TUCSON ORTHOPAEDIC INSTITUTE PHYSICAL THERAPY PATIENT QUESTIONNAIRE AND PAST MEDICAL HISTORY

Name: ______________________________ Date of Birth: ____________ Account: _____________

How did your problem begin?

____ Motor vehicle accident
____ Unknown cause
____ Sports/training injury
____ Work-related injury
____ Post surgical
____ Chronic illness/condition
____ Other: ____

Have you received previous treatment for this condition?

____ Yes Describe: ____
____ No

Recent tests (past 3 months):

____ X-ray ____ CT Scan ____ MRI ____ EMG ____ Bone Scan ____ Blood Tests ____ Other

Have you ever been diagnosed as having any of the following conditions? (check all that apply)

____ Anemia
Arthritis: ____ Rheumatoid ____ Other Arthritis
____ Asthma
____ Cancer
____ Chemical Dependency
____ Depression
____ Diabetes
____ Emphysema
____ Epilepsy or Seizures
____ Fibromyalgia
____ Heart Disease or other Cardiac Problems
____ Heart Attack
____ Hepatitis
____ High Blood Pressure
____ Tuberculosis
____ Infection (current only please)
____ Kidney Disease
____ Liver Disease
____ Lupus
____ Multiple Sclerosis
____ Osteoporosis
____ Soft Tissue Infection, Rash
____ Stroke
____ Thyroid Problems
____ Temporomandibular joint problems

Other ____

Do you have a pacemaker? ____ Yes _____ No Metal implants? If yes, where? ____________________

If you have cancer, what type? ____

Please explain if you have any cardiac issues: ____

List any surgeries or conditions for which you have been hospitalized.

Approximate Date	Surgery/Reason for hospitalization
____________________	____
____________________	____
____________________	____

List any history of injuries (fractures, dislocations, sprains, etc.).

Approximate Date | Surgery/Reason for hospitalization

______________________ ____

______________________ ____

______________________ ____

List ANY Medications you are currently taking (including oral, injections, skin patches, etc.).

____

List any allergies that you may come in contact with during therapy (Latex, tape sensitivity, cortisone).

____

Check the amount of pain you have had in the last 24 hours:

No Pain ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ Pain requiring ER

1 2 3 4 5 6 7 8 9 10

We are interested in knowing whether you are having difficulty with the activities listed below because of the problem for which you are currently seeking attention. Please provide an answer for each activity. If you do not perform and activity, you may select Not Applicable (N/A).

	1	2	3	4	5	
Today, how much do the problems for which you are seeking attention limit:	I Can't Do This	Much Difficulty	Some Difficulty	Little Difficulty	No Difficulty	N/A
1. Sitting for 30 minutes						
2. Going up and down 1 flight of stairs						
3. Walking 2 blocks						
4. Standing for 30 minutes						
5. Lowering a light weight object (5 lbs.) from the top shelf of a closet						
6. Pulling/pushing a medium weight object (10 lbs.) from under a bed						
7. Completing household chores (vacuuming, dusting, mopping)						
8. Dressing, bathing, self care activities						
9. Carrying/lifting items like a gallon milk jug						
10. Vigorous activities like running, jumping, sports						
11. Sleeping 8 hours						
12. Getting in and out of bed, chairs						
13. Completing job requirements						

Total: /65

Patient Signature: ____

Therapist Signature: ____

AAB	SHD	CJG	DMS	GRB	LAB
ALE	TDG	EMW	LRK	DAF	DEK
ERW	RSD	KEF	JAM	LDG	

Today's Date: ______________________________ Account #: ______________________________

Patient Information

Patient's Full Legal Name: ______________________________ Birth Date: ____________
Marital Status: ____________ Gender: ____ M ____ F Age: _____ Patients SSN: ________________
Patient's Address: ______________________________ City/State/Zip: ____________________
Home Phone: ____________________________ Work Phone: ______________________________
Employer: ______________________________ City/State/Zip: ______________________________

Responsible Party Information

Guarantor/Responsible Party: ________________________ Responsible Party SSN: ______________
Address: ______________________________ City/State/Zip: ____________________________
Emergency Contact: ______________________________ Phone: ______________________
Address: ______________________________ City/State/Zip: ____________________________

Referral Information

Referred to this office by: ____
Name of Primary Physician: ______________________________ Phone: ____________________
Reason for today's exam: ________________________ Date of injury/accident: ________________
Part of body: ______________________________ Right side: ____ Left side: ____
Were you on the job? ____ Yes ____ No In an accident? ____ Yes ____ No

Primary Insurance Information

Primary Insurance: ____
Cardholder/subscriber: ______________________________ Relationship to patient: ______________
Cardholder's date of birth: ____________________ Cardholder SSN: ________________________
Employer's name: ______________________________ Phone: ______________________
Employer's address: ______________________________ City/State/Zip: ______________________
ID#: ______________________________ Group #: ______________________________
Effective date: ________________________ Co-pay amount: $____________________

Secondary Insurance Information

Secondary Insurance: ____
Cardholder/subscriber: ______________________________ Relationship to patient: ______________
Cardholder's date of birth: ____________________ Cardholder SSN: ________________________
Employer's name: ______________________________ Phone: ______________________
Employer's address: ______________________________ City/State/Zip: ______________________
ID#: ______________________________ Group #: ______________________________
Effective date: ________________________ Co-pay amount: $____________________

CONSENT TO TREAT

By signing this form I consent to treatment by my primary Tucson Orthopaedic Institute (TOI) Physical Therapist ______________________________________. I am aware if my primary TOI therapist is unavailable, I will be seen and treated by another TOI therapist providing coverage for the Tucson Orthopaedic Institute, P.C. therapists.

____ ___________________________
Signature of Patient/Responsible Party Date

PAYMENT POLICIES / INSURANCE RELEASE

Tucson Orthopaedic Institute, P.C. will file insurance claims for Medicare services, Worker's Compensation Services, all contracted insurance carriers and all surgical services. I understand that any balance of my account is solely my responsibility. I authorize release of medical information for my insurance claims, and authorize payment of insurance benefits to Tucson Orthopaedic Institute, P.C. I am responsible for attorney fees incurred for collection purposes.

____ ___________________________
Signature of Patient/Responsible Party Date

PF-1000 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.

Uses and disclosures

Treatment Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations Your health information may be used as necessary to support the day-to-day activities and management of Tucson Orthopaedic Institute, P.C. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information

Appointment Reminders Your health information will be used by our staff to send you appointment reminders.

Information about treatments. Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

Individual Rights You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information.
- The right to receive confidential communications concerning your medical condition and treatment.
- The right to inspect and copy your protected health information.
- The right to amend or submit corrections to your protected health information.
- The right to receive an accounting of how and to whom your protected health information has been disclosed.
- The right to receive a printed copy of this notice.

Tucson Orthopaedic Institute, P.C.'s Duties We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information You may generally inspect of copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the Medical Records Supervisor or the Privacy Officer. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Privacy Officer/Administrator, Tucson Orthopaedic Institute, P.C., 2424 N. Wyatt Dr., Tucson, AZ 85712.

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint. Send to:

Privacy Officer/Administrator, Tucson Orthopaedic Institute, P.C., 2424 N. Wyatt Dr., Tucson, AZ 85712.

The name and address of the person you can contact for further information concerning our privacy practices is:

Privacy Officer/Administrator, Tucson Orthopaedic Institute, P.C., 2424 N. Wyatt Dr., Tucson, AZ 85712. Phone: 520-784-6250.

This notice is effective on or after April 14, 2003.

PF-2000 Acknowledgement of Receipt of Notice of Privacy Practices

Tucson Orthopaedic Institute, P.C. reserves the right to modify the privacy practices outlined in the notice.

Signature:
I have received a copy of the Notice of Privacy Practices for Tucson Orthopaedic Institute, P.C.

____
Name of Patient (Print)

____
Signature of Patient

________________________ ________________________
Date Account #

____
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