NEW PATIENT INFO. & MEDICAL HX-PI

First Name _____ Last Name _____ Middle Initial ____ Sex (M / F)

Address _____
(number) (street) (city) (state) (zip code)

Social Security# _____-_____-_____ Birth Date ____ / ____ / _____ Age _____

Phone # (_____) _____ - _____ Cell # (_____) _____ - _____Email_____

Married ( ) Single ( ) Other ( ) _____ Spouse's Name _____

Occupation _____ Employer _____ Work Address_____

IN CASE OF AN EMERGENCY, CONTACT_____
Name Relationship Phone #

Have you ever had physical therapy before? (YES / NO) If yes, when was your last treatment? _____

What are your health goals? (Check one of the following)

( ) Reduce symptoms only **( )** Reduce symptoms and show me how to prevent flair-ups **( )** Reduce symptoms, prevent flair-ups and maintenance care

Do you have any type of health insurance? (YES / NO) Primary Insurance _____ Secondary Insurance_____

Is this injury work related? (YES / NO) Is this injury due to a motor vehicle accident? (YES / NO)

*** IF YOU ANSWERED YES TO EITHER OF THE TWO PREVIOUS QUESTIONS, PLEASE NOTIFY THE FRONT DESK ***

MEDICAL HISTORY

Check any of the following symptoms you are currently experiencing or have experienced within the past 6 months.

Musculoskeletal
__Low Back Pain
__Pain Between Shoulders
__Neck Pain
__Headaches
__Arm Pain/Numb/Tingling
__Leg Pain/Numb/Tingling
__Joint Pain/Stiffness
__Walking Problems
__Difficulty Chewing
__Weakness

EENT
__Vision Problems
__Dental Problems
__Sore Throat
__Ear Pain/Ringing
__Hearing Difficulty

General
__Allergies
__Loss of Sleep
__Fever/Night Sweats
__Eczema (skin rash)
__Weight Loss/Gain

Genitourinary
__Bladder Trouble
__Painful Urination
__ Excessive Urination
__Discolored Urine

Male Specific
__Difficulty Urinating
__Impotence
__Sterility

C-V-R
__Chest Pain
__Short of Breath
__Blood Pressure
__Heart Problems
__Wheezing
__Lung Problems
__Varicose Veins
__Arm/Leg Swelling
__Asthma
__High Cholesterol
__Bruise Easily

Female Specific
__Menstrual Irregularity
__Menstrual Cramping
__Sterility
__Breast Pain

*****ARE YOU PREGNANT? (YES / NO)*****

Nervous
__Numbness
__Paralysis
__Dizziness
__Forgetfulness
__Confusion
__Depression
__Fainting
__Convulsions
__ADHD/Hyperactivity
__Anxious
__Tremor/Shaking

Gastrointestinal
__Gas/Bloating
__Heartburn
__Poor Appetite
__Excessive Appetite
__Excessive Thirst
__Decreased Appetite
__Colitis
__Vomiting
__Diarrhea
__Constipation
__Black/Bloody Stool
__Hemorrhoids
__Liver Problems
__Abdominal Pain
__Frequent Nausea

Name of your family physician _____Last appointment with your physician _____Phone # _____Fax # _____
Do you give us permission to send your medical doctor an updated report on your status? (YES / NO)
Have you been hospitalized in the past? (YES / NO) If yes when and why? _____
Please list any surgeries you have had and when.
_____
Please list any medications you are taking.
_____

PATIENT SIGNATURE _____ **DATE** _____

NEW PATIENT COMPLAINT(S)

Name _____ (Complete #1-10) Date _____

1. What is your **worst** complaint? _____

When and How did your condition begin? _____

Rate your pain/discomfort on the scale. (circle) (none) = **0 1 2 3 4 5 6 7 8 9 10** = (severe)

How often do you experience this complaint? (circle) Occasionally (0-25% of the day) Intermittently (26-50% of the day) Frequently (51-75% of the day) Constantly (76-100% of the day)

How are your symptoms changing? (circle) **Improving** **Not Changing** **Worsening**

2. What is your **second worst** complaint? _____

When and How did your condition begin? _____

Rate your pain/discomfort on the scale. (circle) (none) = **0 1 2 3 4 5 6 7 8 9 10** = (severe)

How often do you experience this complaint? (circle) Occasionally (0-25% of the day) Intermittently (26-50% of the day) Frequently (51-75% of the day) Constantly (76-100% of the day)

How are your symptoms changing? (circle) **Improving** **Not Changing** **Worsening**

3. Briefly describe any other complaints. _____

_____

4. How much have these symptoms interfered with the following activities? (check all that apply)

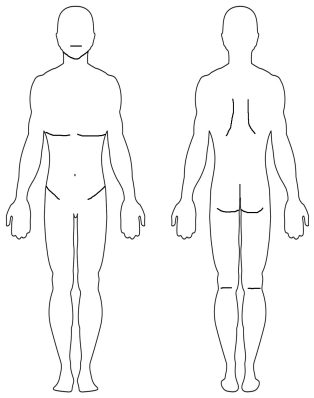
Work	Social Activities
___ Not at all	___ Not at all
___ A little bit	___ A little bit
___ Moderately	___ Moderately
___ Quite a bit	___ Quite a bit
___ Extremely	___ Extremely

5. Circle any other symptoms you are experiencing.

(Sharp Pain) (Dull Ache) (Shooting Pain) (Burning Pain) (Throbbing Pain) (Popping) (Weakness)

6. Please indicate on the diagram to the right where you experience your symptoms. (Use the key below)

Pain XXX **Numbness OOO** **Tingling √ √ √** **Stiffness / / /** **Burning + + +**



7. Who have you seen for your symptoms?(check) ___No One ___Medical Doctor ___Chiropractor ___Physical Therapist ___Other

a. What treatment did you receive and when? _____

b. Circle any tests have you had for your symptoms? (X-Rays) date:____ (CT Scan) date:_____ (MRI) date:_____ (Other)

8. Have you had similar symptoms in the past? (YES / NO)

If yes, when was the last time you experienced those symptoms? _____ How long did your symptoms last? _____

9. What is your occupation? _____ Are you required a disability note for your employer / teacher? (YES / NO)

10**. Family History:** Does anyone in your immediate family (including your grandparents) have any of the conditions listed? (Circle all that apply)

Arthritis, Asthma, Birth Defects (i.e. heart defects), Cancer, Diabetes, Genetic Conditions (i.e. Cystic Fibrosis), Heart Disease, Mental Illnesses (i.e. Alzheimer's, Parkinson's), Obesity, Seizures

DOCTORS NOTES: _____

_____

Blue Room Physical Therapy—410 S Melrose Dr Suite 200, Vista, CA 92081—Ph/ Fax: 760.630.8060

Blue Room Physical Therapy
410 S. Melrose Drive Suite 200
Vista, CA 92081

Consent for treatment: I, as a patient, consent to physical therapy at Blue Room Physical Therapy as prescribed by my referring provider. I consent to maintain the confidentiality of other patients of the facility and not to disclose to anyone anything discussed at the facility by anyone other than myself.

Initials: _____

Authorized Release of Information: I hereby authorize Blue Room Physical Therapy to release medical records pertaining to my treatment to any entity that is responsible for payment of physical therapy charges. I understand that this authorizes my insurance company to pay any benefits directly to Blue Room Physical Therapy. In addition, I further understand that I am ultimately responsible for any remaining co-insurance or co-payment.

Initials: _____

HIPPA Patient Information Consent: I understand that Blue Room Physical Therapy 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 or payment. I understand I have the right to restrict how my personal health information I used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand Blue Room Physical Therapy will consider requests for restrictions on a case by case basis but does not have to agree to requests for restrictions. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

Initials: _____

Signature: _____ Date: _____

OFFICE POLICIES / PROCEDURES AGREEMENT AND CUSTOMARY FEE SCHEDULE

FINANCIAL ARRANGMENTS

I understand and agree that health and accident policies are an arrangement between an insurance company carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

INSURANCE BILLING/PAYMENT

Patients are ultimately fully responsible for services provided by our office. For your convenience, our office will make an effort to verify your insurance benefits. However, please note that verification of benefits is not guaranteed. Your insurance company makes the final determination of insurance benefits when they consider the claim. Patients are fully responsible for payment of services not authorized or covered by their insurance company. Patients that are represented by an attorney in PI cases must notify our office the same day if changing or canceling representation.

PAYMENT ARRANGEMENTS

We understand that occasions arise when it may be necessary for you to request to be billed rather than pay at the time of service. This may include setting up a payment plan for those who may require extensive treatments. Payment is due within 30 days of the service rendered. If there are legitimate financial problems, please discuss them with our office manager prior to the 30 days so that we may find a workable solution. If an account is not paid within 30 days and no payment arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account. You will also be charged a monthly interest of 10% based off your principal balance until all fees are paid.

APPOINTMENT SCHEDULING

Canceling or rescheduling appointments requires a 24 hour notice otherwise you will be charged a fee for the missed scheduled service.

NOTICE OF PRIVACY POLICY

We are required by law to make sure your medical information is protected; give you notice describing our legal duties and privacy practices with respect to medical information about you; and follow the terms of the notice that is currently in effect. By signing below you are acknowledging that you have received our Notice of Privacy Policy.

NOTICE OF PRIVATE PRACTICES/ BUSINESSES AND PATIENT'S FREEDOM OF CHOICE

There are separate practices/ businesses within this office. Each entity is owned and operated as separate businesses and may have separate fee schedules and different treatment techniques. I understand that each service offered at this facility are owned and operated as separate businesses and hold each business harmless from any act or omission which may occur by any of the other businesses during the course of my treatment at this facility. Circumstances may arise such as emergencies, or doctor vacation or sick leave and you may request to be treated by another doctor within this office. If you are treated by another doctor you may be charged a different fee. Patients are free to choose any doctor or organization that may be recommended by our doctors. You do not have to use the facilities at our office for treatments and we can assist you on finding an alternative locations or sources.

CONSENT TO TREAT MINOR

I, _____ the parent or legal guardian, who has permission to make medical decisions for _____, a minor child, authorize any necessary treatment at Blue Room Physical Therapy for my minor child and fully agree to the above terms.

_____	_____	_____
PRINT NAME	SIGNATURE	DATE

Blue Room Physical Therapy

Acknowledgement of Receipt of Notice of Privacy Practices

This form will be retained in your medical record.

NOTICE TO PATIENT

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice.

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

I acknowledge that I have **received and had the opportunity to review** the Notice of Privacy Practices on the date below on behalf of _____**Blue Room Physical Therapy.**

I understand that the Notice describes the uses and disclosures of my protected health information by **Blue Room Physical Therapy** and informs me of my rights with respect to my protected health information.

_____ _____

Patient's Signature or that of Legal Representative *Printed Name of Patient or that of Legal Representative*

_____ _____

Today's Date *If Legal Representative, Indicate Relationship*

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ Other (please specify):_____

_____

_____ _____

Employee Name *Today's Date*