

HIPAA – ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the WESTARM Therapy Notice of Privacy Practices (hereafter referred to as "Notice"). I understand that the information the office of WESTARM Therapy acquires or creates about me will only be disclosed to others for treatment, payment and healthcare operations as set forth in the "Notice", or as authorized by me in writing.

Signature of Patient (or substitute decision maker)

Signature of Witness

If substitute decision maker, state relationship

Date

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand this authorization is voluntary. I also understand that if the organization authorized to receive the information is not a health plan or health care provider, the release information may no longer be protected by federal privacy regulations and that it may be re-disclosed by the recipient.

Patient Name: _____

Organization Providing the Information:

WESTARM Therapy Services

Organization(s) or Person(s) Receiving the Information:

Primary Care Physician, Specialist Physician, Insurance Company

Other as designated by patient / guardian: _____ Relationship: _____

Specific Description of Information Disclosed:

Information to be released will include pertinent PT/OT initial evaluation, daily progress notes, re-assessments, discharge summaries, physician reports, prescriptions and daily charge information.

Purpose of Disclosure:

- Communication of pertinent patient treatment information between physician and clinician.
- Communication of pertinent patient treatment information between WESTARM Therapy Services and insurance carriers for payment purposes.

PLEASE READ AND SIGN THE FOLLOWING STATEMENTS:

I understand this Authorization will expire 1 year after discharged from treatment. I also understand that I may revoke this Authorization at any time by notifying WESTARM Therapy Services in writing.

Signature of Patient (or substitute decision maker)

Signature of Witness

If substitute decision maker, state relationship

Date

Name: _____ Date: _____



Initial Questionnaire

HISTORY OF PRESENT CONDITION

1. What are your symptoms? _____

2. Onset of Symptoms: _____ Surgery Date: _____

3. Which of the following **best describes** how your injury occurred? (check all that apply)

- | | | |
|--|---|---|
| <input type="checkbox"/> lifting | <input type="checkbox"/> trauma | <input type="checkbox"/> hit by a ball |
| <input type="checkbox"/> MVA (car accident) | <input type="checkbox"/> degenerative process | <input type="checkbox"/> dental appointment |
| <input type="checkbox"/> a fall | <input type="checkbox"/> during recreation / sports | <input type="checkbox"/> throwing |
| <input type="checkbox"/> cumulative trauma / overuse | <input type="checkbox"/> running | <input type="checkbox"/> unknown |
| <input type="checkbox"/> incident at work | <input type="checkbox"/> blow to the face | <input type="checkbox"/> List other below |

4. Nature of pain/symptoms (check all that apply)

- | | | | | |
|---------------------------------|-------------------------------------|---------------------------------------|-----------------------------------|-------------------------------|
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Throbbing | <input type="checkbox"/> Periodic | <input type="checkbox"/> Constant | <input type="checkbox"/> Dull |
| <input type="checkbox"/> Aching | <input type="checkbox"/> Occasional | <input type="checkbox"/> Other: _____ | | |

5. Other Medical Symptoms? (check all that apply)

- | | | |
|---|---|--|
| <input type="checkbox"/> Bowel / Bladder difficulty | <input type="checkbox"/> Dizziness / Fainting attacks | <input type="checkbox"/> Malaise |
| <input type="checkbox"/> Fever / Chills | <input type="checkbox"/> Weakness | <input type="checkbox"/> Vision / Hearing problems |
| <input type="checkbox"/> Genital / Anal numbness | <input type="checkbox"/> Weight gain / loss | <input type="checkbox"/> None noted |
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Night pain / sweats | <input type="checkbox"/> List other below |

6. Have you had any previous treatment for this condition? (check all that apply)

- | | | |
|--|---|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Bracing / taping | <input type="checkbox"/> TENS unit |
| <input type="checkbox"/> Medication (oral) | <input type="checkbox"/> Injection into the spine | <input type="checkbox"/> Acupuncture |
| <input type="checkbox"/> Chiropractic Care | <input type="checkbox"/> Injection into the skin / muscle | <input type="checkbox"/> Bed Rest |
| <input type="checkbox"/> Exercise | <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Overnight hospitalization |
| <input type="checkbox"/> Massage therapy | <input type="checkbox"/> Hypnosis | <input type="checkbox"/> Casting |
| <input type="checkbox"/> Traction | <input type="checkbox"/> Biofeedback | <input type="checkbox"/> List other below |

7. Have you had any of the following tests? (check all that apply)

- | | | | |
|----------------------------------|--|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> MRI | <input type="checkbox"/> Bone Scan | <input type="checkbox"/> Vestibular |
| <input type="checkbox"/> X-rays | <input type="checkbox"/> Arthrogram | <input type="checkbox"/> NCS | <input type="checkbox"/> Fluoroscope |
| <input type="checkbox"/> CT scan | <input type="checkbox"/> Stress X-ray test | <input type="checkbox"/> Other: _____ | |

8. Other Medical Condition (check all that apply)

- Diabetes
- Neurological Disorders
- Heart Problems
- Hypertension
- Cancer
- Lung Problems
- Stroke
- Infectious Disease (Hepatitis, TB, HIV)
- Fracture
- Rheumatoid Arthritis
- Stomach Problems
- Cognitive Problems
- Osteoporosis
- Blood Disorders
- Allergies
- Other: _____
- Psychological Issues
- Thyroid Problems
- Kidney Problems
- Epilepsy / Seizures
- Arthritis
- Circulation / Vascular Problems
- Obesity

INSURANCE REQUIRED INFORMATION

9. Do you currently use tobacco Yes No or alcohol Yes No
10. Do you feel confident in your ability to overcome or manage this problem? Yes No
11. Do you perform moderate intensity workouts 3 or more times per week? Yes No
12. Height _____ feet _____ inches Weight _____ lbs

MEDICATION

Are you currently taking any medication for the **specific condition** (ailment or injury) for which you are seeking rehabilitative care?

- Prescription (please specify): _____
- Non-prescription (please specify): _____
- Other (please specify): _____
- None

PRIMARY REASON FOR CHOOSING WESTARM PHYSICAL THERAPY (Please circle only one):

- | | | |
|-----------------------------------|---------------------------|-------------------------------|
| Doctor recommended | Employer directed | Yellow pages / telephone book |
| Recommended by friend or relative | Insurance | TV and / or Radio |
| Location | Internet search / Website | Billboard |
| Previous outpatient | Community event | Specialty program |
| Previous Homecare patient | Newspaper | |
| Other: _____ | | |

HAVE YOU RECEIVED WITHIN THE PAST YEAR ANY OF THE FOLLOWING:

- | | | | |
|---------------------------------|-----|----|----------------------------|
| Physical / Occupational Therapy | Yes | No | If Yes, # of visits: _____ |
| Chiropractic Care | Yes | No | If Yes, # of visits: _____ |

EMERGENCY INFORMATION

Emergency Contact Name: _____

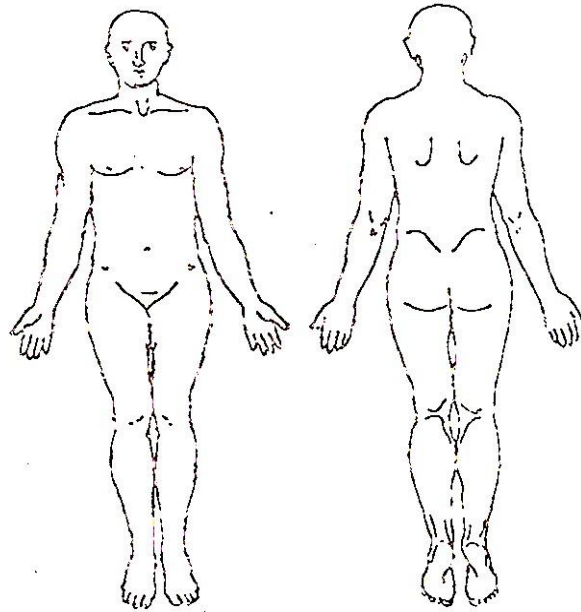
Telephone Number: _____

Relationship to Patient: _____

Pain Scale

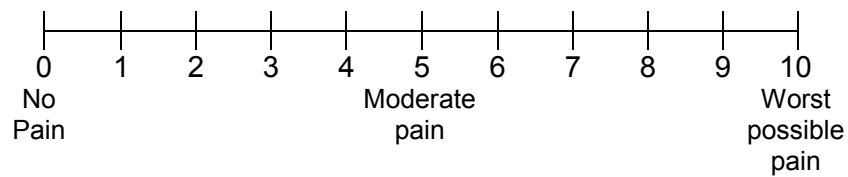
Name _____ Date _____

On the drawings below, mark the areas where you feel pain.

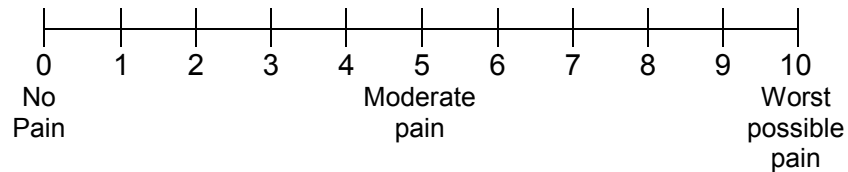


Rate the pain that you are experiencing on the scales below. Circle the appropriate number to indicate the pain level on each of the lines.

Now



Best (last 24 hours)



Worst (last 24 hours)

