Williams Physical Therapy, Inc. Intake Form

Patient Information

Date _____
Name _____
Address _____
City _____ State ____ Zip _____
E-mail _____
DOB ___/____/____ Age ____ Height ____ Weight __

Sex MALE FEMALE

Insurance Company: _____
Member ID#: _____
Group #: _____

Occupation _____
Referred by _____
Primary Physician _____

Phone Numbers

Home _____ Cell _____
Best time to reach you _____ am _____ pm
EMERGENCY CONTACT
Name _____
Home _____ Cell _____

Physical Therapy History

Previous physical therapy experience?
How often?_____
Date of last visit _____
Primary reason for visit? _____
What results would you like to achieve:_____
_____
_____

Patient Condition

When did symptoms appear?_____
_____
What treatment have you already received?
(Circle all that apply)

Medication Surgery Physical Therapy
Chiropractic None Other _____

Level of discomfort 1 2 3 4 5 6 7 8 9 10

Type of discomfort

Sharp Dull Throbbing Numbness
Aching Shooting Burning Tingling
Cramps Stiffness Swelling Other _____

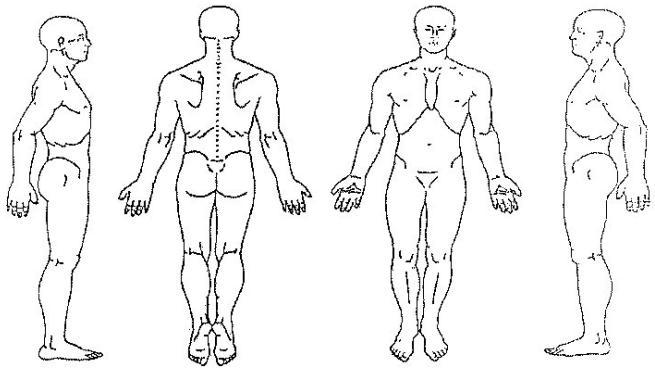
How often do you have this pain? _____

Is it constant or does it come and go? _____
Does it interfere with your (Circle)

Work Sleep Daily Routine Recreation

_____

On the photo below, mark specific area(s) you would like the physical therapist to evaluate during today's session.



Comments: _____
_____

Health History

Please mark an (X) for current conditions or a (P) for past conditions

____ Allergies/Sensitivities
____ Anemia
____ Anorexia
____ Arthritis
____ Asthma
____ Athlete's Foot
____ Birth Control/IUD
____ Blood Clots
____ Breathing Difficulty
____ Bursitis
____ Bronchitis
____ Bulimia
____ Cancer
____ Chemical Dependency
____ Chronic Pain
____ Circulatory Problems
____ Constipation/Diarrhea
____ Diabetes
____ Depression
____ Emphysema
____ Epilepsy
____ Fatigue
____ Fibromyalgia
____ Fractures
____ Glaucoma
____ Head Injuries
____ Hearing Problems/Deafness
____ Heart Disease
____ Hepatitis
____ Hernia
____ Pinched Nerve
____ Tension/Stress
____ Herniated Disk
____ Herpes
____ High Blood Pressure
____ Infectious Diseases
____ Jaw Pain/TMJ
____ Lymphedema
____ Migraine Headaches
____ Mononucleosis
____ Multiple Sclerosis
____ Muscle or Joint Pain
____ Numbness/Tingling
____ Osteoporosis
____ Pacemaker
____ Parkinson's Disease
____ Pneumonia
____ Polio
____ Prosthesis
____ Pregnancy
____ Rashes
____ Rheumatoid Arthritis
____ Rheumatic Fever
____ Sinus Problems
____ Skin Condition(s)
____ Sleep Difficulties
____ Spinal Column Disorders
____ Sprains/Strains
____ Stroke
____ Tendonitis
____ Thyroid Problems
____ Tuberculosis
____ Tumors/Growths
____ Ulcers
____ Varicose Veins
__ Vision Problems/ Contact Lenses
____ Whiplash
____ Other medical conditions not listed _____
Other infectious/ communicable diseases not listed _____

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Health History (Continued)

Please explain any areas noted on the previous page:

_____

_____

_____

_____

_____

Please list any medical conditions, surgeries, accidents and bone, joint, nerve or muscle diseases or injuries:

_____ Date: _____

_____ Date: _____

_____ Date: _____

Medications	Work Activity	Lifestyle
Medications Taken For:		
_____	Sitting	Smoking Packs per day _____
_____	Standing	Alcohol Drinks/Week _____
_____	Light Labor	Coffee/Caffeine Cups/day _____
_____	Heavy Labor	High Stress Level_____

Please list all forms and frequency of stress reduction activities, hobbies, exercise or sports participation:

_____

_____

_____

_____

FOR FEMALES ONLY:

Are you pregnant? Yes/No Due Date _____ Note from physician authorizing physical therapy? Yes/No

* Must have a written note from MD before physical therapy can take place.

Privacy Information

I understand that all Information collected by the Therapist will be kept confidential and comply with HIPPA regulations and will not be released without prior written authorization by the patient.

Authorization

The information above is accurate and complete to the best of my knowledge and I freely give my permission to be treated.

I understand that no inappropriate comments or conduct will be tolerated. Any indication of such behavior will automatically end the session.

I agree to inform the therapist of any experience of discomfort during the session so that the pressure and/or strokes can be adjusted to my comfort level.

I agree to inform the therapist in regard to changes in my health and understand that there shall be no liability on the therapist's part should I forget to do so.

I understand that receiving physical therapy does not deter me from seeking medical treatment for any medical condition

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative (if Patient is under 18, Parent or Guardian must sign) Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

Williams Physical Therapy, Inc.

A PROFESSIONAL CORPORATION

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: _____