Physical Examination Patient Information Form (work related injury)

1) *Client Information:*

Title/Name: Mr-Mrs-Ms_____ Date:__/__/___ D.O.B.__/__/___

SSN#____-___-_____*Email: _____

What is your D.O.I. (Date Of Injury)__/__/___ Employer Name: _____

Employer Address:_____ City:_____ State:___ Zip:_____

Employer Phone: (____)_____ Insurance Company Name:_____

Treating Doctor's Name: _____ Check In Time: _____

4) *Intake Profile:*

National Origin: __Hispanic __Non-Hispanic: __African __ American Indian __Caucasian __ Asian __Pacific Island __East Indian __Other __Two or more

Mailing Address:_____ City:_____ State:___ Zip:_____

Contact Phone: (____)_____Name/number of emergency contact:_____(____)_____

Do you have an attorney representing your injury? __Yes __No

Symptoms:

Have you had any recent change or increased awareness in any of these conditions:
(Please circle any of the following that apply) – weight, fevers, vision, eye pain, trouble hearing, nose bleeds, sore throat, chest pain, palpitations, cough, shortness of breath, wheezing, nausea, vomiting, joint pain or swelling, headaches, seizures, changes in memory, weakness or sensory changes in the upper or lower extremities, skin rash, or excess thirst? Or No recent changes?
If yes, please describe/explain? _____
_____
_____

Difficulties with ADL (Activities of Daily Living):

Are you having difficulties with any of the "Activities of daily living" which means the ability to perform the following: (Please circle any of the following that apply)
A. Self cares: urinating (urgency, can't hold it, painful, large volume), defecating (change in bowel movements, can't hold it, or can't go), brush teeth, comb hair, bathe, dressing oneself, and/or eating;
B. Communication: writing, seeing, hearing, and/or speaking;
C. Normal living postures: sitting, lying down, reaching, bending, leaning and/or standing;
D. Physical Activity: walking, climbing stairs, carrying, lifting, pushing, pulling, climbing, exercising;
E. Sensory Function: hearing, seeing, smelling, taste, touch;
F. Hand Function: holding, pinching, writing, grasping and tactile discrimination;
G. Travel: driving, riding, travel by air or train;
H. Sexual function: participating in usual sexual activity;
I. Sleep: ability to have restful sleep pattern; and
J. Social and recreational activities: ability to participate in group activities, ability to participate in sports.

Are you able to do most of these activities, but with pain? _Y_N

Hobbies/Interests:
*(P)*Please list any hobby(s) you currently have (such as reading, rock climbing, bowling, etc):
_____

Are you able to do most of these hobbies, but with pain? _Y_N

Substance Use (tobacco, alcohol, etc.):
*Tobacco: Do you smoke?_Y_N - How much? _>1/2 pack/day_1 pack/day_ 2 packs/day _3+
For how long? __ - If you quit what year? _____

*Alcohol: Do you drink alcoholic beverages?_Y_N – How many per week? _0-3_4-7_8-14_15+

Select any description of your drinking alcohol: __ Social drinker

How did you get to this appointment? __Drove self __Brought by friend/family __ Bus __ Cab/Uber __Other

CASE INFORMATION – *Injury/Illness Information:*
Describe how and where you got injured or became ill. (complete sentences):_____
_____
_____
_____
_____

When did you report the injury/illness? _immediately _Same Day _ Next Day _ Same Week
_Following Week _ Following Month _ Other:_____ Whom did you inform?:_____

Did you continue working after your illness? _Y_N For How Long? _____

Did you have to go to the ER? __Yes __No When was your first doctors visit? __/__/___

Which state did the injury occur in? _____

Describe the pain of your injury/illness:_____
_____
_____

What helps decrease the pain?:_____

What makes the pain worse?: _____

What is your occupation/job title (at the time of the injury)? _____

Is the insurance company paying for your current condition? __Yes __No

EMPLOYMENT INFORMATION – *Employment Information:*
*Have you ever missed work due to your injury? __Yes __No If so what date did it start?__/__/___

If you have returned to work, select the most accurate statement: __Same job same employer

__ - Same job new employer __Different job same employer__ Different job new employer

Are you currently working? __Yes __No Part time _Y_N - Full time _Y_N –With Restrictions _Y_N

When did you return to work?_/__/__ Or Are you retired __Yes __No Date you retired? __/__/___

MEDICAL INFORMATION – *Medical Conditions (evaluee):*

*PAST Medical History:_ Heart Disease _High Blood Pressure _ Stroke _Diabetes (the sugars) _Liver Disease _Kidney _Lung Disease _Eye Disease _Arthritis _Cancer _Bowel Dysfunction _Bladder Dysfunction _Blood Disorders _Other:_____

*CURRENT Medical History:_ Heart Disease _High Blood Pressure _ Stroke _Diabetes (the sugars) _Liver Disease _Kidney _Lung Disease _Eye Disease _Arthritis _Cancer _Bowel Dysfunction _Bladder Dysfunction _Blood Disorders _Other:_____

*Surgical History Related to This Current Injury: _Hernia _Fracture Repair _Neck _Back _Shoulder _ Elbow _Wrist _ Hip _Knee _Ankle_ Toes _Other:_____

Dates of related Surgical Interventions: _____

*Surgical History NOT Related to This Current Injury: _Hernia _Fracture Repair _Neck _Back _Shoulder _ Elbow _Wrist _ Hip _Knee _Ankle_ Toes _Other:_____

Dates of unrelated Surgical Interventions: _____

*Have you had any previous work related injuries? __Yes __ No If yes, please explain: _____
_____

*Have you ever been injured on this job or another before that is not related to this injury ___Yes ___No
If yes, please describe/explain? _____

*Have you ever been injured in the same area prior to this injury? ___Yes ___No
If yes, please describe/explain? _____

What are the areas of your current injury?_____

Are you currently suffering from another injury right now? ___Yes ___No
If yes, please describe/explain? _____

Have you had any injections for your injury ___ Yes ___ No
If yes, how many?____ Where on your body did you get an injection?_____ _____

Did it/they help? _Y _N If they did help, for how long?

Have you ever had physical therapy or a functional restoration program before? ___Yes ___No
If yes, please describe/explain? _____

Are you in therapy for this injury now? ___Yes ___No

When was your last office visit? __/__/___ When did you last receive treatment for this injury?__/__/___

What diagnostics have you had? _X-ray _MRI _EMG _CT _Doppler_ Ultrasound, other:_____

Please fill out your current medication prescription (or provide a printed list):

Medication/Dosage	**Date filled**	**Quantity**	**Usage**	**Purpose**	**Rx Doctor Phone**	**Pharmacy Ph. #**
Example Darvocet N100/ 1 po prn q 4h pain	7-04-11	100 Tabs 0 refill	1 po QID	Pain relief	Dr. Smith	

*Are you taking any over the counter medicine? ___Yes ___No
If yes, please describe: _____

Are you allergic to any medications? ___Yes ___No
If yes, what?_____

Are you allergic to anything besides medicine? ___Yes ___No
If yes, what?_____

Medical Conditions (maternal/mother and/or paternal/father):

Do you have any illnesses that run in your family on your mother and/or fathers side? ___Yes ___No
If yes, what? _ cancer _ diabetes _high blood pressure _ cardiac disease _ Other:_____

The purpose of this evaluation is for examination only – not for treatment.

If you have any questions or comments regarding the examination, please ask the doctor at any time.

6) *Physical Information:*

Age:____ Gender:__Male __Female Describe height: ___ weight: ___lbs You are: ___ right ___ left handed

Supportive Device:

Do you have or use a brace of any kind for your injury? ___Yes ___No

If yes, please describe what type of brace: _____

Where do you wear it:_____ For how long: _____

Patient's Signature:_____ Date:__/__/__

Evaluator's Signature:_____ Date:__/__/__

HIPAA Notice of Privacy Practices

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!

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. AProtected health information@ is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician=s practice, and any other use required by law.

Treatment
We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment
Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations
We may use or disclose, as needed, your protected health information in order to support the business activities of you physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical/chiropractic students, licensing, marketing and fund-raising activities, dictation and transcription, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical/chiropractic students that see patients at our office. In addition, we may use a sign-in-sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners: Funeral Director, and Organ Donor Research: Criminal Activity: Military Activity and National Security: Workers= Compensation: inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164-500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law. **You may revoke this authorization** , at any time, in writing, except to the extent that your physician or the physician=s practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment, or healthcare operations. You may also disclose request that any part of your personal health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Protection. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or to an alternative location. You have the right to obtain a paper copy of this notice from us upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone.

Signature below is only acknowledgment that you have received this Notice of our Privacy Practices:

Observer Name: _____ Signature: _____ Date: __/__/__

Release Of Information Consent Form

I give permission to the testing center to release information, verbal or written, contained in my medical record, and other related information, to my doctor, insurance company, rehab nurse, case manager, and employers. Information released without patient identifiers may be used for quality assurance purposes. Dictation Services may be used for reporting purposes.

I have read and hereby understand the above release.

_____ __/__/__

Client or Guardian Signature Date

*This release is good for 90 days from the date initially signed and for any evaluation performed by this facility.