PATIENT HISTORY

Patient's Name _____ Date of Birth _____
(First) (Last)

Mailing Address _____
(Number and Street) (City) (State) (Zip)

Home # (____) _____ Cell # (_____) _____

Employer _____

Email address _____ Add to eNewsletter List? Y N

In Case of Emergency Contact _____ Phone # (___) _____

Referring/Primary Care Physician _____ Date of Injury _____

How did you hear about Bridle Trails Physical Therapy? Please check all that apply.

Doctor recommendation	_____	Location	_____
Friend recommendation	_____	Prior Patient	_____
Saw Sign	_____	Newspaper Ad	_____
Internet Search	_____	Phone Book	_____
Website	_____	Other	_____

► If Workers Compensation/MVA, (otherwise present card in office)◄

Subscriber's Name _____ Group # _____ ID # _____

► Workers Compensation Carrier ◄ _____ Claim # _____

► IF PATIENT IS UNDER THE AGE OF 18 ◄

Parent/Guardian Name _____ Employer _____

Cell/Work # (___) _____

For patients under 18 years of age, the parent, relative, or person *escorting* the patient is responsible for any payments due at the time of the service.

Bridle Trails Physical Therapy Policy

- I understand that I am responsible for all charges incurred regardless of insurance or third party liability.
- I authorize contact by the use of my mobile/cell phone number for discussing treatment, confirming appointments and resolution of the balance of my account.
- I authorize Bridle Trails Physical Therapy to release any medical information necessary to process my claim to my insurance company or to any other concerned third party.
- I understand that I will bear the cost for all associated collections and/or attorney/legal fees if my account is placed with a 3rd party agency and/or attorney for collections or legal action.
- I authorize my insurance company or any other concerned third party to make payment directly to Bridle Trails Physical Therapy.

_____ _____

Signature (Parent/Guardian's signature if patient is under 18 years old) **Date**

13200 Old Redmond Road Ste 140 • Redmond, Washington 98052
Phone (425) 889-0776 • Fax (425) 889-0857 • www.bridletrailspt.com

NOTICE OF PRIVACY PRACTICES - HIPAA

This Notice of Privacy Practices contains a detailed description of how our office will protect your health information, your rights as a patient, and our common practices in dealing with patient health information.

Uses and Disclosure of Health Information:
We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers.

Uses and Disclosures Based on Your Authorization:
Except as stated in more detail in the Notice of Privacy Practice, we **will not** use or disclose your health information without your written authorization.

Uses and Disclosures Not Requiring your Authorization:
In the following circumstances, we may disclose your health information without your written authorization:

- To family members or close friends who are involved in your health care (primary caretakers)
- For purpose of health and safety
- To Government agencies for purposes of their audits, investigations, and oversight activities
- To Government authorities to prevent child abuse and domestic violence
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders
- When required by court orders, search warrants, subpoenas, and as otherwise required by law

Patient Rights:
As our patient, you have the following rights:

- To have access to and/or copies of your health information
- To receive an account or certain disclosures we have made of your health information
- To request restrictions as to how your health information is used or disclosed
- To request that we communicate with you in confidence.
- To request that we amend your health information
- To receive notice of our privacy practices

Please contact us with any questions, concerns, or complaints regarding our privacy practices.

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so choose) and understand the Notice.

_____
Patient Name (Please Print)

_____
Parent or Authorized Representative (If Applicable)

_____ _____
Signature **Date**

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PATIENT HISTORY FORM

*Note: This is a confidential record and will be kept in your PT chart. Information contained here will not be released to anyone without your authorization to do so.

First Name _____ Last Name _____

Today's Date ____ /____ /____ Date of Birth ____ /____ /____

Date of last Physician exam ____ /____ /____ Height _____ Weight _____

History of Present Problem

What is the main reason for your Physical Therapy evaluation today?

_____

_____

On a scale of 0-10 (0 is no pain, 10 is worst pain imaginable), **circle the number that best describes your average pain?**

0 1 2 3 4 5 6 7 8 9 10

When did you first notice the problem?
days ago weeks ago months ago years ago

Other _____

Problem **worsens** with:
Movement Inactivity Standing Lying Sitting
Other _____
_____

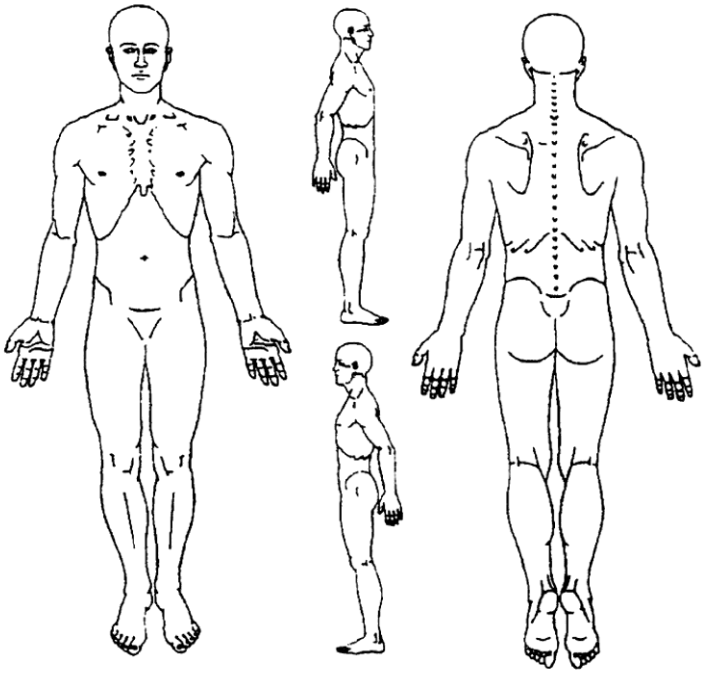
Problem **improves** with:
Movement Inactivity Standing Lying Sitting
Rest Medication Heat Ice
Other _____

How frequently are you bothered by this proble
Constant Occasional/Variable
Other _____

How would you describe the problem?
Dull Sharp Dull then Sharp Very sharp then leaves
Other _____

Do you have any other symptoms?
Yes No If yes, Please explain _____
_____

Please mark the location of the pain on the diagram below.



Does the problem interfere with daily functions? No Yes, please explain: _____

_____

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Past Medical & Social History

List any personal past illnesses &/or surgeries and when they occurred.

Illness or Surgery	Date
_____	_____
_____	_____
_____	_____

Please list any current medications, including over-the-count and supplements:

_____ _____

_____ _____

_____ _____

Do you have allergies? No Yes Please explain _____
Do you smoke? No Yes How much?_____
Do you drink? No Yes How much?_____

Review of System

Since your symptoms began, have you had any of the following?

Bowel/Bladder Issues	Y	N	Fever/Chills/Sweats	Y	N
Weakness	Y	N	Significant Weight Change	Y	N
Dizzy/Fainting	Y	N	Hearing/Vision Problems	Y	N
Numbness/Tingling	Y	N	Difficulty Swallowing	Y	N
Pain at Night	Y	N	Numbness in Anal Genital Area	Y	N
NONE	Y	N			

Do you currently have or have you had a history of any of the following? (Select all that apply)

Cancer/Tumor	High Blood Pressure	Angina/Cardiac arrhythmia	Gout
Pacemaker	Headaches/Migraines	Blood Clots	Fibromyalgia
Diabetes	Bruising Easily	Peripheral vascular disease	Depression
Neuro Conditions	Sleep Disorder	Seizures/Epilepsy	Stroke
Thyroid Problems	Pulmonary Conditions	Multiple Sclerosis	Fractures
Kidney Problems	Parkinson's Disease	Sensitivities/Allergies	Anemia
Osteoporosis	Osteoarthritis	Chemical Dependency	
Joint Replacement	Arthritis/Swollen Joints	Rheumatoid Arthritis	

OTHER: _____

Miscellaneous

1) Do you have any other conditions that may limit your response to exercise?
   Y___ N ___ If yes, Please explain: _____

2) What are your hobbies/recreational activities? _____

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