EL PASO
MANUAL PHYSICAL THERAPY

# Patient Information Form

*Thank you for taking the time to fill out this form as completely as possible prior to your appointment. This is to ensure that this does not take up evaluation and treatment time. It should take approximately 30-45 minutes to complete.*

| First Name: | Middle: | Last: | Gender (circle one) M F |
|---|---|---|---|
| Age: | DOB: | Height: | Weight: |

What name do you prefer to be called?

| |
|---|
| |

Marital status: (Circle One)

| SINGLE | MARRIED | DIVORCED | WIDOWED |
|---|---|---|---|

How did you hear about us? (please provide a name if possible)

| Friend/Family | Physician | Fitness Group | Website | Other |
|---|---|---|---|---|
| | | | | |

## Contact Information

| Cell Number: | Home Number: | Work Number: | Email Address: |
|---|---|---|---|
| | | | |

Address

| Street: | City: | State: | Zip Code: |
|---|---|---|---|
| | | | |

What is the best way for us to communicate with you? (circle all that apply)

| Phone Call | Email | Text |
|---|---|---|

Who may we contact in the event of an emergency?

| Name: | Relationship: | Phone Number: |
|---|---|---|
| | | |

## Work Information

What is your occupation?

| |
|---|
| |

What is the percentage of time at your job spent doing the following?

| | | |
|---|---|---|
| Sitting: | Standing: | Other: |

## Physical Activity

What are your preferred form(s) of exercise?

| |
|---|
| |

| How many days/week do you exercise? | How long ago did you begin this activity? |
|---|---|
| | |

## Physician Information

| | | |
|---|---|---|
| Name: | Specialty: | Address: |
| Phone Number: | Fax Number: | Email: |

## Medications

Please list your current medications (including pills, injections, herbs, skin patches, etc)

| | | | |
|---|---|---|---|
| 1. | 2. | 3. | 4. |
| 5. | 6. | 7. | 8. |

List any known allergies (food or drug)

| | | | |
|---|---|---|---|
| 1. | 2. | 3. | 4. |

## Past Medical History

How would you rate your overall health? (Circle One)

| | | | |
|---|---|---|---|
| Poor | Fair | Good | Excellent |

Do you smoke? (Circle your answer)

| YES | NO |
|---|---|
| If yes, how much? | |

Have you ever had cancer?

| YES | NO |
|---|---|
| If yes, what kind? | |

WOMEN ONLY

| | | |
|---|---|---|
| Are you currently pregnant? | YES | NO |
| If no, is your menstrual cycle regular? | YES | NO |

Have you ever been diagnosed with any of the following? (Circle all that apply)

| | | | | |
|---|---|---|---|---|
| Cancer | Circulation Problems | Blood clots | Lung Problem | Other Arthritis |
| Heart Problems | Bone/Joint Infection | Drug Addiction | Tuberculosis | Stroke |
| Chest pain/angina | Bladder/Urinary disease | Alcoholism | Asthma | Anemia |
| High Blood Pressure | Kidney problem | Depression | Rheumatoid Arthritis | STD/STI |
| Pelvic Inflammatory Disease | Thyroid Problem | Diabetes | Hepatitis | Pneumonia |
| Osteoporosis/penia | Multiple Sclerosis | Epilepsy | Liver Problems | Fibromyalgia |

## Surgical History (Please provide the following information)

| | Type of surgery | Body Part | Date |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |

## Diagnostics

Please list all radiographs/blood work that have been done recently.

| | Test (X-ray, MRI, blood work) | Test Findings | Date of Test |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |

Are you currently depressed or have you been depressed in the past 3 months?

| YES | NO |
|---|---|

Have you recently had any of the following? (Please circle all that apply)

| | | | | | |
|---|---|---|---|---|---|
| Fatigue | Fever | Nausea/Vomiting | Weight loss/gain | Fainting | Falls |
| Chest Pain | Abdominal Pain | Numbness/Tingling | Difficulty Swallowing | Dizziness | Headache |
| Constipation | Diarrhea | Changes in Bowel/Bladder function | Dark stool/blood | Short of breath | Cough |

## Current Condition

How long ago did your condition begin?

| |
|---|
| |

Was there a specific incident or accident that set off your pain?

| YES | NO | If yes, explain: |
|---|---|---|

Did you have physical therapy for this before?

| YES | NO |
|---|---|

What other treatments have you had for this?

| |
|---|
| 1. |
| 2. |

## Pain Rating

0 means no pain at all and 10 means you need an ambulance to take you to the hospital.
Please circle one number on each row.

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| What is your pain level right now? | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| What has been your worst pain in the past 24 hours? | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| What has been your best pain in the past 24 hours? | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

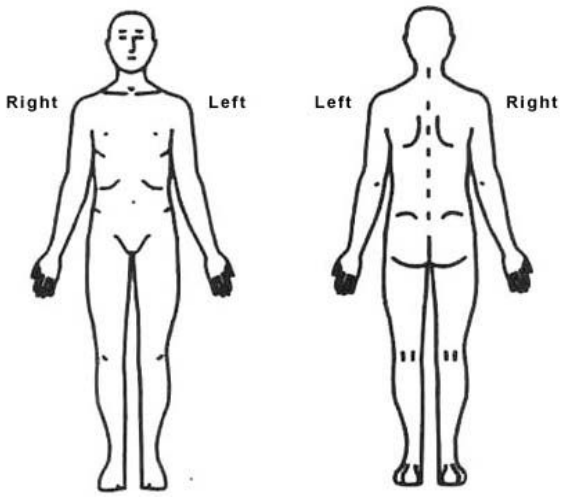
Does your pain wake you up at night?

| YES | NO |
|---|---|

## Pain Diagram

Using the picture on the right, draw the appropriate symbols on the picture that represent your pain.

| | |
|---|---|
| Numbness | \|\|\|\|\|\|\| |
| Pins and Needles | :::::: |
| Burning | XXX |
| Stabbing | ^^^^ |
| Ache | 000 |




What do you hope to gain from physical therapy?

## Financial Policy Statement

I understand that El Paso Manual Physical Therapy (EPMPT) is out of network with all insurance carriers. I understand that I am foregoing my in-network physical therapy benefits to receive physical therapy services by EPMPT. I understand that due to federal law, Medicare beneficiaries cannot receive private pay physical therapy services. I am prepared to make the complete payment that is required at the time of each service. In the event a legal suit or outside collections are necessary to enforce payment of the account, you agree to pay for all the collection fees and/or attorney's fees and court costs as may be deemed reasonable.

**Initial here >** ☐

## Consent for Treatment

I agree and give my consent for EPMPT to provide medical care and treatment (including spinal and extremity manipulation) that is considered necessary and proper in diagnosing and treating my condition.

**Initial here >** ☐

## No Show/Cancellation Policy

I understand that all no shows or cancellations made without at least a 24 hour notice will forfeit that visit. You will not be able to recover the value of the forfeited visit. For example, if you bought a treatment package of 8 visits and you forfeit one, then you will only be seen for 7 visits total.

**Initial here >** ☐

## Media Consent

I hereby consent to participation in media (including but not limited to photos, videos, use of quotes and interviews) for the educational and promotional purposes of EPMPT. I understand that I may be identifiable from such media. I allow EPMPT to use my full name and profession.

**I agree** ☐ **I do not agree** ☐

## Blog Sign Up

I wish to be added to the email list for blog updates and promotional information from EPMPT. We promise not to sell your information to third parties. You may unsubscribe via the links at the bottom of the email updates.

**I agree** ☐ **I do not agree** ☐

## Privacy Policy

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. This notice takes effect on the date the acknowledgement is signed and remains in effect until we replace it.

**1. Our pledge regarding medical information:**

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

**2. Our legal duty:**

Law requires us to:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the current notice.

We have the right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices:

1. Before we make an important change in our privacy practice, we will change this notice and make the new notice available upon request.

**3. Use and disclosure of your medical information:**

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us at the address provided at the end of this notice.

For treatment: We may use medical information about you to provide you with the medical treatment for services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

For payment: We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third party payer. The information on or accompanying the bill may include your medical information. For health care operations: We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

Additional uses and disclosures: In addition to using and disclosing your medical information for treatment, payment and health care operations, we may use and disclose medical information for the following purposes:

Facility Directory: Unless you notify us that you object, the following medical information about you will be placed in our facility directories: your name; your location in our facility; your condition described in general terms; your religious affiliation, if any. We

may disclose this information to members of the clergy or, except for your religious affiliation, to others who contact us and ask for information about you by name.

Notification: We may use and disclose medical information to notify or help notify: a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition, or death. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray or medical information for you.

Disaster Relief: We may share medical information with a public or private organization or person who can legally assist in disaster relief efforts.

Fundraising: We may provide medical information to one of our affiliated fundraising foundations to contact you for fundraising purposes. We will limit our use and sharing to information that describes you in general, not personal, terms and the dates of your health care. In any fundraising materials, we will provide you a description of how you may choose not to receive future fundraising communications.

Research in Limited Circumstances: We may use medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.

Funeral Director, Coroner, Medical Examiner: To help them carry out their duties, we may
share the medical information of a person who has died with a coroner, medical examiner, funeral director, or an organ procurement organization.

Specialized Government Functions: Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

Court Orders and Judicial and Administrative Proceedings: We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

Public Health Activities: As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling a disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purpose of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacements, to track products, or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

Victims of Abuse, Neglect, or Domestic Violence: We may use and disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share your medical information if it is necessary to prevent serious threat to your health or safety or the health or safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.

Workers Compensation: We may disclose health information when authorized or necessary to comply with laws relating to workers compensation or other similar programs.

Law Enforcement: Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.

Appointment Reminders: We may use and disclose medical information for purposes of sending you appointment postcards or otherwise reminding you of your appointments.

Alternative and Additional Medical Services: We may use and disclose medical information to furnish you with information about health-related benefits and services that may be of interest to you, and to describe or recommend treatment alternatives.

**4. Your individual rights:**

You Have a Right to:

1. Look at or get copies of certain parts of your medical information. You may request that we provide copies in a format other than photocopies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. You may get the form to request access by using the contact information listed at the end of this notice. You may also request access by sending a letter to the contact listed at the end of this notice. If you request copies, we will charge you a flat fee of $35 and postage if you want the copies mailed to you. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

2. Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment, and health care operations and other specified exceptions.

3. Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of emergency).

4. Request that we communicate with you about your medical information by different means or to different locations. Your request that we communicate your medical information to you by different means or at different locations must be made in writing to the contact person listed at the end of this notice.

5. Request that we change certain parts of your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.

6. If you have received this notice electronically, and wish to have a paper copy, you have the right to obtain a paper copy by requesting in writing to the contact person listed at the end of this notice.

Questions and Complaints:
If you have any questions about this notice or if you think that we may have violated your privacy rights, please contact us. You may also submit a written complaint to the U.S. Department of Health and Human Services. You may contact us to submit a complaint or submit requests involving any of your rights in Section 4 of this notice by writing to the following address:

El Paso Manual Physical Therapy, PLLC
12135 Esther Lama Dr. #1100
El Paso, TX 79936
915-252-5012

We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services. We will not retaliate in any way if you choose to file a complaint.

## Printed Name (parent/guardian name if applicable)

## Signature (parent/guardian signature if applicable)

## Date