Name _____ Date_____ Referring Physician _____

Date of Birth _____ Height _____ Weight _____ Primary Care Physician _____

Date of Onset _____

Was your injury work related? ☐ Yes ☐ No Injury Date: _____

Was your injury from an auto accident? ☐ Yes ☐ No Injury Date: _____

Is an attorney involved? ☐ Yes ☐ No

Have you had any diagnostic tests for this condition? ☐ Yes ☐ No

If so, list test (i.e. XRay, MRI, etc) and date _____

What activities aggravate your pain most?_____

_____

What activities/positions make your pain better? _____

_____

Please list any medications you are taking, include dosage/frequency

_____ _____mg ___x/day _____ _____mg ___x/day

_____ _____mg ___x/day _____ _____mg ___x/day

_____ _____mg ___x/day _____ _____mg ___x/day

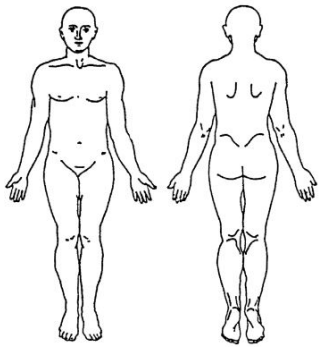
_____ _____mg ___x/day _____ _____mg ___x/day

Please rate your pain (circle current level)

0 1 2 3 4 5 6 7 8 9 10

No Pain Extreme Pain

Please identify your pain.



Have you RECENTLY noted any of the following (check all that apply)?

☐ changes in bowel/bladder function ☐ weight loss/gain ☐ pain at night

☐ nausea/vomiting ☐ shortness of breath ☐ fever/chills/sweats

☐ dizziness/lightheadedness ☐ headaches ☐ weakness/fatigue

☐ difficulty maintaining balance ☐ changes in appetite ☐ difficulty swallowing

During the past month have you been feeling down, depressed or hopeless? ☐ Yes ☐ No

During the past month have you been bothered by having little interest or pleasure in doing things? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No _____packs/day

FOR WOMEN: Are you currently pregnant or think you could be pregnant? ☐ Yes ☐ No

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

☐ cancer (type) _____ ☐ rheumatoid arthritis ☐ diabetes

☐ heart disease ☐ stroke/TIA ☐ multiple sclerosis

☐ high blood pressure ☐ depression ☐ kidney/liver problems

☐ circulation problems ☐ asthma ☐ anemia

☐ stomach ulcers ☐ emphysema/bronchitis ☐ sleeping problems

☐ pacemaker ☐ tuberculosis ☐ seizures/epilepsy

☐ osteoporosis ☐ thyroid problems ☐ Parkinson's disease

☐ chemical dependency ☐ vision/hearing problems ☐ Alzheimer's

☐ urinary/fecal incontinence ☐ Allergies _____ ☐ other _____

Have you had a fall in the last year? ☐ Yes ☐ No How many? Did you sustain an injury? ☐ Yes ☐ No

Please list ANY surgeries or other conditions for which you have been hospitalized (include dates):

1) _____ 2) _____

3) _____ 4) _____

5) _____ 6) _____

Have you had any physical therapy this calendar year? ☐ Yes ☐ No If yes, how many visits? _____

What is your goal for physical therapy? _____

_____ _____

Patient Signature Date

_____ _____

Therapist Signature Date

focus
PHYSIOTHERAPY

Privacy Policy

The purpose of this policy is to describe how Focus Physiotherapy may use and disclose your health information to provide the highest quality physical therapy care possible while protecting the confidentiality of the PHI of our patients to the highest degree possible. This notice describes your rights with respect to your health information. Below is a brief summary of our uses and disclosures as well as your rights as a patient of Focus Physiotherapy.

- Focus Physiotherapy may use and share Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow Focus Physiotherapy to submit requested PHI to the insurance company/companies provided to us by the patient for the purpose of payment.
- The patient has the right to examine and obtain a copy of their own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
- A patient's written consent need only be obtained one time for all subsequent care given the patient in this office. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
- For the patient's security and right to privacy, all staff have been trained in the area of patient record privacy. We have taken all precautions that are known by this office to assure that patient records are not readily available to those who do not need them.
- Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
- If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the physical therapist has the right to refuse to give care.

Is there anyone we are able to share your health information with regarding your care, your appointment times and dates, or your payments related to your care? ☐ YES ☐ NO

If yes, contact person(s) name _____

How did you hear about us? Please check one.

☐ Physician	☐ Co-worker	☐ School, Club, Sports Team
☐ Past Patient	☐ Work Related Injury	☐ Other Advertising
☐ Friend or Family Member	☐ Internet, Website	☐ Other _____

I, the undersigned, attest that I have read the above statements, understand them, and have had my questions answered.

_____ _____

Patient / Guardian Signature Date

Appointment Policy

It is the policy to Focus Physiotherapy to schedule your appointments as the most convenient time slot, as to ease the difficulty to physical therapy appointments. If you are unable to attend one of your appointments, please provide us with a 24-hour notice. This will allow us to adjust our schedules to offer the best service to all patients.

Should you have to cancel an appointment, we will work with you in all possible ways to get that appointment rescheduled. It is best for your health and recovery to maintain the prescribed plan of care. It is our intent to provide the most appropriate care for your condition. If you do not call to cancel and fail to show for an appointment, we will call you that same day to reschedule that appointment.

If you are going to be late for an appointment, please call to let us know, so we can adjust our schedules as necessary. We will make all reasonable efforts to administer your full treatment, however time restraints may limit us from doing so.

If you miss 3 scheduled appointments, we will send a notice to your referring physician informing him / her that the plan of care has not been adhered to and that the therapist may choose to discharge your case. There are many life events which may impact your ability to attend therapy and will always work with you during such events to ensure your complete rehabilitation.

Informed Consent

I understand that as a patient of Focus Physiotherapy,

- I have the right to complete and current information concerning my diagnosis (to the degree known by Focus Physiotherapy), treatment, and any known prognosis. My therapist will communicate this information to me and ensure I understand it.
- I have the right to accept or refuse medical treatment to the extent allowed by law. I will be informed of the medical consequences should I refuse treatment. I understand that should I refuse medical treatment, Focus Physiotherapy has the right to terminate our relationship.
- I have the right to discuss and have all my questions answered regarding “Patient’s Rights”, which will be posted in a prominent area.

I, the undersigned, attest that the above policies have been explained to me and I have had all my questions answered.

_____ _____

Patient / Guardian Signature Date