



NEW PATIENT ORIENTATION

- Welcome to Nexus Physical Therapy. Your doctor has prescribed Physical Therapy for you condition. It is important that you understand what to expect from your treatment and what you can do to improve your chances for a successful outcome.
- Your first visit will consist of an evaluation to enable us to design a treatment program for you condition. We will explain what our evaluation findings are and review the recommended treatment program for you.
- **PLEASE KEEP ALL SCHEDULED APPOINTMENTS BECAUSE YOUR TREATMENT PROGRAM WILL BE PROGRESSIVE. MISSED APPOINTMENTS MAY REDUCE A SUCCESSFUL RECOVERY.**
- **MISSED APPOINTMENTS WITHOUT 24 HOURS NOTICE WILL RESULT IN A LATE CANCELLATION FEE OF \$20.00.** Please allow us enough time to schedule another patient in your absence.
- Please sign your name on the sign-in sheet located at the front desk upon arrival.
- Please let us know of all of your upcoming doctor appointments during your treatment here so that we may write the appropriate reports to your referring doctor to update them on your condition.
- During your treatment program you will be given exercises to do at home. It is very important that you follow these recommendations because without your participation, your recovery may be limited.
- Please wear loose-fit, appropriate clothing for your injury allowing easy access to the body part(s) affected. For example, if you have a low back problem, please avoid tight jeans. If you have a knee problem, bring or wear shorts. If you have a shoulder problem, please wear a t-shirt.

I, the undersigned, have read and understand the above information.

Patient signature

Date

MEDICAL HISTORY FORM

Name: _____ DOB: _____ Age: _____

Email Contact: _____

Social Security Number: _____ Occupation: _____

Referring Physician: _____ Next doctor's Appointment: _____

What is your condition/injury? _____

Date of injury/onset: _____ Date of surgery, if any: _____

What happened? _____

What treatment was given? _____

Have you had the problem(s) before? Yes No

Please list any medications you are currently taking:
(prescription) _____

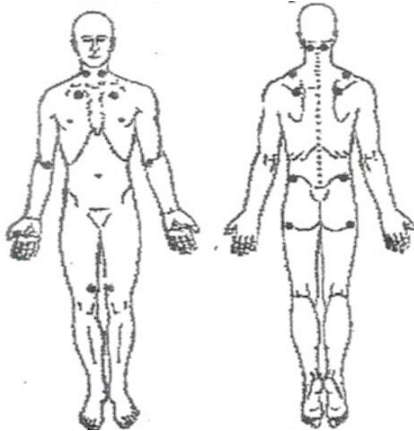
(non-prescription i.e. herbs, supplements) _____

Have you had any tests for this problem? X-Ray MRI EMG C.T. Scan Other: _____

Are you presently receiving any other medical or health services? Chiropractor Acupuncture Other: _____

Please shade area of pain

What does the pain feel like?



- | | | | |
|------------------------------------|---|-----------------------------------|---------------------------------------|
| <input type="checkbox"/> Aching | <input type="checkbox"/> Pinching | <input type="checkbox"/> Pulsing | <input type="checkbox"/> Tender |
| <input type="checkbox"/> Burning | <input type="checkbox"/> Pins & Needles | <input type="checkbox"/> Sharp | <input type="checkbox"/> Throbbing |
| <input type="checkbox"/> Deep | <input type="checkbox"/> Pricking | <input type="checkbox"/> Shooting | <input type="checkbox"/> Tight |
| <input type="checkbox"/> Dull | <input type="checkbox"/> Pounding | <input type="checkbox"/> Sore | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Knot-like | <input type="checkbox"/> Pressing | <input type="checkbox"/> Stabbing | |

What makes the pain worse? _____

What makes the pain better? _____

Rate your pain on a scale of 0 to 10, 0 being no pain/discomfort and 10 being the worst pain imaginable. Indicate by circling the appropriate number.

Pain at its least: 0 1 2 3 4 5 6 7 8 9 10

Pain at its worst: 0 1 2 3 4 5 6 7 8 9 10

Medical History (check all that you have ever had):

- | | | | |
|---|--|--|---------------------------------------|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Cancer | <input type="checkbox"/> Metal Implants | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Head Injury | <input type="checkbox"/> Muscular Dystrophy | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> Back Injury | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Broken Bones/Fractures | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Parkinson's Disease | |

Are you having any of these symptoms? (check all that apply)

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Numbness | <input type="checkbox"/> Visual Problems |
| <input type="checkbox"/> Coordination Problems | <input type="checkbox"/> Headaches | <input type="checkbox"/> Pain at Night | <input type="checkbox"/> Weakness |
| <input type="checkbox"/> Difficulty Sleeping | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Swelling | <input type="checkbox"/> Other: _____ |

Is it possible you are pregnant? Yes No

Have you had any physical therapy treatment before? Yes No When? _____ Where? _____

What type of treatment did you receive? _____

Patient Signature: _____

Date: _____

3.5.1C PATIENT PRIVACY NOTICE

THE FOLLOWING ABBREVIATED NOTICE BRIEFLY DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE UNUSED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

- **For Treatment:** We may use health information about you to provide you with health care treatment or services. We may disclose health information about you to personnel who are involved in taking care of you.
- **For Payment:** We may use and disclose health information about you so that the services you receive from us may be billed to insurance carriers and payment collected.
- **For Health Care Operations:** We may use and disclose health information about you for operations that are necessary to run our practice.
- **Threat to Health or Safety:** We may use and disclose health information about you when necessary to prevent a serious threat to you health and safety or the health and safety of the public or another person.
- **Military and Veterans:** If you are a member of the armed forces or separated/discharged from military services, we may release health information about you as required by military command authorities or the Department of Veterans Affairs.
- **Workers' Compensation:** We may release health information about you for workers compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.
- **Lawsuits and Disputes:** If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order, etc.
- **Law Enforcement:** We may release health information if asked to do so by a law enforcement official.

RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

- **Right to Inspect and Copy:** You have the right to inspect and copy health information that may be used to make decisions about your care.
- **Right to Amend:** If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information.
- **Right to an Accounting of Disclosures:** You have the right to request a list accounting for any disclosures of your health information we have made, except for uses and disclosures for treatment, payment, and health care operations, as previously described.
- **Right to Request Restrictions:** You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment, or health care operations.
- **Right to Request Confidential Communications:** You have the right to request that we communicate with you about health matters in a certain way or at a certain location.

I, the undersigned, have read and understand the above information.

Patient signature

Date