Balance Physical Therapy & Human Performance Center, Inc.

143 John Street, Salinas, CA 93901 ♦ Phone: (831) 422-4782 Fax: (831) 422-4784

PATIENT INFORMATION

Patient's Name:	DOB:	Age:	Sex:	SS#:
Employment Status: Employed _____ Unemployed _____ Retired _____ Student _____			Marital Status: Single _____ Married _____ Other _____	
Address:	City, State, Zip		E-Mail Address:	
Home Phone:	Work Phone:		Cell Phone:	
Employer:	Referring MD:			

Emergency Contact:	Relationship:	Home Phone:
Address:	City, State, Zip	Work/Cell Phone:

Financial Party (if patient is a minor)	Relationship:	SS#:	DOB:
Home Phone:	Work Phone:	Employer:	

CANCELLATION / NO SHOW POLICY

At Balance Physical Therapy, we pride ourselves on quality care while providing a level of service that exceeds your expectations. In order to do so, we ask that you notify us 24 hours in advance to cancel and/or reschedule your appointment times. All appointments not kept without at least 24 hours notice are subject to a $25 fee. Thank you for your understanding and your commitment to your recovery.

I, the undersigned, accept responsibility for my scheduled appointments, and I understand that I will be charged $25 for appointments that are cancelled or not kept without 24 hour advance notice.

Patient's Signature: _____ Date: _____

(guardian's signature if patient is a minor)

INFORMED CONSENT POLICY

Consent for Physical Therapy Treatment

The above information is correct to the best of my knowledge. In signing below, I agree to be treated by the staff of Balance Physical Therapy & Human Performance Center, Inc., as prescribed by my physician and recommended by my physical therapist. If I would become ill while undergoing treatment at Balance Physical Therapy I give permission to the staff to administer treatments which they consider necessary to my well-being. I authorize the release of medical information to my insurance company necessary to process claims for services rendered by Balance Physical Therapy. I authorize payment of medical benefits directly to Balance Physical Therapy. I understand that I am financially responsible to Balance Physical Therapy for all unpaid balances.

Patient's Signature: _____ Date: _____

(Guardian's signature if patient is a minor)

Balance Physical Therapy & Human Performance Center, Inc.

PATIENT MEDICAL HISTORY FORM

Name:	Age:	Current Concern/Problem:	Date of Onset:

I). HAVE YOU EVER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING CONDITIONS?

CANCER Yes _____ NO _____	Type(s), include date of diagnosis:

INFECTION:	Yes	No	CARDIOVASCULAR:	Yes	No
Urinary Tract/Kidney Infection			Heart Disease		
Pneumonia			Deep Venous Thrombosis (DVT)		
Bone/Joint Infection			Arterial Blockage of the Legs		
Viral Conditions			High Blood Pressure		
Other Infection: (Please List Below)			Stroke / TIA		
			Pace Maker		

GENERAL MEDICAL CONDITIONS:	Yes	No	GENERAL MEDICAL CONDITIONS:	Yes	No
Rheumatologic Disorders			Osteoarthritis: (Wear &Tear Arthritis)		
Lung Disorders			Osteoporosis / Osteopenia		
Liver / Kidney Conditions			Dizziness or falls		
Gastrointestinal Disorders			Depression		
Neurological Disorders			Bowel / Bladder Incontinence		
Anemia / Blood Disorders			Headaches (more than 1 per week)		
Thyroid Conditions			Vision or hearing difficulty		
Gout			Immunologic / Allergy Conditions		
Diabetes			Genitourinary/Gynecologic Conditions		
Dermatologic Conditions			Other conditions		

PLEASE LIST ALL MEDICATIONS INCLUDING FREQUENCY AND DOSAGE: (Over-the-Counter and Prescribed)					
Name of medication	Frequency	Dosage	Name of medication	Frequency	Dosage

SURGERIES AND / OR HOSPITALIZATIONS:			OTHER CURRENT CONDITONS:	Yes	No
	Date:		1. Recent, unplanned weight loss?		
	Date:		2. Unexplained night pain?		
	Date:		3. Fevers or night sweats?		
	Date:		4. Nausea / Vomiting?		
	Date:		5. Unexplained weakness or fatigue?		
	Date:		6. Are you currently pregnant? (Women)		

HEALTH-RELATED HABITS	Yes	No	How much/often?		Yes	No
Smoking				Ice Sensitive?		
Caffeine				Heat Sensitive?		
Alcohol						

Previous experience with physical therapy? Yes _____ No _____

If Yes, Where & why? _____

I affirm that the above information is accurate and true to the best of my knowledge.

Patient's Signature: _____ **Date:** _____

(Guardian's Signature if patient is a minor)

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MEDICAL RECORDS RELEASE

Please Print

Patient's First Name:	M.I.:	Last Name:	DOB:

_____ Yes, I authorize Balance Physical Therapy to obtain the following medical records relating to my present condition.

_____ No, I do not authorize Balance Physical Therapy to obtain medical records relating to my present condition.

I, the undersigned, do hereby authorize _____

to release copies of the following records to Balance Physical Therapy & Human Performance Center, Inc.

_____ Office Visits Date: _____

_____ Operative Report Date: _____

_____ Radiology Reports

_____ X-Ray Date: _____

_____ MRI Date: _____

_____ CT Date: _____

_____ Bone Scan Date: _____

_____ Other Date: _____

_____

(Please Specify)

Patient's Signature: _____ **Date:** _____

(Guardian's Signature if patient is a minor)

Please fax reports to (831) 422-4784.

Balance Physical Therapy & Human Performance Center, Inc.

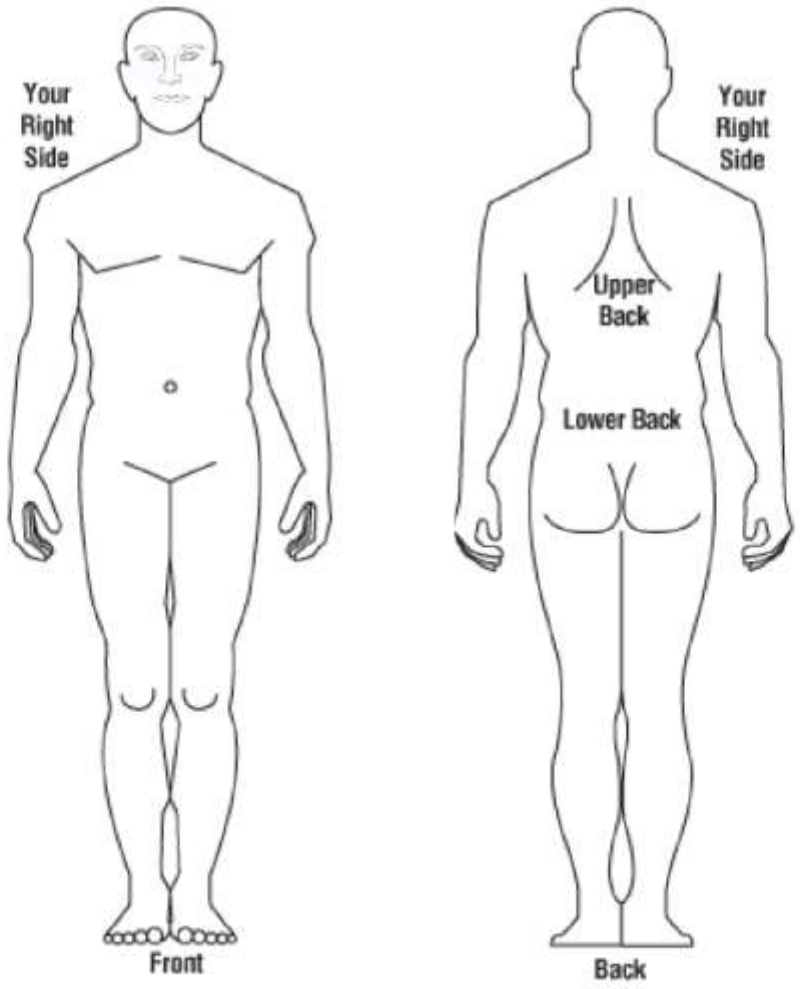
Pain Scale Diagram

Patient's Name: _____ Date: _____

Please rate your pain on a scale of zero to ten. Zero is no pain, ten is the worst amount of pain imaginable. Put an "X" in the box below the number that best describes your level of pain.

0	1	2	3	4	5	6	7	8	9	10

Please mark the location of your pain on the body chart below.



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PRIVACY PRACTICES ACKNOWLEDGEMENT

I have read and fully understand Balance Physical Therapy & Human Performance Center, Inc., Notice of Privacy Practices. I understand that Balance Physical Therapy & Human Performance Center, Inc., 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 that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that Balance Physical Therapy & Human Performance Center, Inc., will consider request for restriction on a case-by-case basis, but does not have to agree to request for restrictions.

Patient's Name: _____ DOB: _____
(please print)

Patient's Signature: _____ Date: _____
(Guardian's signature if patient is a minor)

Balance Physical Therapy & Human Performance Center, Inc.

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used or disclosed or how you can get access to information. Please review it carefully.

BALANCE PHYSICAL THERAPY'S LEGAL DUTY

Balance Physical Therapy & Human Performance Center, Inc. is required by law to protect the privacy of your personal health information, provide this notice about our privacy practices and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

Balance Physical Therapy & Human Performance Center, Inc. uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, we may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

Balance Physical Therapy & Human Performance Center, Inc. may also use or disclose your personal health information without prior authorization for emergencies, research studies, auditing purposes, and public health/statistical purposes. We also provide information when required by law. In any other situation, our policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

Balance Physical Therapy & Human Performance Center, Inc. may change its policy at any time. When changes are made, a new Notice of Privacy Practices will be posted in the waiting room and one will be provided to you at your next visit. You may also request an updated copy of our Notice of Privacy Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy or your personal health information at any time. If you request copies we may charge you a fee. You may contact us using the information listed at the end of this notice for a full explanation of our fee structure. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes. You may also request in writing that we do not use or disclose your personal health information for treatment, payment and administrative purposes except when required by law or in emergency circumstances. Balance Physical Therapy & Human Performance Center, Inc. will consider all such requests on a case-by case basis, but the practice is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that we may have violated your privacy rights or if you disagree with any decision we have made regarding access or disclosure of your personal health information, please contact our office manager at the address listed below. You may also send a written complaint to the US Department of Health and Human Services at the address listed below.

Balance Physical Therapy & Human Performance Center, Inc.
Attn: Jessica Murillo, Practice Manager
143 John Street
Salinas, CA 93901
www.balancept.com
Phone: (831) 422-4782 Fax: (831) 422-4784

US Department of Health and Human Service
200 Independence Avenue, S.W.
Washington, DC 20201
www.os.dhhs.gov

*****Please retain this copy for your records*****

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I, the undersigned, accept responsibility for my scheduled appointments, and I understand that I will be charged $25.00 for appointments that are cancelled or not kept without 24-hour advance notice.

Print Patient Name: _____

Patient Signature: _____

Date: _____

Patient's Name: _____ Date: _____

DISABILITIES OF THE ARM, SHOULDER AND HAND

Please rate your ability to do the following activities in the last week by circling the number below the appropriate response.

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. Open a tight or new jar.	1	2	3	4	5
2. Write.	1	2	3	4	5
3. Turn a key.	1	2	3	4	5
4. Prepare a meal.	1	2	3	4	5
5. Push open a heavy door.	1	2	3	4	5
6. Place an object on a shelf above your head.	1	2	3	4	5
7. Do heavy household chores (e.g., wash walls, wash floors).	1	2	3	4	5
8. Garden or do yard work.	1	2	3	4	5
9. Make a bed.	1	2	3	4	5
10. Carry a shopping bag or briefcase.	1	2	3	4	5
11. Carry a heavy object (over 10 lbs).	1	2	3	4	5
12. Change a lightbulb overhead.	1	2	3	4	5
13. Wash or blow dry your hair.	1	2	3	4	5
14. Wash your back.	1	2	3	4	5
15. Put on a pullover sweater.	1	2	3	4	5
16. Use a knife to cut food.	1	2	3	4	5
17. Recreational activities which require little effort (e.g., cardplaying, knitting, etc.).	1	2	3	4	5
18. Recreational activities in which you take some force or impact through your arm, shoulder or hand (e.g., golf, hammering, tennis, etc.).	1	2	3	4	5
19. Recreational activities in which you move your arm freely (e.g., playing frisbee, badminton, etc.).	1	2	3	4	5
20. Manage transportation needs (getting from one place to another).	1	2	3	4	5
21. Sexual activities.	1	2	3	4	5

Patient's Name: _____ Date: _____

Disabilities of the Arm, Shoulder and Hand

	NOT AT ALL	SLIGHTLY	MODERATELY	QUITE A BIT	EXTREMELY
22. During the past week, *to what extent* has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbours or groups? *(circle number)*	1	2	3	4	5

	NOT LIMITED AT ALL	SLIGHTLY LIMITED	MODERATELY LIMITED	VERY LIMITED	UNABLE
23. During the past week, were you limited in your work or other regular daily activities as a result of your arm, shoulder or hand problem? *(circle number)*	1	2	3	4	5

Please rate the severity of the following symptoms in the last week. *(circle number)*

	NONE	MILD	MODERATE	SEVERE	EXTREME
24. Arm, shoulder or hand pain.	1	2	3	4	5
25. Arm, shoulder or hand pain when you performed any specific activity.	1	2	3	4	5
26. Tingling (pins and needles) in your arm, shoulder or hand.	1	2	3	4	5
27. Weakness in your arm, shoulder or hand.	1	2	3	4	5
28. Stiffness in your arm, shoulder or hand.	1	2	3	4	5

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	SO MUCH DIFFICULTY THAT I CAN'T SLEEP
29. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand? *(circle number)*	1	2	3	4	5

	STRONGLY DISAGREE	DISAGREE	NEITHER AGREE NOR DISAGREE	AGREE	STRONGLY AGREE
30. I feel less capable, less confident or less useful because of my arm, shoulder or hand problem. *(circle number)*	1	2	3	4	5

DASH DISABILITY/SYMPTOM SCORE = $\left[\frac{(\text{sum of n responses})}{n} - 1\right] \times 25$, where n is equal to the number of completed responses.

A DASH score may <u>not</u> be calculated if there are greater than 3 missing items.