Peak Orthopedic physical therapy
520 N. Prospect Ave., Suite 100 Redondo Beach, CA 90277 | (310) 376-9222 | Fax (310) 376-9888
31244 Rancho Palos Verdes Drive West, Suite 209, Rancho Palos Verdes, CA 90275 | (310) 544-7325 | Fax (310) 544-2625

PATIENT INFORMATION FORM

Please print legibly.

Name:		SS #:
Date of Birth:	Age:	Sex: □ M □ F
Home Address: _____		
City:	State:	Zip Code:
Home Phone:		Cell Number:
Email Address:		

Employer Information (Only for patients with a Workman's Compensation Claim)

Employer Name:	Phone #:
Address: _____	
City: State:	Zip Code:

Emergency Contact Information:

Name:		Relationship to Patient:
Cell #:	Home #:	Work #:

Financially Responsible Party If Not The Patient:

Name:		Relationship to Patient:
Home Address: _____		
City:	State:	Zip Code:
Cell #:	Home #:	Work #:
Driver's License #:	SS #:	DOB:

Referral Information:

How did you hear about us?

□ Insurance □ Internet/Mailer □ Walk In □ Former Patient

□ Physician Name:_____

□ Family/Friend Name:_____

□ Other: _____

Peak Orthopedic physical therapy

Health History Questionnaire

Please provide us with the following background information to allow us to complete a thorough examination and formulate the best plan of care.

Name:	Date:

Reason for Visit

1. Please describe briefly what we will be treating today in Physical Therapy?

_____

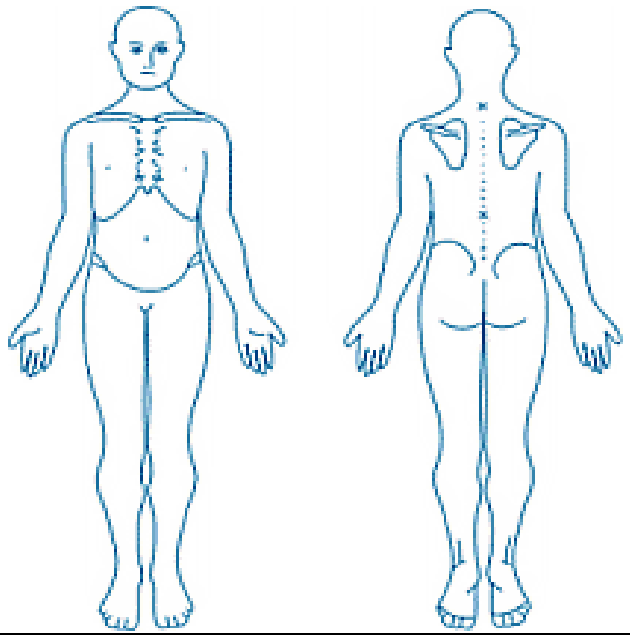
_____

2. Please mark the areas of discomfort on the diagram to the right.

XXX = Pain

000 = Numb/Tingle

//// = Weakness



3. Circle all the words that describe your discomfort.

Constant On/Off Dull Sharp Burning Radiating

Throbbing Cramping Numb Pins/Needles Other_____

4. What tests have you had for this injury?

TEST:	DATE/RESULT
□ X-rays	_____
□ MRI	_____
□ CT Scan	_____
□ EMG	_____
□ Other _____	_____

Current Review of Systems

5. Please check off any of the following symptoms that you are currently experiencing or have experienced in the last 3 months?

□ Fever/sweats	□ Night Pain	□ Fainting spells
□ Headaches	□ Vision changes	□ Dizziness
□ Bowel problems	□ Extreme fatigue	□ Nausea/Vomiting
□ Bladder problems	□ Shortness of breath	□ Numbness/Tingling
□ Tremors	□ Chest pains	□ Skin rash
□ Sexual dysfunction	□ Sudden weight loss	□ Difficulty swallowing
□ Weakness	□ Problems sleeping	□ Problems with balance/falls
□ Hearing problems	□ Difficulty breathing	□ Stress at home or work
□ Excessive bleeding/bruising	□ Joint/muscle swelling	□ Indigestion/heartburn

Medical History

Please check all illnesses or conditions that apply to you either presently or in the past.

□ Anemia	□ Glaucoma	□ Osteopenia
□ Ankylosing Spondylitis	□ Gout	□ Osteoporosis
□ Asthma	□ Guillain-Barre	□ Osteoarthritis
□ Bleeding/Blood Disorder	□ Headaches	□ Paralysis
□ Bone/Joint Infection	□ Hearing Loss	□ Parkinson's Disease
□ Cancer	□ Heart Attack	□ Pelvic Inflammatory Disease
□ Cataracts	□ Heart Disease	
□ Chronic Fatigue Syndrome	□ Hepatitis/Jaundice	□ Rheumatic Fever
□ Chronic Pain Syndrome	□ Hernia	□ Rheumatoid Arthritis
□ Colitis	□ HIV/AIDS	□ Shortness of Breath
□ Depression	□ Hypertension	□ Stroke
□ Diabetes	□ Kidney Disease	□ Thyroid Disease
□ Dizziness/Fainting	□ Kidney Stones	□ TMJ/ Jaw Problems
□ DVT/ Blood clot in legs	□ Liver Disease	□ Tuberculosis
□ Emotional/Mental Illness	□ Lupus	□ Ulcers
□ Emphysema	□ Lung Disease	□ Urinary/Bladder infection
□ Endometriosis	□ Multiple Sclerosis	□ Other: _____
□ Epilepsy/Seizures		_____
□ Fibromyalgia		_____

Allergies

Are you allergic to any of the following?

Tape	□ Yes □ No	
Latex	□ Yes □ No	
Medications	□ Yes □ No	Please list them:

Family History

Has anyone in your immediate family ever been treated for any of the following?

- □ Cancer
- □ Tuberculosis
- □ Stroke
- □ Depression
- □ Heart Disease
- □ Arthritis
- □ Mental Health Disorder
- □ Alcoholism
- □ Diabetes
- □ High Blood Pressure
- □ Kidney Disease
- □ Other:_____

_____

Surgical History

Please check off all of the following surgeries that you have had.

- □ Brain Surgery
- □ Heart Surgery
- □ Other surgery:
- □ Bone/Joint Surgery
- □ Other organ surgery

_____

_____

Current Medications

Please check off all medications that you have taken in the last month.

1. OVER THE COUNTER

- □ Antacids (ie. Tums, Rolaids, Pepsid, Zantac)
- □ Anti-inflammatory (ie. Advil, Motrin)
- □ Aspirin
- □ Decongestants/Antihistamines
- □ Herbal/Homeopathic Medications
- □ Laxatives
- □ Tylenol
- □ Vitamins
- □ Other Medications:

_____

_____

_____

_____

_____

2. PRESCRIBED BY A DOCTOR

- □ Antibiotics
- □ Anti-depressants (ie. Prozac, Zoloft)
- □ Anti-inflammatory (ie. Naproxyn, Relafen)
- □ Aspirin
- □ Asthma Medication
- □ Birth Control Pills
- □ Cholesterol Medication
- □ Decongestants/Antihistamines
- □ Diabetes Medication
- □ Heart Medication
- □ High Blood Pressure Medication
- □ Hormone Replacement Therapy
- □ Insulin
- □ Laxatives
- □ Muscle Relaxants (ie. Flexaril, Soma)
- □ Pain Relievers (ie. Percocet, Vicodin)
- □ Seizure Medication
- □ Thyroid Medication
- □ Tylenol
- □ Ulcer Medication
- □ Water Pills
- □ Other Medications: _____

Social History		
Do you exercise?	□ Yes □ No	Number of days in a week?
Do you consume caffeinated drinks?	□ Yes □ No	Number of cups per day?
Do you consume alcohol?	□ Yes □ No	Number of drinks per week?
Do you use tobacco products?	□ Yes □ No	Number of cigarettes per day? Frequency of e-cigarette use per day? Amount of chewing tobacco?

Over the last 2 weeks, how often have you been bothered by any of the following problems? Please circle only one number for each problem.

	Not at all	Several days	More days than not	Nearly every day
1. Feeling nervous, anxious, or on edge.	0	1	2	3
2. Not able to stop or control worrying.	0	1	2	3
3. Feeling down, depressed, or hopeless.	0	1	2	3
4. Little interest or pleasure in doing things.	0	1	2	3
5. The thought of harming myself has occurred to me. (circle one)	No		Yes	

Peak Orthopedic Physical Therapy Policies and Procedures

Thank you for choosing Peak Orthopedic Physical Therapy for your rehabilitation care. Your appointment schedule allots the appropriate time to work with our staff for your healing. In order to provide you with the quality of care we strive for, we ask that you follow the policies and procedures noted below:

- In order to avoid disruptions for other patients, **please arrive for your appointment on time.** Patients arriving **10 minutes** late may be asked to reschedule their appointment.
- If you need to **cancel your appointment**, please provide **at least 24 hour notice** whenever possible.
- Three consecutive **canceled** appointments (not canceled within 24 hours) will prevent a patient from booking future appointments in advance.
- "No Shows" for scheduled appointments may result in a $30 fee.

The above policies are needed to ensure that every patient receives the treatment and care they deserve to ensure a successful and speedy recovery.

Thank you for your cooperation.

Peak Orthopedic Physical Therapy

I,_____ , acknowledge that I have read the Peak Orthopedic

Physical Therapy Policies and Procedures.

_____ _____

Signature *Date*

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NOTICE OF PATIENT PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO INFORMATION. PLEASE REVIEW IT CAREFULLY.

Peak Orthopedic Physical Therapy **LEGAL DUTY**

Peak Orthopedic Physical Therapy is required by law to protect the privacy of your personal health information, provide this notice about our information practices, and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

Peak Orthopedic Physical Therapy use your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, Peak Orthopedic Physical Therapy may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

Peak Orthopedic Physical Therapy may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law.

In any other situation, Peak Orthopedic Physical Therapy's policy is to obtain your written authorization before disclosing your personal health information. If you provide us with written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

Peak Orthopedic Physical Therapy may change its policy at any time. When changes are made, a new Notice of Patient Privacy Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request an updated copy of our Notice of Patient Privacy Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. **Peak Orthopedic Physical Therapy** will consider all such requests on a case by case basis, but the practice is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that **Peak Orthopedic Physical Therapy** may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our practice manager at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on Peak Orthopedic Physical Therapy's health information practices or if you have a complaint, please contact the office administrator:

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Acknowledgement of Receipt of Patient Privacy Practices

I,_____, have received the Notice of Privacy Practices from Peak Orthopedic Physical Therapy.

X:_____ Date: _____

In lieu of patient signature, I,_____, a staff member of Peak Orthopedic Physical Therapy, state that _____ has been given our current Notice of Privacy Practices.

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