N-Balance Physical Therapy
203 N. Alamo Rd. Rockwall, Texas 75087
972 722-1212

Patient History Information

Patient Name: _____ Date: _____

Height: _____ ft _____in. Weight: _____lbs.

1. What is your chief complaint? Why are you seeking physical therapy treatment?

   _____

   _____

2. Explain how and when your injury/symptoms occurred: _____

   _____

3. Have you had this problem or anything like this before? Y/N. If yes, explain

   _____

4. What activities make your pain worse? _____

   When is your pain worse (i.e. morning, night) _____

   What activities are limited due to pain? _____

5. Have you had any diagnostic test for this current problem?
   X-ray date/results: _____
   MRI date/results: _____
   Other test: _____

6. (a) On a scale of 0-10, with 0 being no pain at all and 10 being the worst pain imaginable, how would you rate your pain RIGHT NOW?

   No pain _____Worst pain imaginable
   0 1 2 3 4 5 6 7 8 9 10

   (b) On the same scale, how would you rate your USUAL level of pain during the last week?

   No pain _____Worst pain imaginable
   0 1 2 3 4 5 6 7 8 9 10

   (c) On the same scale, how would you rate your BEST level of pain during the last week?

   No pain _____Worst pain imaginable
   0 1 2 3 4 5 6 7 8 9 10

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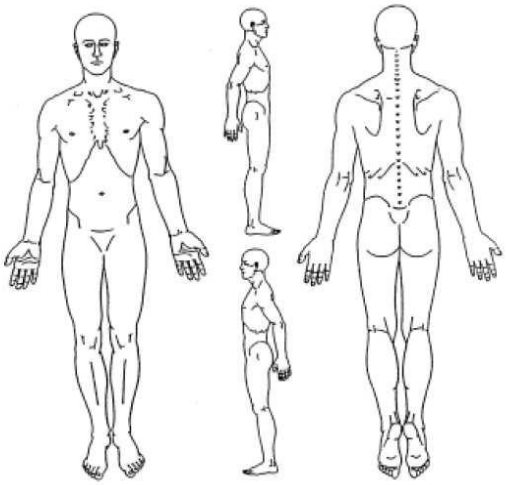
(d) On the same scale, how would you rate your WORST level of pain during the last week?

No pain _____Worst pain imaginable
0 1 2 3 4 5 6 7 8 9 10

7. Please shade all areas of pain/discomfort. Describe any areas of abnormal sensations. (such as tingling, numbness, sharp, shooting, aching, stabbing)



9. How is your general health? Good ____ *Fair ____ *Poor ____
*fair or poor please explain: _____

_____

10. Do you participate in 2 ½ hours (150 minutes) of moderate-intensity aerobic physical activity EACH WEEK? Yes No

11. Do you work? Y/N
If yes, what type of work do you do: _____

What are the physical requirements of your job? _____

_____

Are you able to perform your job without difficulty and/or pain? Y/N

If no, please explain: _____

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12. Please check any of the following health conditions that apply to you:

Autoimmune Disease
____ Hepatitis
____ HIV
____ Lupus
____ Diabetes Type I
____ Hypothyroidism
____ Hyperthyroidism
____ Inflammatory Bowel Disease (Crohn's)
____ Multiple Sclerosis

Cardiovascular
____ High Blood Pressure
____ Heart Disease
____ Heart Attack
____ Peripheral Vascular Disease (PVD)

Endocrine System
____ Diabetes Type II

Musculoskeletal
____ Osteoarthritis
____ Fibromyalgia
____ Osteoporosis

Gastrointestinal Disease
____ Reflux
____ GERDs
____ Peptic Ulcer

Neurological
____ Stroke or TIA
____ Parkinson Disease
____Chronic Headaches/Migraines

Pulmonary
____ Asthma
____ COPD

Psychology
____ Depression
____ Anxiety
____ Panic Disorder

Sensory
____ Hearing Impairment
____ Visual Impairments
____ Balance Problems (Vertigo, Dizziness

Current or history of Cancer:
Location: _____
Date: _____

Other health conditions: _____
_____
_____

FEMALE ONLY
____ Menopausal Age ____
____ Hysterectomy Year ____, Partial ____, Complete ____
____ Incontinence: Stress Incontinence, Urge Incontinence, Mixed Incontinence
____ Pregnancy(s) Number ____, Births ____, C- Section(s) ____, Vaginal birth(s) ____
____ Breast augmentation or reduction
____ Tummy Tuck
____ Other _____

MALE ONLY
____ Prostate problems
____ Other _____

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13. Please check **SURGERIES** and the date of the surgery.

SPINE

Cervical spine Date _____ Type _____
Lumbar spine Date _____ Type _____

EXTREMITIES

Hip	Right/Left	Date _____	Type _____
Knee	Right/Left	Date _____	Type _____
Leg/Ankle	Right/Left	Date _____	Type _____
Shoulder	Right/Left	Date _____	Type _____
Arm/wrist	Right/Left	Date _____	Type _____

GENERAL

Gall Bladder (cholecystectomy)	Date: _____
Heart Pace maker	Date: _____
Heart Stent	Date: _____
Heart Bypass	Date: _____
Hernia	Date: _____
Other _____	Date: _____

14. Are there any other health conditions that we need to be aware of that will affect your rehabilitation?_____
_____

15, List all present medications you are taking: _____
_____

16. What is your outcome goal with Physical Therapy? Decreasing and/or eliminating pain is always a goal. Please make your goal functional, an activity that pain is preventing or limiting you in participating or performing.

_____

_____

_____

N-BALANCE PHYSICAL THERAPY

NOTICE OF PRIVACY PRACTICE

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 DISCLOSURES OF THE PHI (PERSONAL HEALTH INFORMATION)

- N-Balance Physical Therapy (NBPT) is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.
- NBPT uses your personal health information for treatment, obtaining payment for treatment, conducting internal administrative activities and evaluating the quality of care that we have provided.
- NBPT may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.
- NBPT may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for emergencies, and when required by law.
- It is NBPT's policy to obtain your written authorization before disclosing your personal health information.
- NBPT's policy is to allow access to PHI on a "need to know basis" such as needed for treatment delivery, healthcare operations and related billing services.
- PHI includes, but not limited to, the patient/client's name, address, date of birth, age, gender, phone number, email, SS#, employer information, diagnosis, prognosis, past medical history, treatment, and billing records.

PATIENT/CLIENT'S RIGHTS

- If you have provided us with written authorization to release your information, you may later revoke that authorization to stop future disclosures, this must be in writing.
- When paying for services out of pocket (fee for service, not filing with your insurance) you may request in writing to restrict disclosure of your PHI to any health plans.
- You have the right to review or obtain a copy of your PHI. There may be a nominal fee for copying of your records.
- You have the right to request that we correct any inaccurate or incomplete information in your records.
- You have the right to request a list of instance where we have disclosed your PHI for reasons other than treatment, payment or other related administrative purpose.
- Expect that his/her PHI will be handled, secured or disposed of in full compliance with federal privacy regulations. Has the right to see our policy and procedures we have in place for PHI protection.

PATIENT/CLIENT'S RESPONSIBILTIY

- Provide the proper picture ID at the initial visit, if no photo ID, have 2 forms of identification. If minor (under age 18), the picture of the parent of guardian must be presented.
- Give complete and accurate information and demographics.
- Adhere to department guidelines while at this facility including, but not limited to courteous interaction with other patients/clients and staff members. Do not ask about the health, condition, or progress of other patients/clients.
- Do not come to therapy while under the influence of alcohol or illegal drugs.

CONCERNS AND COMPLAINTS

If you have any concerns, or feel your PHI have been compromised please contact the Privacy Officer of NBPT at (972)722-1212. It is the practice and commitment of all employees and agents of NBPT to respect and ensure the legal, ethical and moral rights of the patients/clients it serves.

_____ _____

Patient/Client Signature Date

_____

Patient/Client Printed Name

Revised Jan 2017

Patient Name: _____

N-BALANCE PHYSICAL THERAPY
AUTHORIZATION FOR RELEASE OF INFORMATION

I. Who to Contact

I hereby give permission to N-Balance Physical Therapy to disclose and discuss any information related to my medical condition(s) to/with the following family member(s), other relative(s) and/or close personal friend(s):

_____ _____
Name Relationship

_____ _____
Name Relationship

_____I do not wish to give permission for additional family members, relatives or close personal friends to have access to any information regarding my medical condition(s).

II. **How to Contact** - Check **ALL** that apply

I wish to be contacted in the following manner:

Telephone

Home Phone: □ OK to leave message with detailed information □ Leave message with call-back number only

Cell Phone: □ OK to leave message with detailed information □ Leave message with call-back number only

Work Phone: □ OK to leave message with detailed information □ Leave message with call-back number only

TEXT Messages

□ OK to TEXT appointment reminders to this Mobile/Cellular Number _____

Written Communication

□ OK to send e-mail messages Email _____

□ OK to mail to my home address Address_____

□ OK to mail to my work/office address Address_____

III. **In case of an emergency contact:**

_____ _____ _____
Name Relationship Phone Number

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that requests for medical information from persons not listed above will require a specific authorization prior to the disclosure of any medical information.

_____ _____
Signature of Patient or Legal Representative Date