

## 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:

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

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.)?  
\_\_\_\_\_