Patient Name:			Today's Date: _____/_____/_____	
Date Of Birth ____/_____/_____	Age:	Height:	Weight:	Male Female

Please, Tell us about your condition: **Email:**

When did you first notice the symptoms or have functional problems due to this condition/injury? (estimated date)

____

What activities are most limited by this condition?____ ____

How did your injury/symptoms occur?______________ ____

What do you expect to accomplish with physical therapy?____

Are your symptoms: Constant? Intermittent? Getting Better? Getting Worse? Staying the same?

Have you had any falls this annual year? Yes No

Have you had any other treatment for your condition?

Surgery: When ____/____/_____ What type?____

Injection: When ____/____/_____ What type?____

Physical Therapy: When ____/____/____ Did it help? Yes No

Chiropractic: When ____/____/_____ Did it help? Yes No

Medications:____________________________________ Exercises____

MRI:____ X-Ray____

CT Scan:_______________________________________ Other____

Work Information:

Who is your employer?________________________ What is your job title/responsibilities?________________________

Are you currently working? Yes No If yes, number of hours per week____ Full Duty Restricted Duty

How many work days have you missed due to your injury/condition?__________

Other health problems may affect your treatment. Please check (√) any of the following that apply to you:			
	Arthritis (rheumatoid / osteoarthritis)		Cancer
	Osteoporosis / Osteopenia		Kidney, bladder, prostate or urination problems
	Asthma		Previous motor vehicle accidents
	Chronic Obstructive Pulmonary Disease (COPD), acquired respiratory distress syndrome (ARDS), or emphysema		Visual impairments (such as cataracts, glaucoma, macular degeneration)
	Angina		Allergies
	Congestive heart failure (or heart disease)		Incontinence
	Heart attack (Myocardial infarction)		Anxiety or panic disorders
	High blood pressure		Depression
	Neurological Disease (such as Multiple Sclerosis or Parkinson's Disease)		Hearing impairment (very hard of hearing, even with hearing aids)
	Stroke or TIA		Hepatitis / AIDS
	Peripheral Vascular Disease		Prior surgery:___________________________________
	Headaches		Prosthesis / Implants
	Diabetes Types I and II		Sleep Dysfunction
	Gastrointestinal Disease (ulcer, hernia, reflux, bowel, liver, gall bladder)		Back pain (neck pain, low back pain, degenerative disc disease, spinal stenosis, etc)

Pain Assessment Questionnaire

1. **Is pain a symptom of the problem for which you are seeking treatment?**

☐ Yes ☐ No

2. Rate the level of pain you have had in the past 24 hours (circle one)

0 1 2 3 4 5 6 7 8 9 10

3. Over the past month, how would you rate your pain when it was the best? (circle one)

0 1 2 3 4 5 6 7 8 9 10

4. Over the past month, how would you rate your pain when it was the worst? (circle one)

0 1 2 3 4 5 6 7 8 9 10

5. What % of time have you experienced pain the past 24 hours (circle one)

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

6. How many days in the last week have you experienced pain?____________(0-7)

7. How many weeks have you had this pattern of pain?__________________________________

8. Select all of the activities that increase your pain. (check all boxes that apply)

☐ Bending	☐ Lifting
☐ Sitting	☐ Pushing/Pulling
☐ Standing	☐ Gripping
☐ Laying	☐ Lifting Overhead
☐ Sleeping	☐ Rest
☐ Walking	☐ Other
☐ Running	☐ None

9. Select all of the activities that reduce your pain. (check all boxes that apply)

☐ Bending	☐ Lifting
☐ Sitting	☐ Pushing/Pulling
☐ Standing	☐ Gripping
☐ Laying	☐ Lifting Overhead
☐ Sleeping	☐ Rest
☐ Walking	☐ Other
☐ Running	☐ None

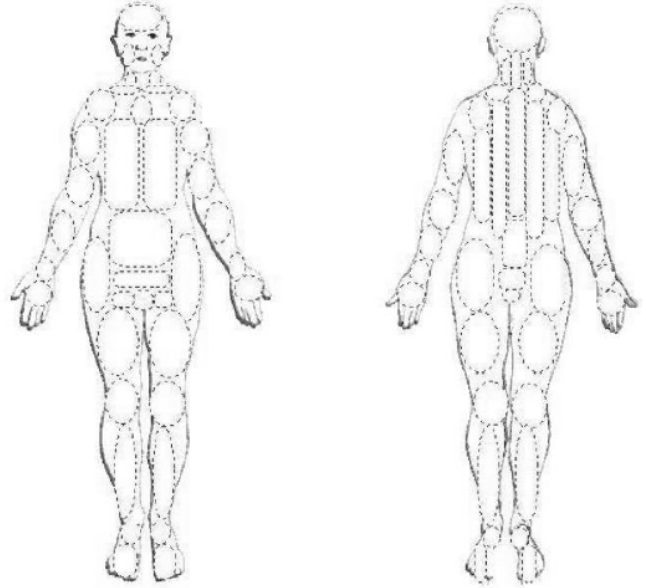
10. Does pain keep you awake or wake you at night?

☐ Always

☐ Sometimes

☐ Never

11. Mark all areas where you are experiencing pain on the diagram below:



12. Select the qualities of your pain and CIRCLE the degree of these symptoms to the right.

☐ Throbbing	Severe	Moderate	Mild
☐ Shooting	Severe	Moderate	Mild
☐ Stabbing	Severe	Moderate	Mild
☐ Sharp	Severe	Moderate	Mild
☐ Cramping	Severe	Moderate	Mild
☐ Gnawing	Severe	Moderate	Mild
☐ Aching	Severe	Moderate	Mild
☐ Heavy	Severe	Moderate	Mild
☐ Tender	Severe	Moderate	Mild
☐ Splitting	Severe	Moderate	Mild
☐ Tiring/Exhausting	Severe	Moderate	Mild
☐ Sickening	Severe	Moderate	Mild
☐ Fearful	Severe	Moderate	Mild
☐ Hot/Burning	Severe	Moderate	Mild

CURRENT MEDICATIONS LIST REPORT

LIST ALL THE PRESCRIPTIONED MEDICATIONS YOU ARE CURRENTLY TAKING			
NAME OF THE MEDICATION	DOSAGE (how many or how much you take)	FREQUENCY (how often do you take it)	ROUTE (how do you take it? i.e oral, injection, etc.)
LIST ALL OVER THE COUNTER MEDICATIONS			
NAME OF THE MEDICATION	DOSAGE (how many or how much you take)	FREQUENCY (how often do you take it)	ROUTE (how do you take it? i.e oral, injection, etc.)
LIST ALL HERBAL VITAMINS, MINERALS, NUTRITIONAL SUPPLEMENTS			
NAME OF THE MEDICATION	DOSAGE (how many or how much you take)	FREQUENCY (how often do you take it)	ROUTE (how do you take it? i.e oral, injection, etc.)

PATIENT NAME: **DATE:**

ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

As part of my health care, **Cal Rehab And Sports Therapy Brea** creates and stores information about me. This includes records concerning my health history, symptoms, examinations, test results and plans for future care.

I understand that this information serves as a basis for my continuing care. I understand that this information is used as a means of communication among personnel, and with medical personnel outside of this practice. I understand that this information serves as a source of information for applying my diagnoses and treatment to my bill.

I understand that this information is a way for third party insurance companies to assure that a service we billed for was actually performed.

I understand that this information can be used as a tool to assess the quality of care provided to patients. I have been provided an opportunity to review the Notice of Privacy Practices which provides a more complete review of information uses and disclosures. I understand that I have the right to review the Notice of Privacy Practices before signing this consent.

I understand that the Notice of Privacy Practices may change at any time and that a current copy will be available for my inspection during regular business hours of each medical office and at the central billing office.

I understand for **Worker's Compensation Cases**, the minimum necessary PHI/ePHI will be released to my employer, my worker's compensation insurance carrier, third party administrator, rehab nurse or nurse case manager unless otherwise restricted below.

I understand that I have the right to request restrictions as to how my information may be disclosed to carry out treatment, payment or other healthcare operations and that **Cal Rehab And Sports Therapy Brea** is not required to agree to the restrictions requested. The procedure to request **restriction** on information use and disclosure is contained in the Notice of Privacy Practices. Please complete the following that apply.

[__] I **DO NOT** authorize release of my information with the following individuals or organizations (enter names below and initial the box to left):

[__] I **DO** authorize sharing of my information with the following individuals or organizations (enter names below and initial the box to left):

[_______] Spouse/Children:____

[_______] Other: ____

These restrictions and/or authorizations to release information will remain in effect until terminated in writing.

Appointment Communication Preference: I prefer to be contacted in the following manner:

[__] Home Phone [__] Work Phone [__] My Mobile Phone [__] Email

Provide email address or phone number:____

I acknowledge that I have received a copy of the Notice of Privacy Practices and that the full version is posted at my treatment facility and available upon request. I agree to the liability limitations explained therein.

_____________________________________ ________________ ________________________

Signature of patient or legal representative Date Relationship to Patient

____

Printed name of patient

AUTHORIZATION AND CONSENT TO TRANSMIT PROTECTED HEALTH INFORMATION AND ELECTRONIC PROTECTED HEALTH INFORMATION VIA UNSECURED INTERNET

Patient's Name: ____ Date of Birth: _________________________

I, ____, expressly request, authorize, direct, permit and unequivocally consent to **Cal Rehab And Sports Therapy Brea** transmitting my Protected Health Information ("PHI") and Electronic Protected Health Information ("ePHI") to me via the unsecured Internet. I expressly and unequivocally acknowledge that **Cal Rehab And Sports Therapy Brea** does not have the capability to respond to my electronic mail transmissions through encrypted or otherwise secured Internet connections. I expressly and unequivocally waive any claims or rights with respect to transmission of ePHI or PHI via the unsecured Internet. I fully understand that third parties may attempt to or actually access, use and disclose PHI or ePHI transmitted by **Cal Rehab And Sports Therapy Brea** pursuant to my electronic mail inquiry. I fully understand the risks of transmitting unencrypted electronic mail containing ePHI, I am willing to accept those risks. I knowingly, intentionally and voluntarily waive all rights, claims and damages relating to the negligence, breach of confidentiality or other tort and all other legal claims that could be asserted against **Cal Rehab And Sports Therapy Brea** or any of its employees, agents, members or otherwise as a result of any third person improperly accessing, using or disclosing my PHI or ePHI as a result of transmission via the unsecured Internet. I intend to be legally bound hereby.

e-Mail Address: ____

______________________________ _____________ __________________________

Signature of Patient, Patient Representative or Legal Guardian | Date | Relationship to Patient

PHYSICAL REHABILITATION NETWORK

Consent and Statement of Financial Responsibility

1. **CONSENT FOR TREATMENT:** I consent to and authorize my physical therapist, occupational therapist and other healthcare professionals and assistants who may be involved in my care, to provide care and treatment prescribed by and/or considered necessary or advisable by my physician(s)/health care provider(s). I acknowledge that no guarantees have been made to me about the results of treatment

2. **APPOINTMENT ATTENDANCE AGREEMENT:** I understand the importance of attending therapy consistently and arriving promptly for my appointment. I acknowledge that I may be rescheduled if I arrive more than 10 minutes late for my scheduled appointment, I understand the importance of scheduling appointments in advance and acknowledge that appointment times given one week do not automatically follow through to subsequent weeks. I agree to provide at least 24 hours' notice when I need to cancel or reschedule an appointment and that cancellation of less than 24 hours or not showing up for an appointment will likely result in a **cancel/no show charge of $25 for the first occurrence and $50 for each subsequent occurrence.**

WORKERS COMPENSATION PATIENTS: We appreciate your full cooperation in attending all scheduled therapy sessions. We are required to inform your Workers Compensation Adjuster and/or Rehabilitation Manager of all missed or canceled appointments. It is also required that all missed visits be rescheduled.

3. **RESPONSIBILITY FOR PAYMENT**: All co-payments are due at the time of service. I acknowledge that in consideration of the services provided to me by PRN/E&L Physical Therapy, I am financially responsible for payment of my bill. I acknowledge that it is my responsibility to provide **Cal Rehab And Sports Therapy Brea** with current insurance information and to familiarize myself with my insurance plan and its policies. Any questions I have regarding my health insurance coverage or benefit levels should be directed to my health plan. My health insurance plan may provide that a portion of the charges and balance will remain my personal responsibility, such as my deductible, co-payment, co-insurance or charges no covered or denied by my health insurance, Medicare, or other programs which I am eligible.
Please note that refusal to sign this form does not change responsibility for payment in any way.

4. **HIPPA CONSENTS:** In compliance with HIPAA regulations, I consent to the following individuals receiving verbal infomration regarding the billinf of my account:

______________________ Name/Relationship

______________________ Name/Relationship

______________________ Name/Relationship

5. **ASSIGNMENT OF BENEFITS**: I hereby assign **Cal Rehab And Sports Therapy Brea** all my rights and claims for reimbursement under y health insurance policy. I agree to provide information as needed to establish my eligibility for such benefits.

6. **ACCESS TO AND RELEASE OF HEALTH INFORMATION**: I understand **Cal Rehab And Sports Therapy Brea** may document medical and other information related to my treatment in electronic and other forms and that such information will be used in the course of my treatment, for payment purposes and to support those who are caring for me. I authorize my clinician(s) and **Cal Rehab And Sports Therapy Brea's** administrative staff to contact other healthcare professionals that may have information related to my prior and current health conditions and treatment. I acknowledge that I have received **Cal Rehab And Sports Therapy Brea's** Notice of Privacy Practices and that it outlines how my health information will be sued and disclosed and how I may gain access to and control my health information.

7. **CONSENT FOR EMERGENCY CONTACT INFORMATION:**

______________________ Name

______________________ Telephone Number

______________________ Relationship

By my signature below, I certify that I have read, understand, and fully agree to each of the statements in this document and sign below freely and voluntarily.

______________________________ Signature of Patient or Legally Responsible Person

______________ Date

______________________________ Print Name of Above

______________ Date

PRN
PHYSICAL REHABILITATION NETWORK

PRN
PHYSICAL REHABILITATION NETWORK