

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:

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Fall History

Is your injury a result of a fall in the past year?

Have you had two or more falls in the past year?

Yes No


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?

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

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

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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:

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Have you received prior treatment: Yes \_\_\_\_\_ No \_\_\_\_\_

What type: \_\_\_\_\_

What were the results: \_\_\_\_\_

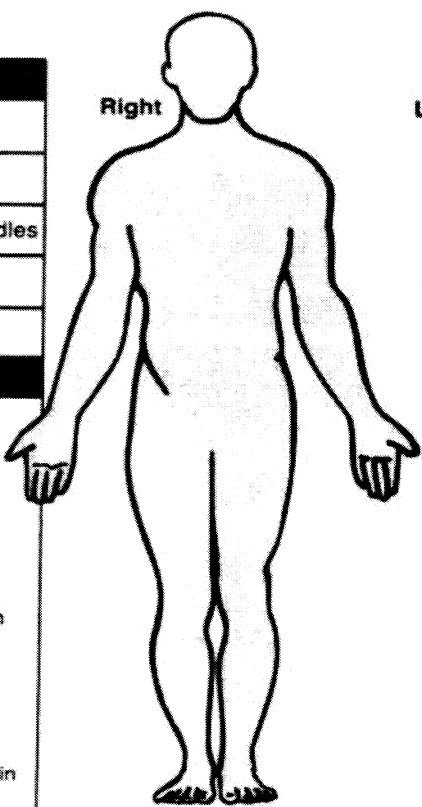
## Pain Drawing

Instructions: Mark these drawings according to where you hurt (if the right side of your neck hurts, mark the drawing on the right side of the neck, etc.). Please indicate which sensations you feel by referring to the key below.

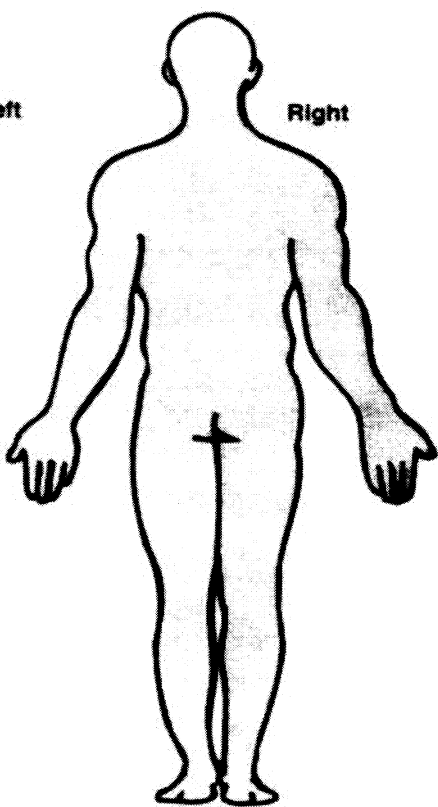
RIGHT HANDED  
 LEFT HANDED

KEY	
/////	Stabbing
XXXX	Burning
0000	Pins & Needles
====	Numbness
++++	Aching
PAIN LEVEL	
0	No pain
1	Mild pain; you are aware of it but it doesn't bother you
2	Moderate pain that you can tolerate without medication
3	Moderate pain that requires medication to tolerate
4-5	More severe pain; you begin to feel antisocial
6	Severe pain
7-9	Intensely severe pain
10	Most severe pain; it may make you contemplate suicide

Right



Left



Right

**CIRCLE YOUR CURRENT PAIN LEVEL**

0 1 2 3 4 5 6 7 8 9 10

TOUCH OF LIFE PHYSICAL THERAPY, INC.  
7301 Medical Center Drive, Suite 104  
West Hills, CA 91307  
818-887-7667

**PATIENT INFORMATION**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Sex: M F Marital Status: \_\_\_\_\_

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? \_\_\_\_\_

Have you had Physical Therapy or Chiropractic Care this calendar year? \_\_\_\_\_ # of Visits: \_\_\_\_\_

Have you had Occupational or Speech Therapy this calendar year? \_\_\_\_\_ # of Visits: \_\_\_\_\_

Medicare patients, have you received any Home Health Services this year? \_\_\_\_\_

**INSURANCE/BILLING INFORMATION**

Please circle what is applicable:

Private Insurance      Please provide us with a copy of your insurance card(s)

Medicare      Please provide us with a copy of your insurance card(s)

Other      Please provide details

**All co-pays, co-insurances, deductibles and payments are due at the time of service.**



**YOUR SIGNATURE IS REQUIRED FOR US TO PROCESS ANY INSURANCE CLAIMS AND TO ENSURE PAYMENT OF SERVICES RENDERED.**

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. Your contract with your insurance company sets these amounts.

It is your responsibility to obtain a prescription for Physical Therapy from a physician, and to fill out any approval paperwork, if necessary, prior to your treatment.

If your visits are denied payment by your insurance company, we will help appeal the decision but cannot guarantee that they will pay.

**You are ultimately responsible for all balances due.**

ASSIGNMENT OF BENEFITS: I hereby authorize payment directly to Touch of Life Physical Therapy, Inc. for any Physical Therapy and/or Medical Benefits otherwise payable to me for services rendered.

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: \_\_\_\_\_



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 an aide 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



## To Our Patients Regarding Cancellations and No-shows

The following are our policies regarding cancellations and no-shows. We take this subject seriously at the clinic because it can make the difference between whether you succeed in your treatment or not. Usually your referring doctor and/or your therapist have prescribed a set frequency of treatment. Showing up as scheduled for these visits is your most important job. Other than that, all you need to do is follow your therapist's instructions and we will be able to help you achieve your goals in treatment.

- We require 24 hours notice in the event of a cancellation. It is your responsibility, when you call in, to have an alternative time in mind that will ensure you get in the full prescribed number of treatments that week whenever possible. (In some cases, this may not work since some forms of treatment do not work well if given two sequential days.)
- There is a \$95 charge for a cancellation without proper notice. This charge will not be covered by insurance but will have to be paid by you personally.
- You may need to see a therapist other than the one who normally treats you if you do re-arrange your appointment. All of our therapists are experienced professionals and they will study your patient chart, so you will be in good hands. You will return to your original therapist in the next regularly scheduled visit.
- Please understand that your pain will probably increase and decrease as your course of treatment progresses and before it is finally erased. Either condition can seem to be a reason not to come in: a) you're feeling worse and think the treatment is not working or, b) you're feeling better and it's a great day for wind-surfing. Neither of these conditions is legitimate as a reason not to come: a) if you're in pain, come in and get it fixed, b) if you're out of pain, now is the time that we can begin doing some real correction of the underlying causes of your problem, educate you so you won't re-injure yourself, etc.

When you don't show as scheduled, three people are hurt: You because you don't get the treatment you need as prescribed by the doctor and/or PT; the therapist who now has a space in their schedule since the time was reserved for you personally; and another patient who could have been scheduled for treatment if you had given proper notice.

Please co-operate with us in this regard. We're looking forward to working with you.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Interviewer Signature

\_\_\_\_\_  
Date

## Your Information. Your Rights. Our Responsibilities.

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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/](http://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](http://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](http://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.





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: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



To All Medicare Patients:

If you are receiving home health care or have recently had home health care and it is not discharged **before** you start physical therapy with us, Medicare **will** deny your claims and you will be financially responsible for your visits.

It is your responsibility to provide proof of discharge from home health care.

**I understand that I am responsible for all balances due.**

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date