

**Pillsbury Physical Therapy
Medical History**

Name: _____

Date: _____

Gender: M/F

How many days a week do you exercise? _____

Age: _____

Past Surgical History (list & date): _____

Smoker: Yes/No

Current Medications:

Pregnant: Yes/No

Occupation: _____

Work Status (circle one): Employed Unemployed Student: Full-time/Part-time

Past Medical History: Please circle each condition that you have been told you have (or had).

Cancer	Kidney Disease	Liver Disease	Heart Disease
High Blood Pressure	Angina/Chest Pain	Ulcers	Fibromyalgia
Osteoarthritis	STD's	Lung Disease	Allergies/Asthma
Rheumatoid Arthritis	Diabetes	Stroke	Osteoporosis

Have you had a recent illness (if yes, explain)?

Do you take blood thinners? Yes/No

Are you allergic to latex? Yes/No

Do you have a pacemaker? Yes/No

Other:

Currently I am experiencing (circle all that apply):

Fever/chills/sweats	Poor balance (falls)	Unexplained weight loss	Numbness or Tingling
Changes in Appetite	Depression	Dizziness	Difficulty Swallowing
Shortness of Breath	Headaches	Nausea/Vomiting	Increased pain at night
Changes in bowel or bladder function			

How are you able to sleep at night?

Fine Moderate Difficulty Only with Medication

During the past month, have you often been bothered by feeling down, depressed, or hopeless? Yes No

During the past month, have you often been bothered by little interest or pleasure in doing things? Yes No

What date (approximate) did your present pain start? _____

How (gradually, suddenly, injury)?

My symptoms are currently (circle one):

Getting Better About the same Getting Worse

What treatments have you received for this problem so far? _____

What makes your symptoms better? _____

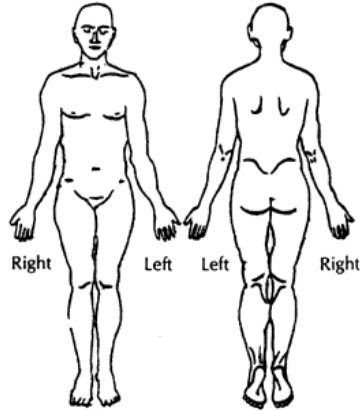
What makes your symptoms worse? _____

What are your personal goals for therapy at this time? _____

Have you had an x-ray, MRI, or other imaging study for this problem? Yes No

Thank You
for taking the time
to fill this out as thoroughly
and accurately as possible

Pillsbury Physical Therapy
Medical History



Body Chart:

Please mark the areas where you feel pain on the chart to the right.

On the scale below, please circle the number which best represents the average level of pain you have experienced over the last 48 hours:

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Worst Pain Imaginable**

Please circle the number below which best represents your overall average level of function:

Cannot do Anything 0 1 2 3 4 5 6 7 8 9 10 **Able to do Everything**

*Identify up to 3 important activities that you are unable to do or are having difficulty with as a result of your problem. List them below and circle the number which best represents your ability:

1.) _____

Unable to perform activity 0 1 2 3 4 5 6 7 8 9 10 Able to perform activity at same level as before injury

2.) _____

Unable to perform activity 0 1 2 3 4 5 6 7 8 9 10 Able to perform activity at same level as before injury

3.) _____

Unable to perform activity 0 1 2 3 4 5 6 7 8 9 10 Able to perform activity at same level as before injury

For Therapist:

Rating: _____

Rating: _____

Rating: _____

AVG: _____

NOTICE OF PRIVACY PRACTICES

(Effective April 14, 2003)

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.

USES AND DISCLOSURE OF YOUR MEDICAL INFORMATION

For Treatment: We may use medical information about you to provide you with medical treatment or services. **For Payment:** We may use and disclose medical information about you so that the treatment and services you receive at our practice may be billed to and payment may be collected from you, an insurance company, or a third party. **For Health Care Operations:** We may use and disclose health information about you for operations of our health care practice. **For Individuals Involved in Your Care or Payment for Your Care:** We may release medical information about you to a friend or family member who is involved in your medical care. **For Health-Related Services and Treatment Alternatives:** We may use and disclose health information to tell you about health-related services or recommend possible treatment options or alternatives that may be of interest to you. **As Required By Law:** We will disclose medical information about you when required to do so by federal, state, or local law. **To Avert a Serious Threat to Health or Safety:** We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. **For Military and Veterans:** If you are a member of the armed forces, we may release medical information about you as required by military command authorities. **For Worker's Compensation:** We may release medical information about you for workers' compensation or similar programs. **For Public Health Risks:** We may disclose medical information about you for public health activities. **For Health Oversight Activities:** We may disclose medical information to a health oversight agency for activities authorized by law. **For Lawsuits and Disputes:** If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. **For Law Enforcement:** We may release medical information if asked to do so by law enforcement officials. **For Coroners, Medical Examiners, and Funeral Directors:** We may release medical information to a coroner or medical examiner. **For National Security and Intelligence Activities:** We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law. **For Protective Services for the President and Others:** We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations. **For Inmates:** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official.

YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION

YOUR RIGHT TO INSPECT AND COPY: To inspect and copy of your medical information, you must submit your request in writing. We may deny your request to inspect and copy, in limited circumstances. If you are denied access to medical information, you may request in writing, that the denial be reviewed. **Your Right to Amend:** If you feel that medical information we have about you is incorrect or incomplete, you may request an amendment in writing. Your request may be denied if you do not include a reason to support the request. **Your Right to an Accounting of Disclosures:** You have the right to request in writing, a list accounting for any disclosures of your medical information we have made, except for uses and disclosures for treatment, payment, and health care operations, as previously described. **Your Right to Request Restrictions:** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. **We are not required to agree to your request.** **Your Right to Request Confidential Communications:** You have the right to request in writing that we communicate with you about medical matters in a certain way or at a certain location. **Your Right to a Paper Copy of This Notice:** You have the right to a paper copy of this notice at any time.

CHANGES TO THIS NOTICE: We reserve the right to change this notice, and will post the current notice in our facility.

COMPLAINTS: If you believe your privacy rights have been violated, you may file a complaint with the practice or with the Secretary of the Department of Health and Human Services.

OTHER USES OF MEDICAL INFORMATION: Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

By my signature below I acknowledge receipt of a copy of the Notice of Privacy Practices.

Patient or Personal Representative Signature

Date