



1111 Raintree Circle, Suite 150
Allen, TX 75013
Phone 214-509-0029
Fax 214-509-0070

Please fill these forms out completely and bring them to your first office visit.

Additional Items to Bring to Your First Visit:

- Prescription for physical therapy from your referring physician
- Government issued, photo ID (such as a driver's license)
- Insurance card(s)
- Appropriate attire (workout clothes)
- Patients who are minors (under 18 years of age) must be accompanied by a parent or guardian for their first visit

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, have received the Notice of Privacy Practices from Allen Sports & SpineCare, L.L.P.

Patient Signature

Date

In lieu of patient signature, I, _____, a staff member of Allen Sports & SpineCare, L.L.P. state that _____ has been given our current Notice of Privacy Practices.

Staff Member Signature

Date

NOTICE OF PRIVACY PRACTICES

Allen Sports & SpineCare, L.L.P.

Effective Date: April 14, 2003

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

OUR PLEDGE REGARDING HEALTH INFORMATION:

We understand that health information about you and your health care is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this health care practice, whether made by your personal physical therapist or others working in this office. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information.

We are required by law to:

- ◆ Make sure that health information that identifies you is kept private;
- ◆ Give you this notice of our legal duties and privacy practices with respect to health information about you;
- ◆ Follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU.

The following categories describe different ways that we use and disclose health information. By coming for care, you give us the right to use your information for treatment, to get reimbursed for your care, and to operate our organization. There are also various other ways in which we may use or disclose your information:

- ◆ To allow oversight of the quality of the healthcare we provide;
- ◆ To allow workers' compensation claims;
- ◆ As required by subpoena in lawsuits and disputes;
- ◆ Various uses as required by law or to avert a serious threat to health or safety.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU.

You have the following rights regarding health information we maintain about you:

- ◆ Right to inspect and copy;
- ◆ Right to amend;
- ◆ Right to an accounting of disclosures;
- ◆ Right to request restrictions;
- ◆ Right to request confidential communications;
- ◆ Right to a copy of this notice.

Information on how to exercise these rights can be seen in the Notice of Privacy Practices.

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in our facility. The notice will contain the effective date on the first page. In addition, each time you register for treatment or health care services, we will offer you a copy of the current notice in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, contact Craig Rettke, PT, Compliance Officer. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

OTHER USES OF HEALTH INFORMATION.

Other uses and disclosures of health 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 health 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 health 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.

INITIAL SELF-EVALUATION

Please take a moment to fill out ALL the following questions as accurately and truthfully as you are able. This information will greatly improve my ability to understand your problems. If you need assistance with any part please contact the front desk.

Patient Name: _____ **Age:** _____ **Sex:** M / F **Date:** _____

Chief Complaint: _____

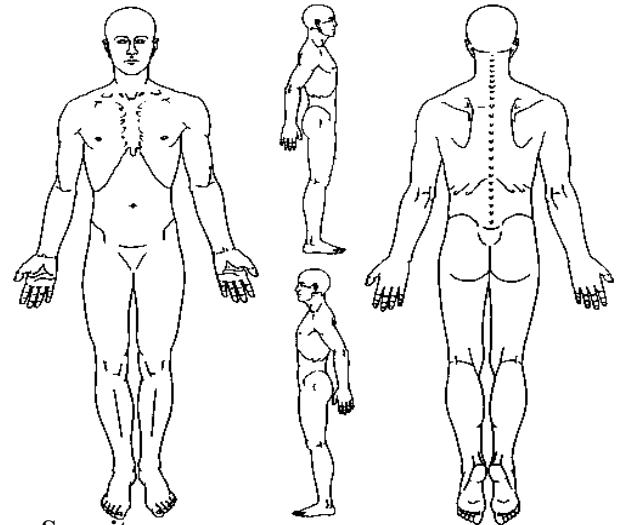
Please use the diagrams to tell me about your symptoms.
 Feel free to include more than one region or description
 (for multiple regions – please number 1,2,3 etc.).

- | | | |
|--------------------------------------|--------------------------------------|------------------------------------|
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Dull | <input type="checkbox"/> Ache |
| <input type="checkbox"/> Stabbing | <input type="checkbox"/> Numb/Tingle | <input type="checkbox"/> Burning |
| <input type="checkbox"/> Weakness | <input type="checkbox"/> Stiffness | <input type="checkbox"/> Radiating |
| <input type="checkbox"/> Other _____ | | |

Please list each symptom area above, and rate it on the scale provided.
 (0 = No pain, 5 = moderately severe, 10 = Most severe (going to ER)).

Symptoms

- 1 _____
 2 _____
 3 _____



Severity

- | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|----|
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

Date of injury / onset: _____ days / week(s) / month(s) ago

Date of surgery: _____ days / week(s) / month(s) ago

What caused pain / injury: _____

Are your symptoms getting: better / worse / staying the same

It hurts when I do: _____

It feels better when I do: _____

How much do your symptoms interfere with your activities?

Daily Activities of Living:

- None (0%) Rarely (25%) Often (50%) Most of the time (75%) Always(100%)

Extra-Curricular:

- None (0%) Rarely (25%) Often (50%) Most of the time (75%) Always(100%)

Are you currently working? Yes / No
Date to return to work: _____

Full time / Part time Hours per week: _____
Restrictions _____

Job Description/ Demands: _____

Diagnostic Tests: X-Ray / MRI / Bone Scan / CT Scan Results: _____

Medications for THIS problem: _____

Effect of current medications: Better / Worse / No Change: _____

Previous Treatment for THIS condition: _____

Have you had any injections for THIS problem: Yes / No Date: _____

Do you have any follow up testing/injection scheduled? Yes / No If yes, what & when: _____

Date of your next scheduled follow up with your doctor who sent you to therapy? _____

PAST MEDICAL HISTORY:

Have you had or do you now have any of the following: (Please Circle ALL that apply).

- | | | | | |
|--|--|--|--|--|
| <input type="checkbox"/> Diabetes / Neuropathy | <input type="checkbox"/> Frequent Fall/s | <input type="checkbox"/> Seizures | <input type="checkbox"/> Dizziness | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Stroke | <input type="checkbox"/> Cancer | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Smoker - Pacs/day _____ | <input type="checkbox"/> Osteoporosis /penia | |
| <input type="checkbox"/> Infectious Disease | <input type="checkbox"/> Shortness of breath and/or chest pain | <input type="checkbox"/> Depression / Anxiety | | |
| <input type="checkbox"/> Surgeries: _____ | | | | |
| Other _____ | | | | |

Do you have an advanced directive on file? Yes / No

Please list ALL medications you are currently taking (include Prescriptions, Supplements, Herbals and Over the Counter Medications) INCLUDING Dosage: May attach list _____

Have you ever had Physical Therapy or other body work *prior to this occasion*? Yes / No
If yes, explain _____

Are you currently receiving ANY Home Health Care benefits? Yes / No

Rehabilitation Goals: I would feel better if/when _____

How did you hear about us: MD referral / internet / insurance co. / personal referral _____

Thank you for taking time to tell me about your symptoms. I look forward to discussing your symptoms with you.

Patient Signature

Date

DO NOT write below this line.

Special Questions:

Bowel / Bladder Retention Yes / No Leg / feet paresthesia Yes / No Night Pain Yes / No
Unexplained Fever/Chills/Night Sweats Yes / No

Seeing / Seen other medical professionals: _____

Height: _____ Weight: _____ lbs. BMI: _____

Fall Risk? Y / N Frequency of falls _____ x week/month/year

Context & characteristics of falls: _____

Diabetic? Y / N Eligible Y / N 18-64 >65y/o

Other: _____

Reviewed by Therapist

Date

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