Swanson McArthur Physical Therapy
& Aquatic Center

PATIENT INFORMATION SHEET

DATE: ________________________

NAME: ____ SSN: __________________________

ADDRESS: ____

CITY: _______________________________ STATE: _________________ ZIP: ______________

HOME PHONE: ___________________________________ CELL PHONE: ___________________________

EMAIL ADDRESS: _______________________________________

DATE OF BIRTH: _____________________ AGE: _______ SEX: M F MARITAL STATUS: M S D W

EMERGENCY CONTACT NAME: ____

EMERGENCY CONTACT NUMBER: ____

EMPLOYER: _______________________________ JOB TITLE: _____________________________

BUSINESS ADDRESS: ____

CITY: _______________________________ STATE: ___________ ZIP: ____________________

WORK PHONE: _______________________ EXT: _______ SUPERVISOR: _____________________

HAVE YOU SIGNED OVER YOUR MEDICARE BENEFITS TO KAISER, SECURE HORIZON, ETC? Y N

PLEASE PROVIDE A COPY OF YOUR PRIMARY AND SECONDARY INSURANCE CARDS.

WORK RELATED? Y N MOTOR VEHICLE ACCIDENT? Y N PERSONAL INJURY? Y N

REFERRING PHYSICIAN: __________________________ DATE OF INJURY: ___________________

HOW DID YOU HEAR ABOUT OUR CLINIC? (Friend, Patient, Internet, Physician, etc): __________________

____

PATIENT GUIDELINES

1. We have set time aside for you. Please be prompt and consistent in keeping your appointments.

2. You should be seeing your referring doctor regularly while attending physical therapy. Please keep us informed ahead of time of the dates you will be seeing your doctor so that we may prepare a report to keep him/her informed of your progress.

3. If you have a co-pay with your insurance, it is due at the time of each visit, or at the last visit of each week. Please choose what will work best for you, and make arrangements with the front office.

4. If your yearly deductible has not been met, we will bill you as a courtesy, and regular payments may be made until it has been satisfied. Your co-pay will be due as stated above.

5. **If you are a worker's compensation patient, please note that we are obligated to inform your insurance carrier with regards to the consistency of your attendance.** For your health and quick recovery, please keep your scheduled appointments.

6. Please be consistent in following through with any instruction given regarding home care or home exercise.

OFFICE FINANCIAL POLICY

_____ I understand that *Swanson McArthur Physical Therapy* requires a 24 hour notification in advance if I am unable to attend a scheduled appointment. If I fail to cancel my appointment, **I will be subject to a "NO-SHOW"/CANCEL charge of $50.00.**

_____ I understand that, regardless of insurance, I remain personally responsible for the total amounts due to *Swanson McArthur Physical Therapy* for services rendered. It is my responsibility to understand my insurance policies and benefits. I authorize the release of any medical information necessary to process my claim. I also request payment of government benefits either to myself or to *Swanson McArthur Physical Therapy.*

______ I authorize payment of medical benefits to *Swanson McArthur Physical Therapy* for the services described on my claim.

Swanson McArthur Physical Therapy* accepts assignment from Medicare. If you have secondary insurance, please provide the name and policy number in order for us to coordinate benefits. Medicare requires a new referral every 30 days from your physician. **THIS IS A MUST, NO EXCEPTIONS.

CONSENT TO TREAT

I understand that I am under the care and control of my physician(s) and that *Swanson McArthur Physical Therapy* is not liable for any act or omission when providing treatment in accordance with my physician's instructions. I consent to have *Swanson McArthur Physical Therapy* provide the treatment and care prescribed by my physician. I understand this consent may be revoked by me at any time.

Patient Signature:_______________________________________ Date:______________

NOTICE OF PATIENT INFORMATION PRACTICES

This notice describes how medical information about you may be used or disclosed and how you can get access to information. **PLEASE REVIEW IT CAREFULLY.**

SWANSON McARTHUR PHYSICAL THERAPY'S LEGAL DUTY

Swanson McArthur Physical Therapy is required by law to protect the privacy of your personal health information, provide this notice about our information practices, and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

Swanson McArthur Physical Therapy 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, Swanson McArthur Physical Therapy may use your personal health information to contact you to provide appointment reminders, information about treatment alternatives, or other health related benefits that could be of interest to you.

Swanson McArthur Physical Therapy may also use or disclose your personal health information without prior authorization for public health purposes, research studies, and emergencies. We also provide information when required by law.

In any other situation, Swanson McArthur Physical Therapy's policy is to obtain 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 further disclosures at any time.

Swanson McArthur Physical Therapy may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room. You may also request an updated copy of our Notice of Information Practices at any time.

PATIENT’S INDIVIDUAL RIGHTS

- You have the right to review or obtain a copy of your personal health information at any time.
- You have the right to request that we correct any inaccurate or incomplete information in your records.
- You have the right to request a fist of instances where we have disclosed your personal health information for reasons other than treatment, payment, or other related administrative purposes.
- You may request in writing that we not use or disclose your personal health information for treatment, payment, and administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances.

Swanson McArthur Physical Therapy 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 Swanson McArthur Physical Therapy may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our practice manager at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on Swanson McArthur Physical Therapy's health information practices or if you have a complaint, please contact the following person:

Swanson McArthur Physical Therapy, Linda McArthur, PHONE: (916) 965-8900 FAX: (916) 965-9630

PATIENT INFORMATION CONSENT FORM

I have read and fully understand Swanson McArthur Physical Therapy's Notice of Information Practices. I understand that Swanson McArthur Physical Therapy may use or disclose my personal health information for the purposes of carrying out treatment; obtaining payment, evaluating the quality or 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 Swanson McArthur Physical Therapy will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Swanson McArthur Physical Therapy Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

Patients Name (printed): ____

Patients Signature: ____

Date: ______________________________

Patient Health Questionnaire

Patient Name: ____ *Today's Date:* ______/__________/_________

Height: ___________ *Weight:* _____________

Have you had surgery for this condition? *Yes* *No*

a. *If yes, when?* ________________________ *Where?* ___________________ *By whom?* ___________________________

Describe your current symptoms:

a. *When did they start?* ____

b. *How did they begin?* ____

____

c. *Relative to your condition, what is your primary concern?* ____

Were you fully functional prior to your injury? *(If no, explain):* ____

____

What are your current functional limitations? ____

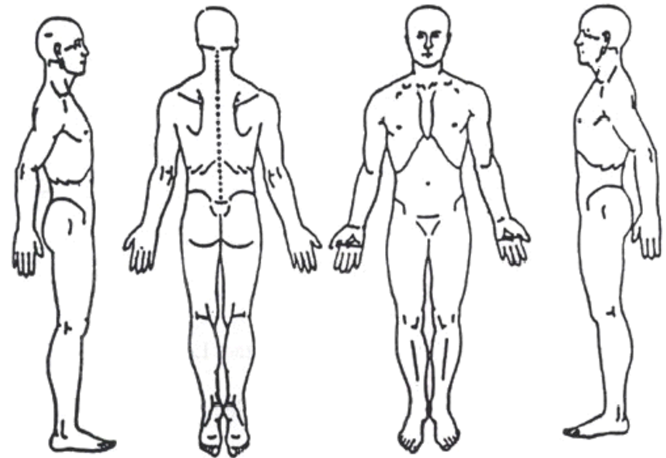
____

Pick 3 important daily activities you have difficulty with as a result of your current condition. Rate your ability using the 0-10 scale below (0 means you cannot perform the activity at all, 10 means you can perform the activity at your pre-injury level).

Activity #1:										
0	***1***	***2***	***3***	***4***	***5***	***6***	***7***	***8***	***9***	***10***
Unable to perform										*Able to **fully** perform activity*
Activity #2:										
0	***1***	***2***	***3***	***4***	***5***	***6***	***7***	***8***	***9***	***10***
Unable to perform										*Able to **fully** perform activity*

Activity #3:										
0	***1***	***2***	***3***	***4***	***5***	***6***	***7***	***8***	***9***	***10***
Unable to perform										*Able to **fully** perform activity*

Indicate where you have pain or other symptoms



How often do you experience your symptoms (please circle)?

Constantly (76-100% of the day)
Frequently (51-75% of the day)
Occasionally (26-50% of the day)
Intermittently 0-25% of the day)

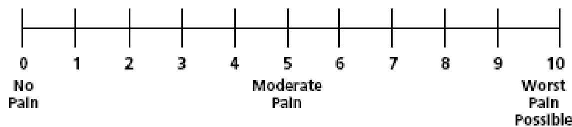
What describes the nature of your symptoms?

Sharp *Shooting*
Dull ache *Burning*
Numb *Tingling*
Other ___________________________

How are your symptoms changing?

Getting better
Not changing
Getting worse

Use the scale to identify your pain intensity:



At worst: _____
Current: _____
At best: _____

Do the symptoms disturb your sleep? ***Yes*** ***No*** ***How many times do you waken per night?*** ____________________________

What makes your symptoms worse? ____

What makes your symptoms better? ____

Have you had similar symptoms in the past? ***Yes*** ***No***

a. If you have had treatment in the past for the same or similar symptoms, who did you see?

No one *Medical Doctor* *Chiropractor* *Physical Therapist* *This Office*

b. What treatment did you receive and when? ____

In general how would you rate your overall health right now?

Excellent *Very good* *Good* *Fair* *Poor*

What is your occupation? ______________________________________

What is your work status? *Unemployed* *Full Time* *Part Time* *Light Duty* *Off Work* *Disabled* *Retired*

If Light Duty, what are your restrictions? ____

Have you fallen in the past 12 months? *Yes* *No* *How many times?* __________

Were you injured as a result of a fall? *Yes* *No* ***Are you afraid of falling?*** *Yes* *No*

What tests have been performed for your condition and when were they performed?

X-Rays *date:* _______ *MRI* *date:* _______ *CT Scan* *date:* _______ *Other* *date:* _______

Are you currently experiencing any of the following (please circle)?

Changes in bowel or bladder function
Symptoms with coughing or sneezing
Unexplained weight loss or weight gain
Difficulty swallowing or speaking
Numbness in the saddle/genital area
Numbness in the hands and /or feet

Please list all medications you are taking.

1. __________________ 2. ___________________ 3. ____________________ 4. _____________________

5. __________________ 6. ___________________ 7. ____________________ 8. ______________________

Do you currently have or have you ever had any of the following?

	Yes	*No*		*Yes*	*No*
High Blood Pressure			*Kidney Problems*		
Cardiac Conditions			*Liver Problems*		
Heart Attack			*Cancer*		
Circulation Problems			*HIV/AIDS*		
Pacemaker/Defibrillator			*Nervous Disorders*		
Seizures			*Vision Problems*		
Dizzy Spells			*Sensitivity to Heat*		
Diabetes			*Sensitivity to Cold*		
Fractures			*Speech Problems*		
Head Injury/Stroke			*Are you Pregnant?*		
Arthritis			*Recent Eye Surgery*		
Headaches			*Osteoporosis*		

Do you have any allergies (latex, chlorine, medications, etc)? ____

What are your treatment goals? ____

When do you return to your referring doctor again? ____/____/____

Patient Signature: ____ ***Date:*** ____________________________________