Woodstown Physical Therapy and Sports Rehab

Are you a previous patient? □ Y □ N

Name _____ **DOB** _____ **(AGE)** _____

SS# _____ **Sex: □ M □ F**

Home Address _____ **City/State** _____ **Zip**_____

Phone (Home) _____ **Phone (Cell)** _____

Emergency Contact _____ Relationship _____ Phone_____

Your E-mail _____ Date of Injury or onset: _____

Is your injury a result of a motor vehicle accident or work related injury: _____

EMPLOYMENT/SCHOOL (Circle appropriate one)

Patient Employer/School _____ Occupation _____

Emp Address _____ City/State _____ Zip _____

Phone (Work) _____

SPOUSE'S/PARENT EMPLOYMENT (Circle appropriate one)

Spouse/Parent Name _____ Spouse/Parent Date of Birth _____

Employer _____ Occupation _____Phone_____

Employer Address_____ City/State _____ Zip _____

APPOINTMENT REMINDERS

Would you like to receive appointment reminders? If Yes, please advise how you would prefer to be reminded:

☐ Text message: (_____) _____ ☐ Email: _____

☐ Telephone Call: (_____) _____

INFORMATION RELEASE AND AUTHORIZATION

I hereby consent to the release and disclosure of my personal health information to the follow: (please list any individuals whom we have permission to discuss you care and appointments with) _____

_____

SIGNATURE:_____ **Date:** _____

Woodstown Physical Therapy and Sports Rehab

Medical History Questionnaire

Patient Name		Date of Birth		Age	
Height		Current Weight			
Reason for Therapy		Date of Injury or Onset			

Are you **currently** receiving any other care for the condition mentioned above? ☐ No ☐ Yes If yes list:

Have you ever received therapy **in the past six months** for the condition mentioned above? ☐ No ☐ Yes If so, when?

Previous Treatment Received From (check any that apply): ☐ Physician ☐ Athletic Trainer ☐ Physical Therapy ☐ Chiropractor

Previous Treatment: ☐ Successful ☐ Unsuccessful

Have you received therapy services for **other problems/conditions during 2017** ☐ No ☐ Yes
If yes, please list:

Could you be or are you pregnant? ☐ No ☐ Yes

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

Condition	Yes	No
Arthritis	☐	☐
Osteoporosis	☐	☐
High Blood Pressure	☐	☐
Heart Disease	☐	☐
Heart Attack	☐	☐
Pacemaker	☐	☐
Vascular Disease	☐	☐
Stroke	☐	☐
Asthma	☐	☐
Shortness of Breath	☐	☐
Chronic Cough	☐	☐
Fainting Spells	☐	☐
Tuberculosis	☐	☐

Condition	Yes	No
Diabetes	☐	☐
Anemia	☐	☐
Hypersensitivity to Heat/cold	☐	☐
Swelling in Ankles	☐	☐
Deep Vein Thrombosis (DVT)	☐	☐
Seizures/ Epilepsy	☐	☐
Metal in Body or Surgical Implants	☐	☐
Cancer/ Tumor	☐	☐
Recent Weight Loss/ or Gain	☐	☐
Current Infection(s)	☐	☐
Hepatitis	☐	☐

Condition	Yes	No
Thyroid Problems	☐	☐
Headaches	☐	☐
Head Injury/ Concussion	☐	☐
Hernia	☐	☐
Kidney/Bladder Problems	☐	☐
Previous Fractures	☐	☐
Previous Surgeries	☐	☐
Hearing Loss	☐	☐
Depression	☐	☐
Anxiety	☐	☐
Substance Abuse	☐	☐
Other	☐	☐

If you answered "yes" on any of the above, please explain and give approximate date(s):

Do you have any allergies? ☐ No ☐ Yes If yes, please list allergies:

Are you presently taking any medications? ☐ No ☐ Yes If yes, please list medications and specify condition:

At the present time, would you say that your heath is (circle one): Excellent Very Good Fair Poor

The information is correct to the best of my knowledge.

X	
Patient/Parent/ Guardian Signature	Date

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

Uses and Disclosures of Your Health Information

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of evaluations will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment for your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health Care Operations. Your health information may be used as necessary to support the day-to-day activities and management of the Company. For example, information on the services you received may be used to support budgeting and financial law-enforcement investigations, and to comply with government mandated reporting.

Law Enforcement. Your health information may be disclosed to public health agencies, without your permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public Health Reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other Uses and Disclosures Require Your Authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing use or disclosure of your information you may submit a written revocation of the authorization. However, our decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

Additional Uses of Information

Appointment Reminders. Your health information will be used by our staff to send you appointment reminders.

Information About Treatments. Your health information may be used to send you information on the treatment and management of your medical condition or new technology that you may find to be of interest. We may also send you information describing other health-related goods and service that we believe may interest you.

Your Health Information Rights.

You have certain rights under federal privacy standards. These include:

- The rights to request restrictions on the use and disclosure of your health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your health information
- The right to amend and/or submit corrections to your health information
- The right to receive an accounting of how and to whom your health information had been disclosed
- The right to receive a printed copy of this notice

Our Health Information Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.

Our Rights to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required to changes in federal and state laws and regulations. The revised policies and practices will be applied to all protected health information that we maintain and will be available at our facility for you upon your request.

Requests To Inspect Protected Health Information

As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form request access to your records by contacting the Company's Privacy Officer.

Complaints

If you would like to submit a comment or complaint about our privacy practices, or if you believe your privacy rights have been violated, you can contact the Company by sending a letter outlining your concerns to:

Privacy Officer
Woodstown Physical Therapy, Inc.
84 East Grant Street, Suite 3
Woodstown, NJ 08098

You may also file a written complaint with the Office of Civil Rights.

Effective Date: January 1, 2011