PATIENT INFORMATION SHEET

Patient's Legal Name _____ Date _____
Preferred Name _____ Date of Birth _____
Parent of Guardian (if minor) _____
Address _____ City _____
State _____ Zip _____ Email _____
Primary Contact (circle one) Home Cell Work Home Phone _____
Cell Phone _____ Work Phone _____
Emergency Contact Name _____ Relation _____ Phone _____

Referring Doctor _____
Do you authorize Direct Performance Physical Therapy to discuss your treatment with your referring doctor? Yes No
Diagnosis/Condition _____
Date of Injury or Illness _____ Date of Surgery _____
If Injury, How & Where Sustained? _____

Primary Insurance _____ ID Number _____
Primary Subscriber _____ Date of Birth _____

Secondary Insurance _____ ID Number _____
Primary Subscriber _____ Date of Birth _____

Is Injury Work Related? _____ Reported to Employer? _____ Date of Injury _____
Employer _____ Occupation _____
Employer Address _____
Adjustor Name _____ Phone _____

PATIENT'S SIGNATURE _____ **DATE** _____
***Notice to All Patients**: You are responsible for your balance accrued at Direct Performance Physical Therapy regardless of insurance coverage.*

CANCELLATION POLICY

We appreciate 24 hour notice if you need to cancel your appointment so that we may open your appointment time to other patients. Cancellations with less than 24 hour notice are charged $25.00 for the missed appointment if we are unable to fill the time, or $50.00 in the event of a missed appointment without cancellation.

I have read and understand Direct Performance Physical Therapy's cancellation policy. Initial here _____

CONSENT FOR TREATMENT

I have been informed by Direct Performance Physical Therapy of the treatment and care which has been prescribed by my physician(s) and will be provided by Direct Performance Physical Therapy. I understand as a patient, I am under the care and control of my physician(s) and that Direct Performance Physical Therapy is not liable for any act or omission when providing treatment in accordance with my physician's instructions.

I acknowledge that no guarantee or assurance has been, nor can be,
made by Direct Performance Physical Therapy as to the result of the prescribed treatment.

By signing this agreement, I consent to have Direct Performance Physical Therapy provide the treatment and care prescribed by my physician. I understand this consent may be revoked by me at any time.

PATIENT'S SIGNATURE _____ **DATE** _____
If patient is a minor, must be signed by a parent or legal guardian.

NOTICE OF PRIVACY POLICIES

We keep our patients' financial and health information private as required by law, accreditation standards, and our own policies. This notice explains your rights, our legal duties, and our privacy practices. We use physical, technical, and procedural methods to protect your private information. We share it only with our employees and affiliates who need it to provide service on your account, to do billing, or for other legally allowed or required purposes. Please review these policies carefully.

YOUR FINANCIAL INFORMATION

We collect and use several types of financial information to carry out billing and insurance activities. This may include your demographic, insurance, and coverage information, as well as that of your family. We keep records about your business with our affiliates, others, or ourselves, such as, insurance coverage, premiums, and payment history.

YOUR HEALTH INFORMATION

We only collect, use, and/or communicate information about you for healthcare treatment, payment, operations, or when allowed or required by law to do so. We may use your protected health information for the following:

FOR TREATMENT: We use and disclose information about your personal health information within our treatments and treatment documentation. We may share this information with your referring medical provider.
FOR PAYMENT: We use and disclose information about you to manage your account or benefits and may submit your protected health information to your insurance company, adjustor, lawyer, or other, as indicated by you.
FOR HEALTH CARE OPERATIONS: We may use and disclose information about you within the scope of the practice to better our services and improve operations.
AS ALLOWED OR REQUIRED BY LAW: Information about you may be shared with regulators for audits, licensure, or other proceedings; for administrative or other legal proceedings; to public health authorities; or to law enforcement officers, such as to comply with a court order or a subpoena.
AUTHORIZATION: We will obtain your written permission before we use or share your protected health information for any other purpose, unless otherwise allowed or required by law. You may withdraw this permission anytime in writing. We will then stop using your information for that purpose. However, if we have already used your information based on your authorization you cannot take back your agreement for those past situations.

YOUR RIGHTS

Under privacy regulations as of April 14, 2003, you have the right to:

RECEIVE a copy of the information that we have about you, or correct personal information that you believe is missing or incorrect. If someone else (such as your doctor) gave us this information, we will tell you who, so that you can ask them to correct it.
ASK us not to use your health information for payment or health care operation activities. If you make this request, it will remain your responsibility to provide required information to your payment provider. We are not required to agree to these requests.
RECEIVE a list of disclosures of your health information that we make on or after April 14, 2003, except when: you have authorized the disclosure; the disclosure is made for treatment, payment, or healthcare operations; The law otherwise restricts the accounting.
ASK us not to communicate with you about health matters using reasonable alternative means or a different address, if communication to your home address could endanger you.

COMPLAINTS

If you believe we have not protected your privacy, you can file a complaint with us or with the federal government. We kindly request notice of your complaints so that we may better serve you and other patients. We will not take action against you for filing a complaint.

COPIES AND CHANGES

You have the right to receive another copy of this notice at any time. Even if you agreed to receive this notice electronically, you are still entitled to a paper copy. We reserve the right to change this notice. A revised notice will apply to information we already have about you as well as any information we may receive in the future. We are required by law to comply with whatever privacy notice is currently in effect. We will communicate any changes to our notice through mail and/or our website.

CONTACT INFORMATION

If you want to exercise your rights under this notice, wish to talk with us about privacy issues, or to file a complaint, please contact the office directly: 757.742.3778.

PATIENT ACKNOWLEDGEMENT FOR USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby acknowledge that Direct Performance Physical Therapy, LLC has the right to use my protected health information for the above governed approved applications.

Patient Signature: _____

Patient Name: _____ Date: _____

DIRECT PERFORMANCE Physical Therapy

PHYSICAL THERAPY MEDICAL SCREENING QUESTIONAIRE

Patients Name _____ Date _____

Age ____ Height _____ Weight _____ Occupation _____

Do you smoke? Yes ◯ / No ◯ Do you have a pacemaker? Yes ◯ / No ◯

For Women: Are you currently pregnant or think you might be pregnant? Yes ◯ / No ◯

What recreational / leisure activities do you enjoy? _____

_____

_____

Please list any surgeries or other conditions for which you have been hospitalized, including dates:

_____

_____

Please list all current medications and dosage, including over the counter medications, vitamins, supplements:

_____

_____

Have you taken steroid medications for any medical conditions? Yes ◯ / No ◯

Have you ever taken blood thinners for any medical conditions? Yes ◯ / No ◯

Past Medical History (check all that apply):

☐ Cancer	☐ Heart Disease	☐ Rheumatoid Arthritis	☐ Blood Clots
☐ High Blood Pressure	☐ Osteoarthritis	☐ Liver Disease	☐ Ulcers
☐ Osteoporosis	☐ Lung Disease	☐ Bladder Infection	☐ Thyroid Problem
☐ Allergies / Asthma	☐ Kidney Problem	☐ Stroke	☐ Tubercolosis
☐ Bone / Joint Infection	☐ Kidney Disease	☐ Fibromyalgia	☐ Depression
☐ Diabetes	☐ Angina / Chest Pain	☐ Sexually Transmitted Disease / HIV	
☐ Lyme Disease	☐ Other: _____		

Has anyone in your immediate family (parents, brothers, sisters) ever been diagnosed with any of the above?

Please list: _____

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

☐ Fatigue	☐ Weight Loss / Gain	☐ Shortness of Breath
☐ Fever / Chills / Sweats	☐ Headaches	☐ Difficulty Walking / Loss of Balance
☐ Nausea / Vomitting	☐ Difficulty Swallowing	☐ Falls
☐ Numbness / Tingling	☐ Constipation / Diarrhea	☐ Dizziness / Lightheadedness
☐ Muscle Weakness	☐ Heartburn / Indigestion	☐ Changes in Bowel / Bladder Function
☐ Depression		

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 ◯

Is this something with which you would like help? Yes ◯ / Yes, but not today ◯ / No ◯

Current symptoms

When did your symptoms first begin? _____

How did your symptoms begin (gradually, suddenly, injury)? _____

My symptoms are currently: ◯ Getting better ◯ Getting worse ◯ Staying the same

DIRECT PERFORMANCE Physical Therapy

Have you received any treatment for this problem? _____

Have you had this problem before? Yes ◯ / No ◯ How long did it take for you to feel better? _____

Have you had an X-Ray, MRI, or special testing for this problem? _____

Do your current symptoms interfere with your sleep? _____

Does coughing, sneezing or taking a deep breath aggravate your symptoms? Yes ◯ / No ◯

Does bending, sitting, lifting or twisting your back aggravate your symptoms? Yes ◯ / No ◯

Has there been any change in bowel habit since onset of your symptoms? Yes ◯ / No ◯

Does eating certain foods aggravate your symptoms? Yes ◯ / No ◯

Has there been any weight change since onset of your symptoms? Yes ◯ / No ◯

Please mark the areas where you feel symptoms on the body chart using the symptoms key below.

Symptoms Key:

↓ = shooting/sharp pain

X = dull/aching pain

≈ = numbness

V = tingling

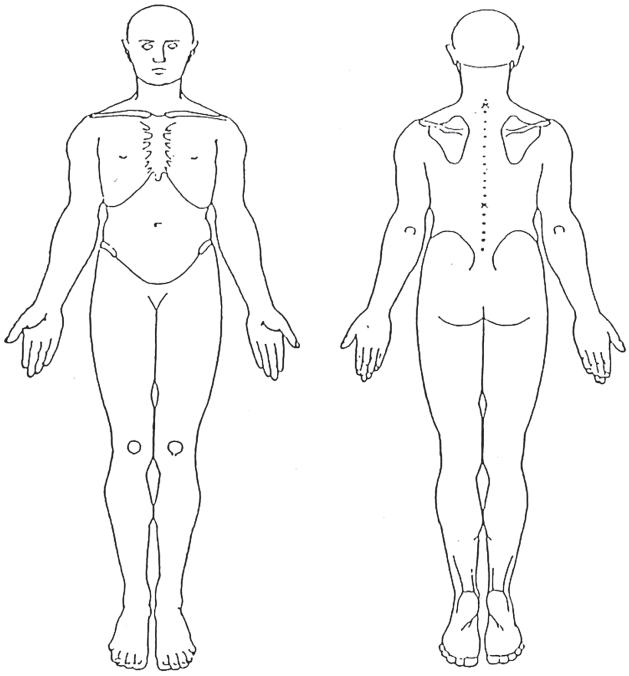
THERAPIST USE ONLY

+/– cough/sneeze

+/– saddle anesthesia

+/– bowel/bladder changes

+/– numb/ting



My symptoms currently:

◯ Come and go

◯ Are constant

◯ Are constant, but change with activity

On the scale below, please circle the number which best describes your pain:

Average pain in the last 48 hours: NO Pain ◯0 ◯1 ◯2 ◯3 ◯4 ◯5 ◯6 ◯7 ◯8 ◯9 ◯10 ◯WORST Pain ◯

Best for the last 48 hours: NO Pain ◯0 ◯1 ◯2 ◯3 ◯4 ◯5 ◯6 ◯7 ◯8 ◯9 ◯10 ◯WORST Pain ◯

Worst for the last 48 hours: NO Pain ◯0 ◯1 ◯2 ◯3 ◯4 ◯5 ◯6 ◯7 ◯8 ◯9 ◯10 ◯WORST Pain ◯

Is there anything you can do to reduce your symptoms? _____

Is there anything that makes your symptoms worse? _____

Do any of these activities make your pain worse? ☐ Lying down ☐ Standing ☐ Walking ☐ Sitting ☐ Squatting

What time of day do you feel your best? ◯ AM ◯ Afternoon ◯ PM ◯ After Exercise

What time of day do you feel your worst? ◯ AM ◯ Afternoon ◯ PM ◯ After Exercise

Aggravating Factors: Identify up to 3 important activities that you are unable to do or are having difficulty with as a result of your problem. List them below:

1) _____

2) _____

3) _____

THERAPIST

Rating _____

Rating _____

Rating _____

Average _____

UNABLE to perform activity **THERAPIST USE ONLY** ABLE to perform activity withouth difficulty

0 1 2 3 4 5 6 7 8 9 10