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

WESTARM PHYSICAL THERAPY

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)

☐ lifting	☐ trauma	☐ hit by a ball
☐ MVA (car accident)	☐ degenerative process	☐ dental appointment
☐ a fall	☐ during recreation / sports	☐ throwing
☐ cumulative trauma / overuse	☐ running	☐ unknown
☐ incident at work	☐ blow to the face	☐ List other below

_____

_____

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

☐ Sharp	☐ Throbbing	☐ Periodic	☐ Constant	☐ Dull
☐ Aching	☐ Occasional	☐ Other: _____		

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

☐ Bowel / Bladder difficulty	☐ Dizziness / Fainting attacks	☐ Malaise
☐ Fever / Chills	☐ Weakness	☐ Vision / Hearing problems
☐ Genital / Anal numbness	☐ Weight gain / loss	☐ None noted
☐ Numbness	☐ Night pain / sweats	☐ List other below

_____

_____

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

☐ None	☐ Bracing / taping	☐ TENS unit
☐ Medication (oral)	☐ Injection into the spine	☐ Acupuncture
☐ Chiropractic Care	☐ Injection into the skin / muscle	☐ Bed Rest
☐ Exercise	☐ Physical Therapy	☐ Overnight hospitalization
☐ Massage therapy	☐ Hypnosis	☐ Casting
☐ Traction	☐ Biofeedback	☐ List other below

_____

_____

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

☐ None	☐ MRI	☐ Bone Scan	☐ Vestibular
☐ X-rays	☐ Arthrogram	☐ NCS	☐ Fluroscope
☐ CT scan	☐ Stress X-ray test	☐ Other: _____	

8. Other Medical Condition (check all that apply)

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

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: _____

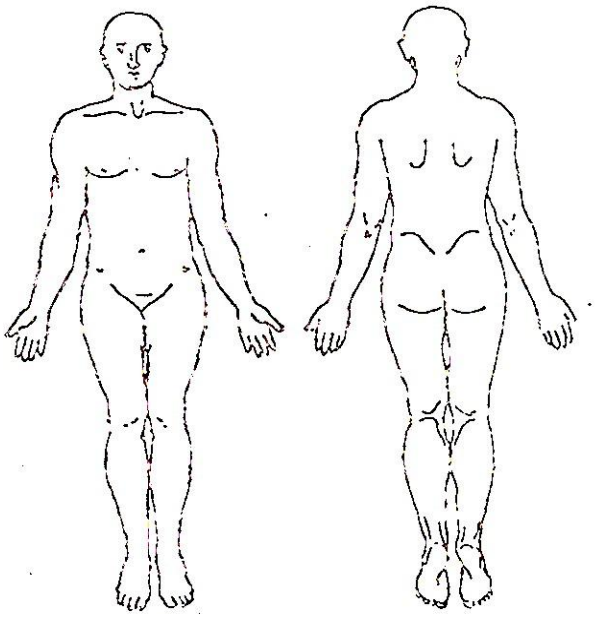
Telephone Number: _____

Relationship to Patient: _____

Pain Scale

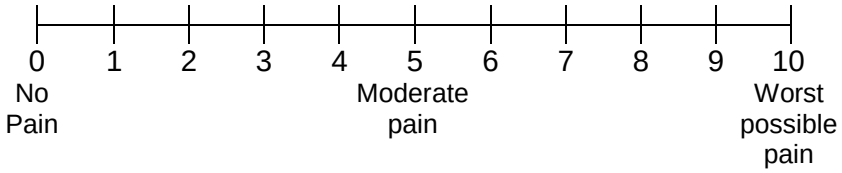
Name _____ Date _____

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



Average over 2 weeks