ESPT | EMERYVILLE SPORTS PHYSICAL THERAPY

MEDICAL QUESTIONNAIRE

NAME: _____ **DATE:** ___/___/___ **BIRTHDATE:** ___/___/___

HOW DID YOU FIND OUT ABOUT OUR CLINIC? FACEBOOK YELP GOOGLE DOCTOR REFERRAL PERSONAL REFERRAL

OTHER_____

WAS A PRESCRIPTION GIVEN TO THE FRONT DESK? Y N

PHONE #: _____**ADDRESS:** _____

EMERGENCY CONTACT: _____**RELATIONSHIP:**_____ **PHONE:** _____

CONDITION TO BE TREATED: _____ **DATE CONDITION BEGAN:** _____

WHO IS YOUR REFERRING PHYSICIAN? _____

HAVE YOU RECENTLY NOTICED ANY OF THE FOLLOWING? CHECK ALL THAT APPLY.

[ ] FATIGUE	[ ] NUMBNESS OR TINGLING	[ ] CONSTIPATION
[ ] FEVER / CHILLS / SWEATS	[ ] MUSCLE WEAKNESS	[ ] DIARRHEA
[ ] NAUSEA / VOMITING	[ ] DIZZINESS/LIGHTHEADEDNESS	[ ] SHORTNESS OF BREATH
[ ] WEIGHT LOSS / GAIN	[ ] HEARTBURN/INDIGESTION	[ ] FAINTING
[ ] DIFFICULTY WITH BALANCE (WALKING)	[ ] DIFFICULTY SWALLOWING	[ ] COUGH
[ ] FALLS	[ ] CHANGE IN BOWEL / BLADDER FUNCTION	[ ] HEADACHES

HAVE YOU EVER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING CONDITIONS? CHECK ALL THAT APPLY.

[ ] CANCER	[ ] LUNG PROBLEMS	[ ] DIABETES
[ ] HEART PROBLEMS	[ ] TUBERCULOSIS	[ ] OSTEOPOROSIS
[ ] CHEST PAIN/ANGINA	[ ] ASTHMA	[ ] MULTIPLE SCLEROSIS
[ ] CIRCULATION PROBLEMS	[ ] RHEUMATOID ARTHRITIS	[ ] EPILEPSY
[ ] BLOOD CLOTS	[ ] OTHER ARTHRITIC CONDITION	[ ] EYE PROBLEMS/ INFECTION
[ ] STROKE	[ ] BLADDER/URINARY TRACT INFECTION	[ ] ULCERS
[ ] ANEMIA	[ ] KIDNEY PROBLEM/ INFECTION	[ ] LIVER PROBLEMS
[ ] BONE OR JOINT INFECTION	[ ] PELVIC INFLAMMATORY DISEASE	[ ] HEPATITIS
[ ] CHEMICAL DEPENDENCY	[ ] THYROID PROBLEMS	[ ] PNEUMONIA
(I.E., ALCOHOLISM)	[ ] LATEX ALLERGY	[ ] DEPRESSION

HAS ANYONE IN YOUR IMMEDIATE FAMILY EVER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING CONDITIONS? CHECK ALL THAT APPLY.

[ ] CANCER	[ ] DIABETES	[ ] TUBERCULOSIS
[ ] HEART PROBLEMS	[ ] STROKE	[ ] THYROID PROBLEMS
[ ] HIGH BLOOD PRESSURE	[ ] DEPRESSION	[ ] BLOOD CLOTS

HAVE YOU HAD SURGERY FOR YOUR CONDITION? Y N IF YES, DATE: _____

IS CONDITION RELATED TO AUTO ACCIDENT? Y N IF YES, DATE: _____

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IS CONDITION RELATED TO **NON-WORK** ACCIDENT? Y N IF YES, DATE: _____

IS CONDITION RELATED TO **WORK** ACCIDENT? Y N IF YES, DATE: _____

HAVE YOU HAD ANY INJECTIONS FOR YOUR CONDITION? Y N IF YES, DATE: _____

PLEASE LIST ANY DIAGNOSTIC TESTS YOU HAVE HAD FOR THIS CONDITION: _____

WHAT ARE YOUR CURRENT SYMPTOMS? _____

HOW DID INJURY OR PROBLEM OCCUR? _____

PLEASE RATE YOUR PAIN USING A 0-10 SCALE (0 = NO PAIN, 10 = WORST PAIN YOU CAN IMAGINE)

WORST PAIN SINCE ONSET: _____ BEST PAIN SINCE ONSET: _____ TODAY'S PAIN: _____

WHERE IS YOUR PAIN OR PROBLEM LOCATED? _____

IS YOUR PAIN? CONSTANT INTERMITTENT DULL SHARP OTHER_____

WHAT MAKES YOUR PAIN / PROBLEM BETTER? _____ WORSE? _____

IS THERE PAIN PRESENT AT NIGHT? Y N WHAT POSITION HELPS YOU SLEEP? _____

HAVE YOU HAD PT FOR THIS CONDITION? Y N IF YES, WHERE? _____

HAVE YOU HAD CHIROPRACTIC SERVICES FOR THIS CONDITION? Y N IF YES, WHERE? _____

EMPLOYMENT HISTORY:

ARE YOU CURRENTLY WORKING? Y N IF NO, HOW MANY TOTAL DAYS OF WORK HAVE YOU MISSED? _____

ARE YOUR WORK DUTIES? FULL RESTRICTED HOW MANY HOURS PER WEEK DO YOU WORK? _____

WHO IS YOUR EMPLOYER? _____

WHAT TYPE OF WORK DO YOU DO? _____

WHAT ACTIVITIES IN YOUR DAILY LIFE HAVE BEEN MOST AFFECTED BY YOUR PROBLEM? _____

WHAT DO YOU HOPE TO ACCOMPLISH WITH THERAPY? _____

ARE YOU EXERCISING AT HOME? Y N IF YES, WHAT TYPE? _____

ARE YOU WEARING A SLING OR BRACE? Y N IF YES, WHAT TYPE? _____

DO YOU SMOKE? Y N IF YES, WHAT TYPE? _____

THERAPIST COMMENTS: _____

THERAPIST SIGNATURE: _____

TO THE BEST OF MY KNOWLEDGE AND BELIEF, THE INFORMATION I HAVE GIVEN IS COMPLETE AND TRUE. I HEREBY GIVE MY CONSENT TO RECEIVE THERAPY SERVICES AT STAC PHYSICAL THERAPY EMERYVILLE, INC. I HAVE RECEIVED A COPY OF THE PATIENT / CLIENT RIGHTS AND RESPONSIBILITIES INFORMATION SHEET.

PATIENT SIGNATURE: _____ DATE: _____

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HIPAA REGULATIONS

PATIENT RIGHTS

AS OUR PATIENT AT **EMERYVILLE SPORTS PHYSICAL THERAPY, YOU HAVE THE RIGHT TO:**

1. RECEIVE MEDICAL TREATMENT WITHOUT REGARD TO SEX, DISABILITY, AGE, DIAGNOSIS, ECONOMIC STATUS, EDUCATION BACKGROUND, RACE, COLOR, ETHNICITY, RELIGION, ANCESTRY, NATURAL ORIGIN, SEXUAL ORIENTATION, MARITAL STATUS, OR THE SOURCE OF PAYMENT FOR CARE.

2. BE INFORMED OF YOUR RIGHTS, IN ADVANCE OF PROVIDING OR DISCONTINUING CARE, WHENEVER POSSIBLE.

3. KNOW THE NAME OF THE PHYSICAL THERAPIST THAT HAS PRIMARY RESPONSIBILITY FOR COORDINATING THE CARE.

4. CONSIDERATE AND RESPECTFUL CARE THAT SAFEGUARDS PERSONAL, CULTURAL, PSYCHOSOCIAL AND SPIRITUAL VALUES.

5. RECEIVE CARE IN A SAFE SETTING THAT IS FREE FROM ALL FORMS OF ABUSE OR HARASSMENT.

6. RECEIVE INFORMATION ABOUT YOUR HEALTH STATUS, COURSE TREATMENT, PROSPECTS FOR RECOVERY AND OUTCOMES OF CARE (INCLUDING UNANTICIPATED OUTCOMES) IN TERMS YOU CAN UNDERSTAND.

7. RECEIVE DIRECT PHYSICAL THERAPY TREATMENT SERVICES FROM AN INDIVIDUAL WHO IS A PHYSICAL THERAPIST LICENSED BY THE PHYSICAL THERAPY BOARD OF CALIFORNIA.

8. PARTICIPATE ACTIVELY IN DECISIONS REGARDING MEDICAL CARE, INCLUDING DEVELOPMENT AND IMPLEMENTATION OF YOUR CARE PLAN.

9. IDENTIFY A SURROGATE DECISION MAKER WHO CAN MAKE HEALTH CARE DECISIONS FOR YOU SHOULD BECOME UNABLE TO DO SO, AND HAVE ALL THE PATIENTS' RIGHTS APPLY TO THIS PERSON OR OTHERS WHO MAY HAVE LEGAL RESPONSIBILITY TO MAKE DECISIONS REGARDING MEDICAL CARE ON YOUR BEHALF.

10. PERSONAL PRIVACY

11. FULL CONSIDERATION OF PRIVACY CONCERNING THE MEDICAL CARE PROGRAM. CASE DISCUSSION, CONSULTATION, EXAMINATION AND TREATMENT ARE CONFIDENTIAL AND SHOULD BE CONDUCTED DISCREETLY. YOU HAVE THE RIGHT TO BE ADVISED AS TO THE REASON FOR THE PRESENCE OF THE INDIVIDUAL.

12. CONFIDENTIAL TREATMENT OF ALL COMMUNICATION, RECORDINGS/FILMS AND RECORDS PERTAINING TO THE CARE. WRITTEN PERMISSIONS SHALL BE OBTAINED BEFORE THE MEDICAL RECORDS AND/OR FILMS CAN BE AVAILABLE TO ANYONE NOT DIRECTLY RELATED WITH THE CARE, UNLESS OTHERWISE AUTHORIZED OR PERMITTED BY LAW.

13. ACCESS INFORMATION CONTAINED IN YOUR MEDICAL RECORDS WITHIN A REASONABLE TIME FRAME.

14. REQUEST AN AMENDMENT TO AND RECEIVE AND ACCOUNTING OF DISCLOSURES REGARDING YOUR HEALTH INFORMATION.

15. BE FREE FROM RESTRAINTS OF ANY FORM USED AS A MEANS OF COERCION, DISCIPLINE, OR RETALIATION BY STAFF.

16. REASONABLE RESPONSES TO ANY REASONABLE REQUESTS MADE FOR SERVICE.

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17. REASONABLE CONTINUITY OF CARE AND TO KNOW IN ADVANCE THE TIME AND LOCATION OF AN APPOINTMENT, AS WELL AS THE IDENTITY OF THE PERSONS PROVIDING THE CARE.

18. EXAMINE AND RECEIVE AN EXPLANATION OF THE ESPT CHANGES REGARDLESS OF SOURCE PAYMENT.

19. RECEIVE PROTECTED HEALTH INFORMATION ELECTRONICALLY (EMAIL AND TEXT). WHILE WE DO OUR BEST TO PROTECT THIS INFORMATION, THE PATIENT ACKNOWLEDGES ASSOCIATED RISKS AND CONSENTS TO RECEIVING THIS MEDICAL INFORMATION DIRECTLY.

PATIENT RESPONSIBILITIES

TO ASSIST US IN PROVIDING THE QUALITY OF HEALTH CARE AND SERVICES YOU EXPECT AND DESERVE, YOU AS A PATIENT AT ESPT HAVE THE RESPONSIBILITY TO:

1. PROVIDE, TO THE BEST OF YOUR KNOWLEDGE ACCURATE AND COMPLETE INFORMATION ABOUT PRESENT COMPLAINTS, MEDICATIONS, PAST ILLNESSES, HOSPITALIZATIONS, AND OTHER MATTERS RELATING TO YOUR HEALTH AND HEALTHCARE.

2. PROVIDE INFORMATION ABOUT ADVANCE DIRECTIVES: GIVE US DIRECTION ABOUT YOUR PREFERENCES FOR FUTURE MEDICAL CARE AND THE IDENTITY OF ANYONE WHO YOU MAY WANT TO MAKE HEALTHCARE DECISIONS ON YOUR BEHALF SHOULD YOU LATER BECOME INCAPABLE OF MAKING SUCH DECISIONS ON YOUR OWN.

3. INFORM US IF YOU HAVE NOT UNDERSTOOD A PROPOSED COURSE OF ACTION OR WHAT IS EXPECTED OF YOU.

4. ASK QUESTIONS ABOUT YOUR TREATMENT, DIAGNOSIS AND/OR PROGNOSIS.

5. INFORM US IMMEDIATELY IF YOU BELIEVE THAT YOU ARE BEING PROVIDED WITH A TREATMENT THAT IS NOT CORRECT OR INTENDED FOR YOU.

6. TALK WITH A PHYSICAL THERAPIST IF YOU ARE DISSATISFIED WITH THE CARE AND OR SERVICE.

BY SIGNING THIS ACTION, YOU ACKNOWLEDGE RECEIPT OF THE NOTICE OF PRIVACY PRACTICES. OUR NOTICE OF PRIVACY PRACTICES PROVIDES INFORMATION ABOUT HOW WE MAY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION.

_____ _____

PATIENT SIGNATURE DATE

_____

PRINT PATIENT NAME

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SPORTS PHYSICAL THERAPY

PHYSICAL THERAPY ATTENDANCE POLICY

(PLEASE READ THOROUGHLY)

EMERYVILLE SPORTS PHYSICAL THERAPY STRIVES TO PROVIDE EACH PATIENT WITH THE HIGHEST QUALITY OF CARE WHILE ATTEMPTING TO ACCOMMODATE YOUR SCHEDULE FOR YOUR CONVENIENCE. THEREFORE, WE PROVIDE RESERVED TIME SLOTS FOR EACH PATIENT WITH A SPECIFIC THERAPIST IN ORDER TO MINIMIZE YOUR WAITING AND ASSURE CONTINUITY OF YOUR PAYMENT. YOUR CONSISTENT ATTENDANCE OF THE PLANNED TREATMENT REGIMEN IS PARAMOUNT TO YOUR FULL RECOVERY.

WHILE WE ARE SENSITIVE TO THE FACT THAT AN EMERGENCY MAY OCCUR IN A RARE INSTANCE, CANCELLATIONS, ESPECIALLY LAST-MINUTE ONES, ALONG WITH PATIENT NO-SHOWS, DECREASE OUR ABILITY TO ACCOMMODATE THE SCHEDULING NEEDS OF THE OTHER PATIENTS. THEREFORE, WE ASK FOR YOUR FULL COOPERATION WITH THE FOLLOWING POLICY:

- IF YOU ARE **MORE THAN 30 MINUTES** LATE FOR YOUR APPOINTMENT AND FAIL TO NOTIFY US, TREATMENT MAY BE CANCELLED, AND A FEE CHARGED FOR MISSING THE APPOINTMENT.

- A SCHEDULED APPOINTMENT **MUST BE CANCELLED AT LEAST 24 HOURS IN ADVANCE** OR THERE WILL BE A FEE CHARGED FOR THAT APPOINTMENT. **$35** IF THE CANCELLATION OCCURS **12-24** HOURS PRIOR TO THE APPOINTMENT AND **$50** IF THE CANCELLATION OCCURS **WITHIN 12** HOURS OF THE APPOINTMENT.

- FAILURE TO SHOW UP FOR AN APPOINTMENT ("NO SHOW") WITHOUT NOTIFYING US WILL RESULT IN A $50 FEE BEING CHARGED FOR THAT APPOINTMENT.

- REPEATED FAILURE TO COMPLY WITH THIS ATTENDANCE POLICY WILL RESULT IN YOUR NAME BEING PLACED ON A "SCHEDULE BASED ON AVAILABILITY" LIST. THIS WILL REQUIRE YOU TO CALL FOR AN OPEN APPOINTMENT ON EACH DAY YOU WOULD LIKE TO RECEIVE THERAPY. WE WILL DO EVERYTHING POSSIBLE TO ACCOMMODATE YOU, AS SPACE ON THE SCHEDULE PERMITS.

WE BELIEVE THAT THIS POLICY IS NECESSARY FOR THE BENEFIT OF ALL OF OUR PATIENTS SO THAT WE MAY CONTINUE TO PROVIDE HIGH QUALITY TREATMENT AND SERVICE TO EVERYONE.

ALL OF THE STAFF AT **EMERYVILLE SPORTS PHYSICAL THERAPY** APPRECIATES YOUR ANTICIPATED ADHERENCE AND COOPERATION WITH THIS POLICY. WE WISH YOU THE BEST OF LUCK WITH YOUR TREATMENT. WE ARE HERE TO HELP YOU ATTAIN ALL OF YOUR GOALS AND OPTIMIZE YOUR RETURN TO ALL OF YOUR PRE-INJURY ACTIVITIES.

_____ _____

PATIENT ACKNOWLEDGEMENT / SIGNATURE DATE

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WE ARE HERE TO HELP YOU ACHIEVE YOUR GOALS

ESPT IS DEDICATED TO HELPING YOU ACHIEVE YOUR GOALS. WE UNDERSTAND EACH PATIENT'S NEEDS ARE DIFFERENT AND OUR TEAM OF THERAPISTS WILL DEVELOP A UNIQUE PLAN FOR YOU THAT PUTS YOU IN THE BEST POSITION TO REACH YOUR GOALS.

PLEASE LET US KNOW WHAT YOU ARE HOPING TO ACCOMPLISH AT PHYSICAL THERAPY.

PATIENT SIGNATURE: _____ DATE: _____

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INFORMED CONSENT

(PLEASE READ THOROUGHLY)

DEAR PATIENT -

PHYSICAL THERAPY INVOLVES THE USE OF THERAPEUTIC PROCEDURES AND MODALITIES AIMED AT REDUCING PAIN, RESTORING STRENGTH AND FLEXIBILITY, AND TEACHING BETTER MOVEMENT. THE SCIENCE BEHIND THESE APPROACHES IS WELL FOUNDED IN MEDICAL LITERATURE. YOU HAVE A RIGHT, HOWEVER, TO REFUSE ANY AND ALL OF THESE APPROACHES. IF YOU FEEL UNCOMFORTABLE WITH AN EXERCISE OR TECHNIQUE, FOR ANY REASON, PLEASE NOTIFY A MEMBER OF OUR STAFF IMMEDIATELY.

INFORMED CONSENT IS YOUR RIGHT. YOU SHOULD ASK QUESTIONS AND PARTICIPATE IN THE DECISION TO USE OR NOT USE VARIOUS TECHNIQUES BASED ON YOUR PREFERENCES AND YOUR PERCEPTION OF RISK AND REWARD. IT IS USEFUL FOR YOUR REHABILITATION PROCESS TO FULLY UNDERSTAND THE METHODS AND DESIRED OUTCOMES, AS WELL AS THE RISKS OF EACH PROCEDURE.

ARE THERE RISKS IN PHYSICAL THERAPY APPROACHES?

MODALITIES: THESE INCLUDE ICE, HEAT, ULTRASOUND, VASOPNEUMATIC COMPRESSION, ELECTRICAL STIMULATION, TRACTIONING AND BLOOD FLOW RESTRICTED EXERCISE. WHILE DESIGNED TO REDUCE INFLAMMATION, FACILITATE CIRCULATION AND REDUCE PAIN, THESE MODALITIES CAN POSSIBLY CAUSE A JOINT OR MUSCLE TO BECOME IRRITABLE. IF YOU ARE UNCOMFORTABLE WITH ANY PROPOSED MODALITY, IT IS YOUR RIGHT TO REFUSE SUCH TREATMENT.

EXERCISES: THE BENEFITS OF EXERCISE INCLUDE STRENGTH, COORDINATION, ENDURANCE, FLEXIBILITY, AND BALANCE. IF DONE INCORRECTLY, HOWEVER, EXERCISE CAN BE INEFFECTIVE AND EVEN CAUSE HARM. YOU SHOULD CHALLENGE ANY EXERCISE SELECTION THAT MAKES YOU FEEL UNCOMFORTABLE.

PLEASE FEEL FREE TO CONTACT US WITH ANY QUESTIONS OR CONCERNS. WE WANT YOU TO KNOW THAT YOUR INDIVIDUAL PREFERENCES AND NEEDS ARE CRITICAL TO SUCCESSFUL OUTCOMES. YOU HAVE THE RIGHT TO REFUSE TREATMENT FOR ANY REASON AND AT ANY TIME.

SINCERELY.

EMERYVILLE SPORTS PHYSICAL THERAPY

_____ _____

PATIENT NAME (PLEASE PRINT) DATE

_____

PATIENT ACKNOWLEDGEMENT / SIGNATURE