TOUCH OF LIFE PHYSICAL THERAPY, INC.
PATIENT QUESTIONNAIRE

Patient's Name:_____ Age:_____ Date:_____

Date of Pain Onset/Surgery:_____

Medical History

	Yes	No		Yes	No		Yes	No
Allergies			Dizzy Spells			MRSA		
Anemia			Emphysema/Bronchitis			Muscular Disease		
Anxiety			Fibromyalgia			Multiple Sclerosis		
Arthritis			Fractures			Osteoporosis		
Asthma			Gallbladder Problems			Parkinsons		
Cancer			Headaches			Rheumatoid Arthritis		
Autoimmune Disorder			Hearing Impaired			Seizures		
Cardiac Conditions			Hepatitis			Smoking		
Cardiac Pacemaker			High/Low Blood Pressure			Speech Problems		
Chemical Dependency			High Cholesterol			Strokes		
Circulation Problems			HIV/AIDS			Thyroid Disease		
Currently Pregnant			Incontinence			Tuberculosis		
Depression			Kidney Problems			Vision Problems		
Diabetes			Metal Implants			Other:		

If YES on any of the above, please explain and give approximate dates:

_____

_____

_____

Fall History

	Yes	No
Is your injury a result of a fall in the past year?		
Have you had two or more falls in the past year?		

Height: _____
Weight: _____

Surgical History

Body Region:_____ Surgery Type:_____ Date:_____
Body Region:_____ Surgery Type:_____ Date:_____

Current Medications:

Drug:_____ Dosage:_____ Frequency:_____ Route:_____ Reason:_____
Drug:_____ Dosage:_____ Frequency:_____ Route:_____ Reason:_____
Drug:_____ Dosage:_____ Frequency:_____ Route:_____ Reason:_____

Have you had any tests done (X-Rays, MRI, etc.)? What were the results?

_____

_____

Briefly describe the onset of your symptoms (include how and when the symptoms began):

_____

_____

Describe what activities, movements, or positions make your symptoms worse:

_____

_____

Describe what activities, movements, or positions make your symptoms better:

_____

_____

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TOUCH OF LIFE PHYSICAL THERAPY, INC.
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List all injuries, falls, or car accidents that have occurred in the past, including childhood, starting with most recent:

_____

_____

_____

_____

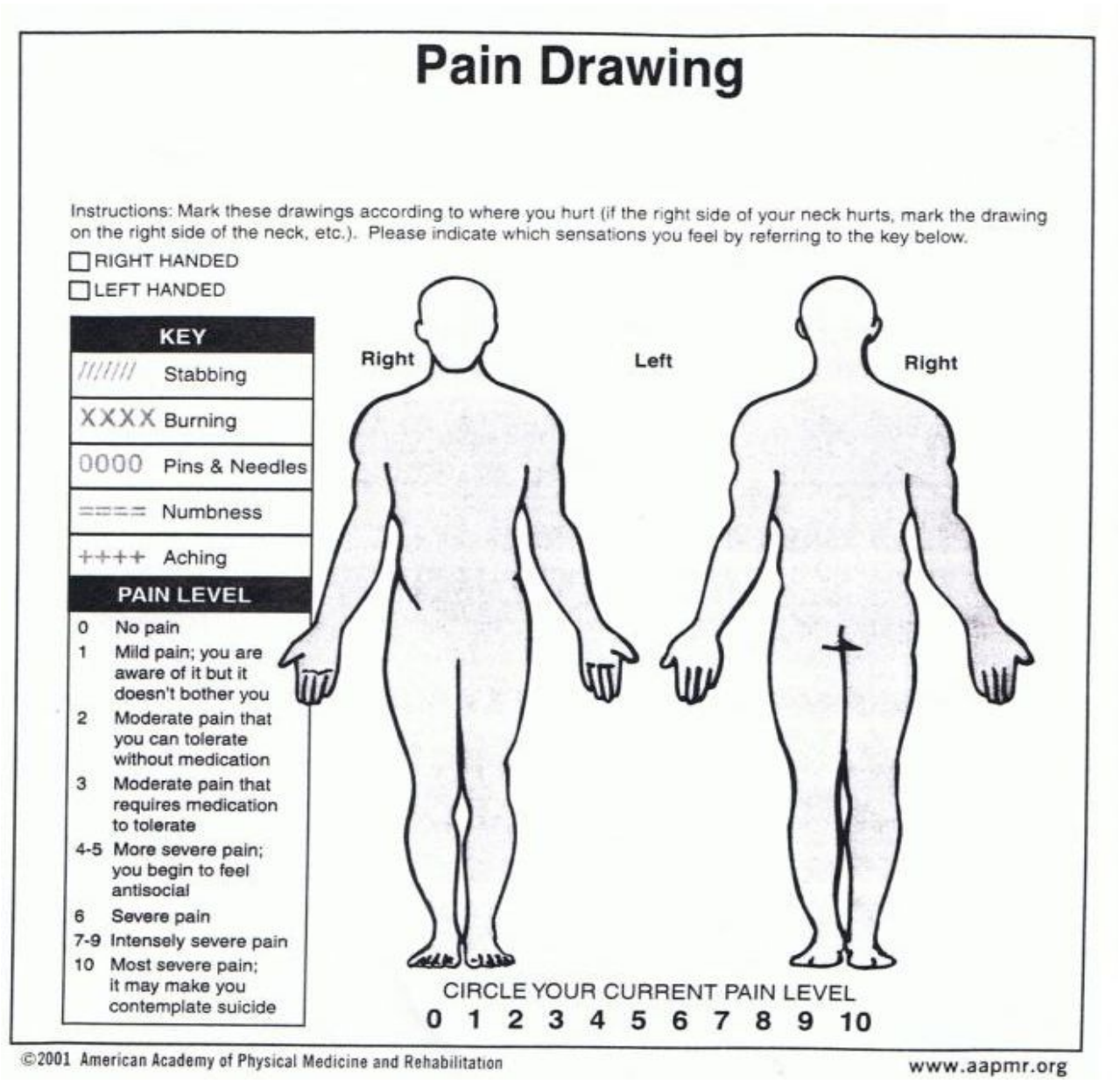
_____

Have you received prior treatment: Yes_____ No_____

What type: _____

What were the results: _____

_____



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TOUCH OF LIFE PHYSICAL THERAPY, INC.
23101 Sherman Place, Suite 150
West Hills, CA 91307
818-887-7667

PATIENT INFORMATION

Name:_____ Date of Birth:_____

Address:_____

City:_____ State:_____ Zip:_____

Social Security Number:_____

Home Phone:_____ Cell Phone:_____

Email:_____

Employer:_____ Occupation:_____

Employer Address:_____

City:_____ State:_____ Zip:_____

Business Phone:_____

In case of emergency, please notify:_____

Phone number:_____

Who referred you to our office?_____

INSURANCE/BILLING INFORMATION

YOUR SIGNATURE IS REQUIRED FOR US TO PROCESS ANY INSURANCE CLAIMS.

It is your responsibility to pay the deductible, co-insurance, and any other balances not paid for by your insurance company. These deductibles and co-insurance amounts are set by your insurance company, not by us.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize Touch of Life Physical Therapy, Inc. to release any information required by my insurance company to process claims.

I agree to be financially responsible for all charges.

I have read this information and I understand it.

Signed:_____ Date:_____

Cancellation / No-show Policy

Required notice for a cancellation is 24 hours prior to your scheduled appointment. The full rate of the scheduled appointment will be charged without the correct amount of notice given. This fee is your responsibility; it is not covered by insurance.

All services are provided by appointment only and this time is reserved for you personally. It is your responsibility to attend all scheduled appointments.

Printed Name:_____ Date:_____

Signature:_____ Date:_____

Privacy Practices Acknowledgement

I hereby acknowledge that I have been notified of the Privacy Practices of Touch of Life Physical Therapy, Inc. and I have been provided an opportunity to review them.

Printed Name:_____ Date:_____

Signature:_____ Date:_____

Your Information. Your Rights. Our Responsibilities.

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

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your

information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office.

Effective Date: This notice is effective on or after June 5 , 2014.

Depending on your diagnosis, it may be necessary for the therapist to ask you questions regarding the following:

- **Sexual Function**
- **Bowel/Bladder Function**
- **Pelvic Floor Function – (i.e. relating to genitalia)**

Please let the therapist know if you do not want to answer the questions or are uncomfortable at any time. If you wish to have a witness present, please ask the therapist.

Please remember that all questions asked serve to help the therapist treat you and improve your condition.

By signing below you are stating that you have read and understand this document.

_____ _____

Patient Name Date

_____ _____

Witness Date

23101 Sherman Place, Suite 150 West Hills, CA 91307 • 818-887-7667 Fax 818-887-7677