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:

1). 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.

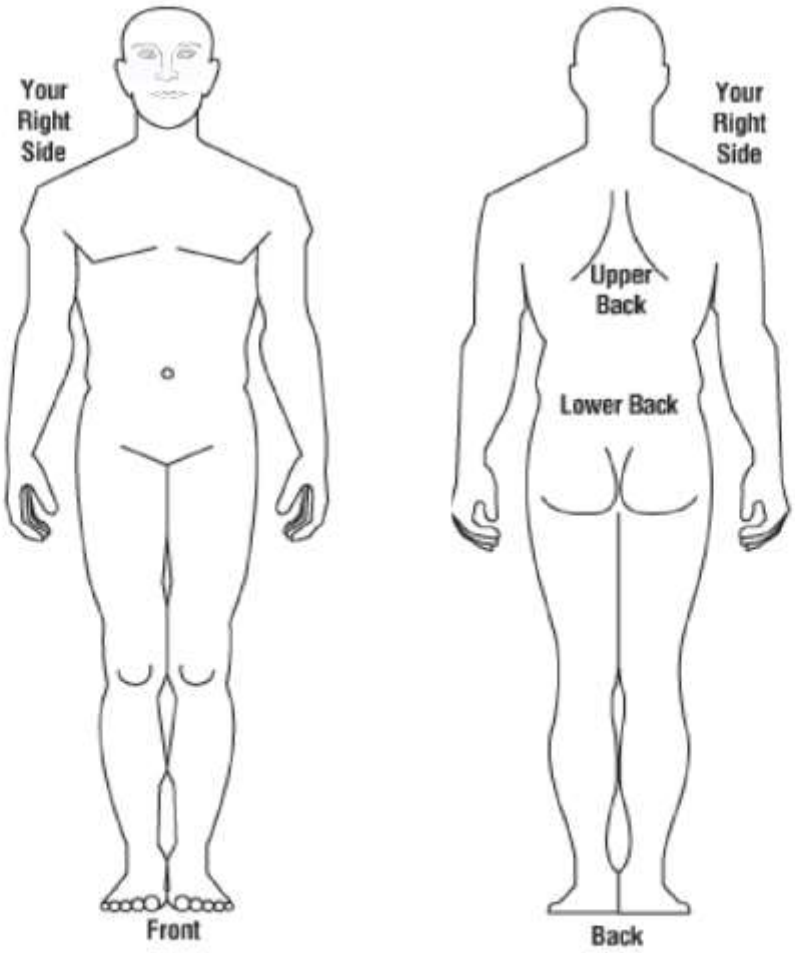
Pain Scale Diagram

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: _____

Neck Index

ACN Group, Inc. Form NI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ **Date** _____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
③ The pain is fairly severe at the moment.
④ The pain is very severe at the moment.
⑤ The pain is the worst imaginable at the moment.

Personal Care

⓪ I can look after myself normally without causing extra pain.
① I can look after myself normally but it causes extra pain.
② It is painful to look after myself and I am slow and careful.
③ I need some help but I manage most of my personal care.
④ I need help every day in most aspects of self care.
⑤ I do not get dressed, I wash with difficulty and stay in bed.

Sleeping

⓪ I have no trouble sleeping.
① My sleep is slightly disturbed (less than 1 hour sleepless).
② My sleep is mildly disturbed (1-2 hours sleepless).
③ My sleep is moderately disturbed (2-3 hours sleepless).
④ My sleep is greatly disturbed (3-5 hours sleepless).
⑤ My sleep is completely disturbed (5-7 hours sleepless).

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
④ I can only lift very light weights.
⑤ I cannot lift or carry anything at all.

Reading

⓪ I can read as much as I want with no neck pain.
① I can read as much as I want with slight neck pain.
② I can read as much as I want with moderate neck pain.
③ I cannot read as much as I want because of moderate neck pain.
④ I can hardly read at all because of severe neck pain.
⑤ I cannot read at all because of neck pain.

Driving

⓪ I can drive my car without any neck pain.
① I can drive my car as long as I want with slight neck pain.
② I can drive my car as long as I want with moderate neck pain.
③ I cannot drive my car as long as I want because of moderate neck pain.
④ I can hardly drive at all because of severe neck pain.
⑤ I cannot drive my car at all because of neck pain.

Concentration

⓪ I can concentrate fully when I want with no difficulty.
① I can concentrate fully when I want with slight difficulty.
② I have a fair degree of difficulty concentrating when I want.
③ I have a lot of difficulty concentrating when I want.
④ I have a great deal of difficulty concentrating when I want.
⑤ I cannot concentrate at all.

Recreation

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

Work

⓪ I can do as much work as I want.
① I can only do my usual work but no more.
② I can only do most of my usual work but no more.
③ I cannot do my usual work.
④ I can hardly do any work at all.
⑤ I cannot do any work at all.

Headaches

⓪ I have no headaches at all.
① I have slight headaches which come infrequently.
② I have moderate headaches which come infrequently.
③ I have moderate headaches which come frequently.
④ I have severe headaches which come frequently.
⑤ I have headaches almost all the time.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Neck Index Score