PATIENT MEDICAL HISTORY

Name: _____ City: _____

Date of Birth: _____ State: _____Zip Code: _____

Height: ____ ft. ___ in. Weight: _____ Phone number: _____

Street Address: _____ Email: _____

How do you want to receive appt reminders? (check one box): ☐ Voice ☐ Text

Emergency Contact: _____

Emergency Contact Phone Number: _____

Who is your Primary Care Provider / Internist? _____

What problem or health condition brings you here? _____

_____

Date of injury/onset of this issue/date of surgery? _____

Have you had this issue before? ☐YES | ☐NO

If yes, did you receive therapy for it previously? ☐YES | ☐NO

This issue started (check one)…☐GRADUALLY | ☐ABRUPTLY

If you had this before, when did you last have this issue (approximately what year)? _____

Have you had imaging prior to starting Physical Therapy? Check all that apply.

☐X-Ray ☐CT scan

☐MRI ☐Other _____

Are your symptoms (check one box)…

☐Getting better ☐Not changing ☐Getting worse

WHEN are your symptoms generally worse (check all that apply)…

☐Morning, upon waking ☐Night, when trying to sleep

☐End of the day ☐All the time (Constant)

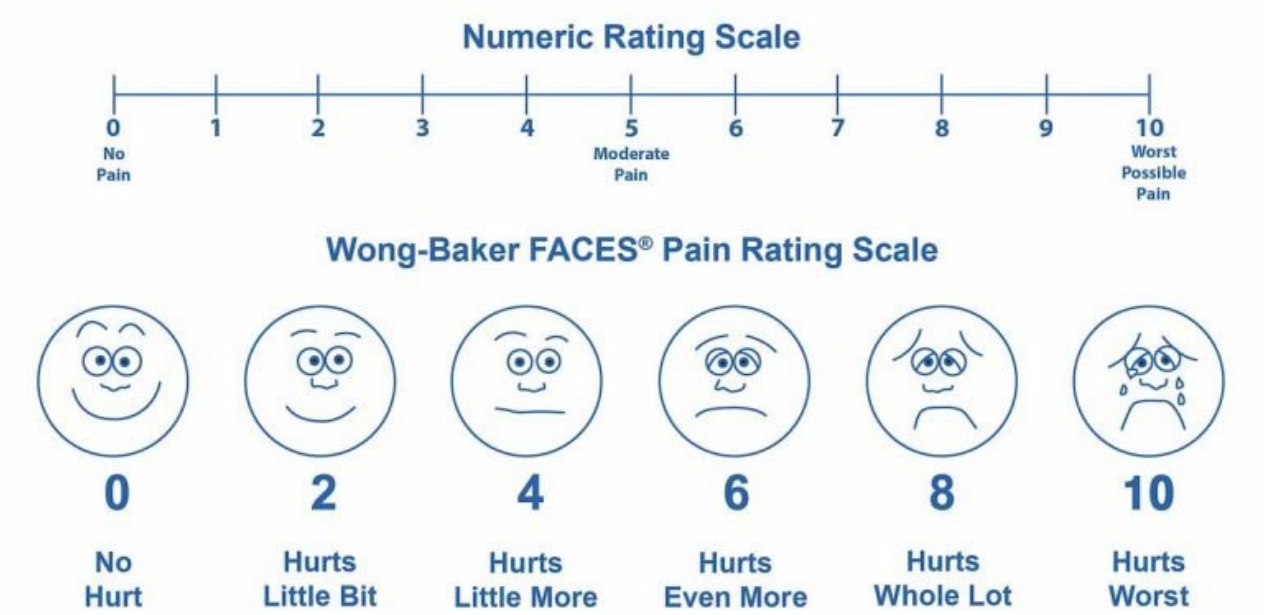
Please describe the **ONE** location of where you have the MOST pain:_____

If there are multiple painful areas, list them in order of most painful to least painful:

_____

_____

Please use the pain scales below to help us understand your pain intensity.



Please rate the **WORST** your pain ever gets, using the scale above (provide number):_____

Please rate your **CURRENT** level of pain, using the scale above (provide number):_____

Please rate the **BEST** your pain gets, using the scale above (provide number):_____

Are any of the following **aggravating factors**? Check all that apply.

☐Sitting	☐Going up stairs	☐Bending
	☐Going down stairs	☐Voiding
☐Walking	☐Sit to Stand	☐Lying down

If you are having neck or back pain, does that pain **radiate** into any extremity? ☐YES | ☐NO

If yes, describe where you have radiating pain? _____

Have you had a fall in the past year? ☐YES | ☐NO

If yes, did you sustain any injury? _____

If yes, how many falls have you had in the last year? _____

Do you have or ever had any of the following health conditions? Check all that apply.

☐Alzheimer's/Dementia
☐Anxiety
☐Cardiovascular Disease / Circulation problems
☐Cauda Equina Syndrome
☐Cerebral Vascular Accident (CVA / TIA)
☐Current Infection
☐Depression
☐Diabetes Mellitus Type 1
☐Diabetes Mellitus Type 2
☐Dizzy Spells / Vertigo
☐Fibromyalgia
☐Fracture or Suspected Fracture
☐High / Low Blood Pressure
☐History of Cancer
☐Huntington's
☐Immunosuppression
☐Lupus
☐Muscular Dystrophy
☐Multiple Sclerosis
☐Obesity
☐Osteoarthritis
☐Osteoporosis
☐Parkinson's
☐Rheumatoid Arthritis
☐Traumatic Brain Injury
☐Other (describe below)

_____
_____
_____

Do you take any medications (prescription or over the counter)? ☐YES | ☐NO

If yes, please list type and dosage below or provide a separate list.

_____

_____

_____

_____

_____

Please describe any hobbies/activities impacted by your current problem or health condition.

_____

_____

_____

Please describe your home environment. Please note if you live alone or are the primary caretaker for one or more individuals.

_____

_____

_____

Are you currently working? ☐YES | ☐NO | ☐RETIRED

If no, is your current problem or health condition preventing you from working? ☐YES | ☐NO

If yes, please describe why you cannot work.

_____

_____

_____

_____

What are your goals for physical therapy? Check all that apply.

☐Improve home / self-care activities

☐Return to work

☐Improve mobility / walking activities

☐Decrease or eliminate pain / discomfort

☐Improve recreation / sports activities

☐Improve strength / balance

☐Other (please describe):_____

_____

To the best of my knowledge, the information above is complete and factual.

Patient Signature: _____Today's Date: _____

Patient Acknowledgment Form

Please Read and Initial:

_____ I consent to evaluation and treatment by FYZICAL Therapy and Balance Centers and realize that I have the right to refuse any procedure after having the risks and benefits explained to me.

_____ The filling of insurance claims is a courtesy that we extend to our patients. You will be responsible for any charges not reimbursed or contractually adjusted by your insurance company. Should your claim not process as you expected or should you have any questions regarding your insurance plan benefits, please contact your insurance company directly.

_____ I authorize the release of information acquired in the course of my treatment including but not limited to medical records, electronic media, and oral communications, to my insurance company representatives, employer, primary care physician, referring physician, other third-party payers and/or the following (i.e., spouse, family member, friend: _____)

_____ I authorize phone, e-mail, and/or text messages regarding my treatment and appointments to be left with persons or machines at the phone numbers provided.

_____ I have received and/or been offered a copy of this facility's Notice of Information/Privacy Practices has been provided to me.

_____ Medicare beneficiaries have an annual cap for combine therapy services including Physical, Occupational, and Speech Therapies.

_____ A $35.00 charge will be charged for any returned checks.

_____ Should a patient account become 60 days past due the account will be placed with a collection agency and a $35.00 collection fee will be charged.

_____ I hereby assign to FYZICAL Therapy and Balance Centers all payment for medical service rendered to myself or my dependents. I understand I am responsible for any amount not covered by my insurance.

_____ I understand I will be charged a fee of $25.00 for cancelled or missed appointments without 24-hour notice. Payment must be rendered prior to next scheduled visit.

_____ _____

Patient signature Today's Date

_____ _____

Patient Legal Representative Today's Date

NOTICE OF PRIVACY PRACTICES

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

Understanding Your Health Information Rights

Although your health record is the physical property of the healthcare provider, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information
- Obtain a paper copy of the notice of information practices upon request
- Inspect and obtain a copy of your health record
- Request to amend your health record
- Obtain an accounting of disclosures of your health information
- Request communications of your health information by alternative means or at alternative locations
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken

Our Responsibilities

- We are required to:
- Maintain the privacy of your health information
- Provide you with a notice as to our legal duties & privacy practices with respect to your information
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction on disclosure or amendment to your record
- Accommodate reasonable requests you may have to communicate health information by alternative means or locations

We reserve the right to change our practices and to make the changes effective for all protected health information we maintain. If our information practices change, we will notify you the next time you come to our office for treatment.

If you have questions and would like additional information, you may contact our Privacy Officer Debbie Giovannozzi at (239) 633-6559. If you believe your privacy rights have been violated, please mail your written complaint to:

Fyzical Therapy and Balance Centers
Attn: Privacy Officer
25241 Elementary Way Suite 200
Bonita Springs, Florida 34135

You may also file a complaint to:
Office for Civil Rights
U.S. Department of Health and Human Services
90 7th Street, Suite 4-100
San Francisco, CA 94103
Customer Response Center: (800) 368-1019

Examples of Disclosures for Treatment, Payment and Health Operations

1. We will use and disclose your health information for payment to FYZICAL Therapy and Balance Centers for services provided to you.
2. Your protected health information may be released to other healthcare providers to assist in your care or in case of an emergency.
3. We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, of your location and general condition.
4. We may contact you by phone, mail, or we may leave a message on an automated answering device concerning appointments, verify insurance/demographic information, etc.
5. We may disclose health information for law enforcement purposes as required by law.
6. As required by law, we may disclose health information to public health or legal authorities charged with preventing or controlling disease, injury or disability

_____ _____

Patient signature Today's Date