ACKNOWLEDGEMENT OF NOTIFICATION OF PRIVACY PRACTICES

Your protected health information will be used by Chittenango Physical Therapy or disclosed to others only for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

Prior to signing this form, you may review the full Notification of Privacy Practices for a more detailed description of how your protected health information may be used or disclosed.

I have been notified of the Privacy Practices for Chittenango Physical Therapy.

____
Name of Patient (Print or Type)

____
Signature of Patient

____
Date

____

Signature of Patient Representative:____
(Required if the patient is a minor or an adult who is unable to sign this form)

____
Relationship of Patient Representative to Patient

CHITTENANGO PHYSICAL THERAPY

Name: ____ Date Of Birth: _______/______/______

SS Number: __________________________________

Address: ____

City State Zip

Best Phone Number: ________________________ Alternate Phone Number: _________________________

E-Mail Address (Optional): ____

Emergency Contact: ______________________________ Contact Phone Number: ______________________

Referring Doctor: ____

Primary Insurance: ____________________________ Secondary Insurance: ____________________________
(Please present your insurance card(s) to the receptionist - thank you!)

Where did you hear about Chittenango Physical Therapy? Family/friend Print Ad Doctor Website
Online Search Yellow pages Insurance Radio Other: ____

DESIGNATED INDIVIDUALS AUTHORIZATION

I hereby authorize one or all of the designated parties below to request and receive any of my protected health information regarding treatment, payment or administrative operations. I understand that the identity of these designated parties will be verified before the release of any information.

Authorized Designees:

Name: ____________________________________ Relationship: __________________________

Name: ____________________________________ Relationship: __________________________

Name: ____________________________________ Relationship: __________________________

Name: ____________________________________ Relationship: __________________________

Name: ____________________________________ Relationship: __________________________

Name: ____________________________________ Relationship: __________________________

____
Patient Signature

____
Date

Name: __________________________ Date: ____________ Next Doctor's Visit: ____________

Briefly describe your current injury/symptoms:____
____

Date of onset and cause of injury/symptoms:____
____

Overall your symptoms have been… (circle one) improving worsening staying the same

Have you recently experienced any numbness, tingling, altered sensation anywhere in your body? YES or NO
If YES, where? ____

What makes your symptoms worse?____
What makes your symptoms better?____

Have you ever experienced these symptoms before? YES or NO If YES, when? _____________________________________

Approximate amount of time you can tolerate: sitting_________ standing ________ walking________

What treatments, if any, have you received in the past for your current injury? ____

Circle any of the following which you have had recently: X-ray MRI CT Scan Bone Scan DXA Scan Ultrasound
What were the results? ____

List any medications you are currently using and **for what purpose** (or provide the front office with a list of medications to photo copy):
____
____

Are you currently working; what is your occupation? ____
Briefly describe your occupational demands: ____

List any orthotics/brace/assistive device you currently use: ____

Circle any of the medical conditions that apply to you**:**

Allergies	**GI disorder**	**Neuropathy**	**Skin Disease**
Alzheimer's	**Headaches**	**Osteoarthritis**	**Stroke**
Anemia	**Heart Problems**	**Osteoporosis**	**Tuberculosis**
Back Disorder	**Hemophilia**	**Pacemaker**	**Ulcer**
Cancer	**High Blood Pressure**	**Parkinson's**	**Double Vision**
Circulatory problems	**Kidney Problems**	**Pinched Nerve**	**Nerve Disorder**
COPD	**Liver Problems**	**Pregnancy**	**Sciatica**
Diabetes	**Metal Implants**	**Psychological disorder (Depression, Anxiety)**	
Dizziness	**Multiple Sclerosis**	**Rheumatoid Arthritis**	

Other medical conditions/disorders: ____
List any major surgeries and date: ____

Currently I am experiencing (circle all that apply):
Fever/chills/sweats **Poor Balance (falls)** **Unexplained weight loss** **Changes in appetite** **Nausea/Vomiting**
Difficulty Swallowing **Changes in Bowel/Bladder Function** **Increased Pain at Night** **Shortness of Breath**

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

Do you participate in any form of exercise on a regular basis: YES or NO What kind? ____________________________________
What activities do you wish to resume (ie hobbies, home activities, sports, etc.)?
____