Patient Health History

Name________________________________ Referring Provider__________________

Primary Care Physician ___________________ Date of Injury/Onset of symptoms___________

Date of last Physician's visit _______________ Date of next Physician visit_______________

Employer ______________________________ Occupation __________________________

Mechanism of injury or how accident/injury occurred________________ Work Related? Yes or No

Did you have surgery for this injury/accident? ________________ When? ___________________

Type of surgery ____

Medications____

Allergies____

Have you had physical therapy before for this injury/condition? ______________________________

What was done for treatment? ____

Have you had tests (please circle all that apply): XRAY, CTSCAN, MRI, OTHER ________________

What is your current Pain Level (1-10) scale (0=no pain, 10=Extreme pain)? ___________________

Do you currently have or have had a history of the following?

Condition		Condition	
CANCER	YES or NO	HIGH BLOOD PRESSURE	YES or NO
PACEMAKER	YES or NO	INCONTINENCE	YES or NO
ARTHRITIS	YES or NO	PELVIC PAIN	YES or NO
HEART DISEASE	YES or NO	BACK PAIN	YES or NO
HEART SURGERY	YES or NO	JOINT PROBLEMS	YES or NO
DIABETES	YES or NO	SEIZURES	YES or NO
HEADACHES	YES or NO	SHINGLES	YES or NO
SWELLING	YES or NO	CIRCULATION ISSUES	YES or NO
OSTEOPOROSIS	YES or NO	INFECTIONS	YES or NO
HERNIA	YES or NO	MULTIPLE SCLEROSIS	YES or NO
HEARING LOSS	YES or NO	PARKINSON'S DISEASE	YES or NO
HEAD INJURY	YES or NO	THYROID PROBLEMS	YES or NO
VISION LOSS	YES or NO	LIVER PROBLEMS	YES or NO
CONSTIPATION	YES or NO	KIDNEY PROBLEMS	YES or NO
ANXIETY	YES or NO	FRACTURES	YES or NO
WEIGHT LOSS	YES or NO	WEIGHT GAIN	YES or NO
WEAKNESS	YES or NO	DIFFICULTY SLEEPING	YES or NO
DEPRESSION	YES or NO	JOINT REPLACEMENT	YES or NO
TUBERCULOSIS	YES or NO	EMOTIONAL PROBLEMS	YES or NO
COLD SENSITIVITY	YES or NO	HEAT SENSITIVITY	YES or NO
NUMBNESS	YES or NO	SCIATICA	YES or NO

Are you or could you be pregnant? Yes or No

Do you have any other medical history, which may prohibit you from exercise or physical therapy?

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What are your goals for Physical Therapy? ____

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Patient Signature: ______________________________ Date: ____________________

Covid-19 Questionnaire

Please Check the **YES** or **NO** boxes.   Do not check both boxes.

Feel free to explain what a yes or no answer means in the Comment section.

1) Have you traveled outside the US in the past 30 days?   **YES** or **NO**

If YES, please list Countries you visited.

____

2) Have you been in close contact with an individual who has traveled outside of the US in the past 30 days?   **YES** or **NO**

If YES, please list the countries he/she has visited.

____

3) Have you been in closed contact, in the past 30 days, with an individual who has had either a Fever, Persistent Cough, Shortness of Breath?   **YES** or **NO**

IF YES, have the been diagnosed and/or seen a doctor? **YES** or **NO**

4) Have you had any of the following symptoms: Fever over 100.4 deg, Persistent Cough, Shortness of Breath.   **Yes** or **No**

If YES, how long have you had these symptoms. ______________
If YES, have you been diagnosed and/or seen a doctor? **Yes** or **No**

Thank you for assisting us in our endeavors to minimize exposure to the Coronavirus in 2021!

______________________________   ________________
Signature   Date

PRIVACY NOTICE

Welcome! We are pleased that you and/or your physician have chosen Stockwell Physical Therapy to provide you with your rehabilitation services. Please read the following information carefully regarding your privacy of medical information. 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. 164.520 (b)(i)(i) Stockwell Physical Therapy is required by law to protect the privacy of its patients regarding all health information.

Your protected health information may be released to your insurance provider and physician for purpose of receiving payment for services rendered. Additionally, information regarding your appointment time, presence at our facility, or other general details of your scheduled appointments may be provided over the phone to callers who request so by you providing their name. Otherwise, your protected health information may be released only after receiving written authorization from you with the exception of those situations listed above or for treatment, payment, or healthcare operations. You may revoke your permission to release protected health information at any time, except if Stockwell Physical Therapy was taken action in reliance of your authorization or consent to use or disclose the protected health information. The revocation must be in writing with effective date and be specific to the health information being protected. Stockwell Physical Therapy is not required to agree to your request.

You have the right to restrict the use of your protected health information. Stockwell Physical Therapy may choose to refuse your restriction if it is in conflict with providing you with quality healthcare or in the event of an emergency situation. Your protected health information may be released to public or law enforcement officials in the event of an investigation in which you are a victim of abuse, crime or domestic violence, unless as otherwise required by law. Your protected health information may be released to other healthcare providers in the event you need emergency care.

You have the right to review and photocopy any/all portions of your health information. Stockwell Physical Therapy has the right to assess a fee for the photocopying of the health information. You will be contacted by Stockwell Physical Therapy by mail, email, or phone to remind you of appointments and verify insurance/demographic information. A message may be left on an answering machine or automated answering device. You have the right to request a more confidential way of providing your protected health information or communication method at the time you are seen at Stockwell Physical Therapy.

You have the right to possess a copy of this Statement of Privacy upon request. This copy can be in the form of an electronic transmission or paper. You have the right to complain to Stockwell Physical Therapy if you believe your rights to privacy have been violated. If you feel your privacy rights have been violated, please mail your written complaint to Stockwell Physical Therapy, Attn: Patient Information Privacy Officer, 54 Park Ave Plaza (PO Box 819) Contoocook, NH 03229-0819, or to the Secretary of the U.S. Department of Health and Human Services, Office of Civil Rights (1-800-368-1019) JFK Building – Room 1875, Boston, MA 02203 (617-565-1340). All complaints will be investigated. No personal issue will be raised for filing a complaint. Stockwell Physical Therapy will abide by the terms of this notice.

CONSENT TO TREAT AND AUTHORIZATION TO RELEASE INFORMATION

I consent to evaluation and treatment by Stockwell Physical Therapy, LLC and realize that I have the right to refuse any procedure after having the risks and benefits explained to me. I authorize the release of protected health and other medical information in the course of my treatment, including, but not limited to, medical records, electronic media, and oral communications, to my insurance company, employer, primary care physician, referring physician, and/or other third party payor. I understand that if my account becomes delinquent, my billing records may be forwarded along to collections and/or relatives in order to obtain payment.

I understand phone messages regarding my appointments or care may be left on a machine at the phone numbers I have provided. I have read and understand my rights and responsibilities as a patient. If you are under the age of 18, a parent or guardian must sign below to authorize consent for evaluation and treatment. **We ask that you give us 24 hours advance notice if you need to cancel or reschedule your visit, as another patient may be able to take that appointment.**

________________________________ ________________________

Patient's Signature Date

________________________________ _________ ____________

Signature of Responsible Party Relationship Date