Williams Physical Therapy, Inc.

A PROFESSIONAL CORPORATION

Names: _____ Male ☐ Female ☐

Address: _____ City: _____ State: _____ Zip: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Date of Birth: _____ SSN: _____

Email: _____ Who may we thank for referring you to our office? _____

Employer: _____ Occupation: _____

Emergency Contact Name: _____

Phone Number: _____ Relationship: _____

Referring Physician: _____ Primary Care Physician: _____

Insurance Information

Private ☐ Worker's Compensation ☐ Auto ☐ Self Pay ☐ Medicare ☐

Name of Insurance Company: _____ Member ID: _____

Policy Holder Name: _____ Date of Birth: _____ SSN: _____

Relationship to patient: _____

If this is a work-related injury, please provide:

Employer Name: _____ Phone:_____ Claim Number: _____

Address (City, State, Zip): _____

I hereby give lifetime authorisation for payment or insurance benefit to be made directly to WILLIAMS PHYSICAL THERAPY/Or its affiliates for services rendered. I understand I am financially responsible for all charges, not paid by my insurance company. In the event of default, I agree to pay all costs of collection and reasonable attorney fees. I hereby authorise this health care provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement is as valid as the original. I further authorise that signature on this form constitutes assignment of benefits to this health Care Provider.

I consent to have this Health Care Provider/or its Affiliates to provide treatment and care prescribed by my physician(s). I understand this consent may be revoked by me at any time.

Any patient who fails to show for his/her scheduled appointment, or cancels with less than 24 hours' notice will be charged $25.00. This will be due and payable at your next visit. Thank you for your courtesy in this matter.

I have read and understood the above policies.

Signature_____ Date: _____

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NOTICE OF PATIENT INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AS WELL AS HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THE FOLLOWING CAREFULLY.

Williams Physical Therapy, Inc is required by law to protect the privacy of your personal health information, provide this information about our Information practices, and follow the information practices that are described herein:

USES AND DISCLOSURES OF HEALTH INFORMATION:
Williams Physical Therapy, Inc uses your personal health information for treatment, obtaining payment for treatment conducting internal administrative activities and evaluation of the quality care that we provide. For example, we may use health information about you to provide with medical treatment services. We may disclose health information about you to doctors, nurses, technicians, office staff or other personnel who are involved in taking care of you and your health. Different personnel in our office may share information about you and disclose information to people who do not work in our office in order to coordinate your care, such as phoning in prescriptions, scheduling lab work and ordering x-rays. We may contact you as a reminder that you have an appointment for treatment or medical care at this office. We may use and disclose health information about you so that the treatment and services you receive at this office may be billed to and payment be collected from you, an insurance company or a third party. We will disclose information about you when required to do so by federal state or local law. In any other situation, Williams Physical Therapy, Inc policies are to obtain your written authorisation before disclosing your personal health information. If you provide us with a written authorisation to release your information for any reason, you may later revoke that authorisation in writing to stop future disclosures at any time.

Williams Physical Therapy, Inc may change its policy at any time. When changes are made, a new Notice of Patient Information Practices will be posted in the waiting, patient treatment areas and will be provided to you on your next visit. You may also request an updated copy at any time.

PATIENT INDIVIDUAL RIGHTS: You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your record. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes. You may also request in writing that we not use or disclose your personal health information for treatment, payment administrative purposes except when specifically authorised by you, when required by law or in emergency circumstances Williams Physical Therapy, Inc will consider all such requests on a case by case basis. Please note the practice is not legally required to accept them.

CONCERNS AND COMPLAINTS: If you are concerned about Williams Physical Therapy, Inc. violating your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our Practice Manger at the address listed below. You may also send a written Complaint to the US Department of Health and Human Services. For further information on Williams Physical Therapy, Inc, Health information practices or if you have a complaint, please contact the following Person:

Williams Physical Therapy, Inc.
Karmen Williams,
970 S. Petit Ave, Suit A
Ventura, CA 93004
Telephone: (805) 672 – 2801

I have read and fully understand Williams Physical Therapy, Inc.'s Notice of Patient Information Services. I understand that Williams Physical Therapy, Inc. May use or disclose my personal Health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment r payment. I understand that I have the right to restrict how my personal health information issued and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that Williams Physical Therapy, Inc. Will consider requests for restriction on a case by case basis, but does not have to agree to request for restrictions.

I hereby consent to the used and disclosure of my personal health information for purposes as noted in Williams Physical Therapy, Inc.'s Notice of Patient Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing any time.

Patient Signature: _____ Date: _____

Patient Name: _____ **Date of Birth:** _____ **Date of Eval:** _____

SUBJECTIVE

Age: _____ **When did your symptoms start?** _____

Hand Dominance: ☐ Right ☐ Left **Date of next Doctor's appointment:** _____

Describe the current problem that brought you here: _____

_____

Are your symptoms: ☐ Improving ☐ Getting Worse ☐ Staying the Same

Have you had any testing? ☐ X-rays ☐ MRI ☐ EMG/ Nerve Conduction Test ☐ CT Scan

☐ Other **Results:** _____

Have you ever had these symptoms before? ☐ Yes ☐ No **Description:** _____

Have you ever had treatment before for these symptoms? ☐ Yes ☐ No **If Yes, please describe:**

☐ **Medication:** **Beneficial?** ☐ Yes ☐ No **Explain:** _____

☐ **Injection:** **Beneficial?** ☐ Yes ☐ No **Explain:** _____

☐ **Physical Therapy:** **Beneficial?** ☐ Yes ☐ No **Explain:** _____

☐ **Massage/Chiropractic:** **Beneficial?** ☐ Yes ☐ No **Explain:** _____

Did you have surgery? ☐ Yes ☐ No **Date of Surgery:** _____

If yes, what procedure did you have done? _____

Have you ever purchased or rented Durable Medical Equipment, Orthotics, Prosthetics, or Supplies?

☐ Yes ☐ No **Explain:** _____

THERAPIST COMMENTS:

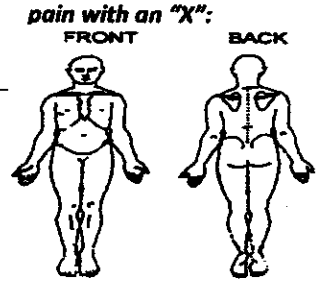
CURRENT COMPLAINTS

If you have pain, what is your pain level?

(0 = No Pain, 10 = Extreme Pain – Circle)

	0	1	2	3	4	5	6	7	8	9	10
AT WORST:	0	1	2	3	4	5	6	7	8	9	10
AT BEST:	0	1	2	3	4	5	6	7	8	9	10
CURRENTLY:	0	1	2	3	4	5	6	7	8	9	10

Mark the location of your pain with an "X":



Are your symptoms: ☐ Constant ☐ Come and Go ☐ Ache ☐ Deep ☐ Superficial ☐ Dull
☐ Sharp ☐ Shooting ☐ Burning ☐ Numbness/Tingling
☐ Other: _____

Day Pattern:

Does your pain seem to be WORSE at a certain time of day? ☐ Yes ☐ No
If Yes, ☐ Morning ☐ Night ☐ Other: _____

Does your pain progress as the day goes along? ☐ Yes ☐ No
If Yes, please explain: _____

Do you have difficulty falling asleep? ☐ Yes ☐ No **If Yes, please explain:** _____

Do you wake due to pain? ☐ Yes ☐ No **If Yes, # of times per night:** _____

THERAPIST COMMENTS:

FUNCTIONAL ABILITIES AND RESTRICTIONS

What were you doing prior to this injury that you are unable to do currently? Please list any additional activities that you are having difficulty completing. _____

☐ Squatting ☐ Sitting ☐ Driving ☐ Reaching ☐ Work Tasks ☐ Gripping/Pinching
☐ Standing ☐ Walking ☐ Lifting ☐ Dressing/Grooming ☐ Stairs ☐ Position Changes
☐ Kneeling ☐ Holding/Carrying Objects
☐ Other: _____

What activities make your pain WORSE? _____

What activities make your pain BETTER? _____

What household duties are you having difficulty performing? ☐ Cooking ☐ Cleaning ☐ Vacuuming
☐ Laundry ☐ Yard Work ☐ Grocery Shopping ☐ Other: _____

Do you use an assistive device? ☐ None ☐ Cane ☐ Walker ☐ Wheelchair ☐ Other: _____

Did you use an assistive device prior to current injury/conditions? _____

Hobbies/ Interests/ Exercise: _____

THERAPIST COMMENTS:

Patient Name: _____ **Date of Birth:** _____ **Date of Eval:** _____

WORK HISTORY/ SOCIAL HISTORY/ INTERESTS/ LIVING ENVIRONMENT

Occupation: _____ **Presently Working:** ☐ **Yes** ☐ **No**

If Yes, ☐ **Full Duty** ☐ **Limited Duty: Restrictions:** _____ **# Days Off Work:** _____

Job Duties: ☐ **Sitting** ☐ **Computer Work** ☐ **Bending** ☐ **Heavy Lifting** ☐ **Traveling** ☐ **Standing**
☐ **Reaching** ☐ **Crawling** ☐ **Twisting** ☐ **Walking** ☐ **Pushing/Pulling**
☐ **Gripping/Pinching** ☐ **Other:** _____

Are you now, or have you ever been disabled (service or work)? ☐ **Yes** ☐ **No** **If Yes, when?** _____
If Yes, please explain: _____

What is your current living arrangement? ☐ **Alone** ☐ **Spouse** ☐ **Partner** ☐ **Family** ☐ **Other:** _____

Does your home have stairs? ☐ **Yes** ☐ **No** **If Yes, # of stairs:** _____

If Yes, do your stairs have handrail? ☐ **Yes** ☐ **No** **If Yes, which side going up?** ☐ **Right** ☐ **Left** ☐ **Both**

THERAPIST COMMENTS:

PREVIOUS MEDICAL HISTORY/ MEDICAL PRECAUTIONS AND CONTRAINDICATIONS

How would you classify your general health? ☐ **Good** ☐ **Fair** ☐ **Poor**

In terms of your general health, please check ALL that apply:

☐ Allergies	☐ Anemia	☐ Liver/Gallbladder Problem
☐ Rheumatoid Arthritis	☐ **Recent Fever**	☐ Fibromyalgia
☐ Metal Implants	☐ **Ringing of the Ears**	☐ Asthma/Breathing Difficulties
☐ **Recent Headaches**	☐ **Recent Nausea/Vomiting**	☐ Seizures/Epilepsy
☐ **Recent Vision Changes**	☐ Heart Attack	☐ **Recent Dizziness/Fainting**
☐ Sexual Dysfunction	☐ **Cancer**	☐ **Recent Change in Bowel/Bladder Habits**
☐ Osteoarthritis	☐ Skin Abnormalities	☐ **Pain with Cough/Sneeze**
☐ Heart Palpitations	☐ Osteoporosis	☐ Smoking History
☐ Chest Pain/Angina	☐ Hernia	☐ Pacemaker
☐ Stroke/TIA	☐ Depression	☐ High/Low Blood Pressure
☐ Physical Abnormalities	☐ Surgeries	☐ Diabetes I or II
☐ Hypoglycemia	☐ Polio	☐ **Unexplained Weight Loss/Gain**
☐ **Night Pain**	☐ Intolerance to Cold/Heat	☐ Pregnancy (Currently)
☐ Urine Leakage	☐ Recent Fractures	☐ **Recent Unexplained Fatigue**
☐ Kidney Problems	☐ Heart Disease	☐ **Numbness/Tingling in Hip/Buttocks Area**

Is there any other information regarding your medical history or are there any factors that may complicate your ability to participate in therapy that we should know about? _____

_____

_____

Have you had any falls in the past 12 months? ☐ **Yes** ☐ **No** **If Yes, how many times?** _____

If Yes, please describe the nature of the fall (s): _____

If Yes, please describe if an injury(ies) occurred: _____

_____

THERAPIST COMMENTS:
☐ **See Attached List**

MEDICATIONS

Please list all of the medications [*with specific NAME, DOSAGE, FREQUENCY, and ROUTE (ie: by mouth)*] that you are currently taking [including over-the-counter, prescriptions, herbals, and vitamins/mineral(s)]:

_____

_____

_____

THERAPIST COMMENTS:
☐ **See Attached List**

PATIENT GOALS FOR THERAPY

What are your goals for participating in Therapy? (I.E: performing household tasks without pain)

_____

_____

THERAPIST COMMENTS:

SIGNATURES

To the best of my knowledge I have fully informed you of the history of my problem and current status.

Patient's Signature: _____ **Date:** _____

Therapist's Signature: _____ **License #:** _____ **Date:** _____

Printed Therapist's Name: _____