk through the mall? _____%
14. …step onto or off of an escalator while you are holding onto a railing? _____%
15. …step onto or off an escalator while holding onto parcels such that you cannot hold onto the railing? _____%
16. …walk outside on icy sidewalks? _____%

*Powell LE & Myers AM. The Activities-specific Balance Confidence (ABC) Scale. Journal of Gerontology Med Sci 1995; 50(1):M28-34.

Total ABC Score: _____

Scoring: _____ / 16 = _____% of self confidence
Total ABC Score

MEDICARE PATIENTS ONLY
100% - _____% Function = _____% Impairment

Patient Signature: _____ Date: _____

Therapist Signature: _____ Date: _____

DIZZINESS HANDICAP INVENTORY – Initial Visit

Name: _____Date:_____

SECTION I

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

SECTION II - Part I

Instructions: The purpose of this scale is to identify difficulties that you may be experiencing because of your dizziness or unsteadiness. Please indicate answer by circling "yes or "no" or "sometimes" for each question. Answer each question as it pertains to your dizziness or unsteadiness problem only.

P1.	Does looking up increase your problem?	Yes[1]	No[2]	Sometimes[3]
E2.	Because of your problem, do you feel frustrated?	Yes[1]	No[2]	Sometimes[3]
F3.	Because of your problem, do you restrict your travel for business or recreation?	Yes[1]	No[2]	Sometimes[3]
P4.	Does walking down the aisle of a supermarket increase your problem?	Yes[1]	No[2]	Sometimes[3]
F5.	Because of your problem, do you have difficulty getting into or out of bed?	Yes[1]	No[2]	Sometimes[3]
F6.	Does your problem significantly restrict your participation in social activities such as going out to dinner, going to the movies, dancing, or to parties?	Yes[1]	No[2]	Sometimes[3]
F7.	Because of your problem, do you have difficulty reading?	Yes[1]	No[2]	Sometimes[3]
P8.	Does performing more ambitious activities like sports, dancing, household chores such as sweeping or putting away dishes increase your problem?	Yes[1]	No[2]	Sometimes[3]
E9.	Because of your problem, are you afraid to leave your home without having someone accompany you?	Yes[1]	No[2]	Sometimes[3]
E10.	Because of your problem, have you been embarrassed in front of others?	Yes[1]	No[2]	Sometimes[3]
P11.	Do quick movements of your head increase your problem?	Yes[1]	No[2]	Sometimes[3]
F12.	Because of your problem, do you avoid heights?	Yes[1]	No[2]	Sometimes[3]
P13.	Does turning over in bed increase your problem?	Yes[1]	No[2]	Sometimes[3]
F14.	Because of your problem, is it difficult for you to do strenuous housework or yard work?	Yes[1]	No[2]	Sometimes[3]
E15.	Because of your problem, are you afraid people might think you are intoxicated?	Yes[1]	No[2]	Sometimes[3]
F16.	Because of your problem, is it difficult for you to go for a walk by yourself?	Yes[1]	No[2]	Sometimes[3]
P17.	Does walking down a sidewalk increase your problem?	Yes[1]	No[2]	Sometimes[3]
E18.	Because of your problem, is it difficult for you to concentrate?	Yes[1]	No[2]	Sometimes[3]
F19.	Because of your problem, is it difficult for you walk around the house in the dark?	Yes[1]	No[2]	Sometimes[3]
E20.	Because of your problem, are you afraid to stay home alone?	Yes[1]	No[2]	Sometimes[3]
E21.	Because of your problem, do you feel handicapped?	Yes[1]	No[2]	Sometimes[3]

E22.	Has your problem placed stress on your relationships with members of your family or friends?	Yes[1]	No[2]	Sometimes[3]
E23.	Because of your problem, are you depressed?	Yes[1]	No[2]	Sometimes[3]
F24.	Does your problem interfere with your job or household responsibilities?	Yes[1]	No[2]	Sometimes[3]
P25.	Does bending over increase your problem?	Yes[1]	No[2]	Sometimes[3]

SECTION II - Part II

Instructions: Put a check in the box that best describes you**:**

- ☐ **Negligible symptoms (0)**
- ☐ **Bothersome symptoms (1)**
- ☐ **Performs usual work duties but symptoms interfere with outside activities (2)**
- ☐ **Symptoms disrupt performance of both usual work duties and outside activities (3)**
- ☐ **Currently on medical leave or had to change jobs because of symptoms (4)**
- ☐ **Unable to work for over one year or established permanent disability with compensation payments (5)**

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