DIAZ-OLSON

Physical Therapy and
Sports Rehabilitation, Inc.

MEDICAL HISTORY

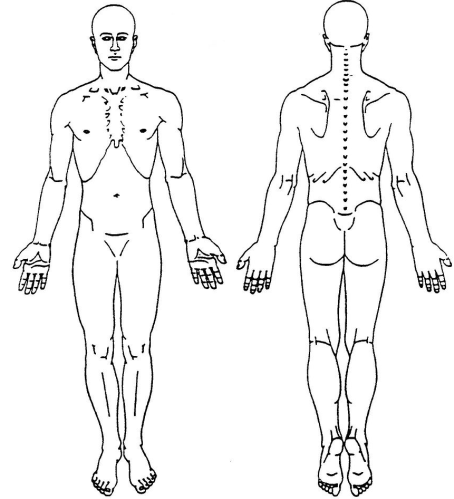
Patient Name: ______________________ Reason for Therapy: ______________________
Height: __________ Weight: __________

Date your current condition began: ______________

Are you currently on any medications? Please list: ____________
____

Have you had and MRI, X-Ray, or any other tests done recently?
If Yes, what/when? ______________________

Please indicate on the BODY CHART where you have pain or other symptoms.



Describe the nature of your symptoms: (Circle One)

Sharp Burning Aching
Tingling Numbness Other:________

How often do you experience your symptoms? (Circle One)

Constantly Frequently Occasionally
Intermittently Other:________

Rate the intensity of your symptoms on a 0-10 Scale (0=None, 10=Severe)

0 1 2 3 4 5 6 7 8 9 10

Activities that aggravate your symptoms: ______________________
Have you fallen recently? If yes, when? How many times? ______________________

Do you have any history of the following? Please circle any of the conditions below that apply to you.

Anemia	Arthritis	Asthma
Cancer	Circulatory Problems	Diabetes
Dizziness/Loss of Balance	Headaches	Heart Conditions/Heart Attack
Hernia	High Blood Pressure	High Cholesterol
Incontinence	Infectious Disease/HIV/Hepatitis	Kidney Disease
Loss of Hearing	Metal Implants/Pacemaker	Nervous disorders/Depression
Osteoporosis	Currently Pregnant	Recent Chills/Fever/Sweats
Recent Fatigue/Weakness	Recent Nausea/Vomiting	Recent Weight Loss/Gain
Seizure	Stroke	Thyroid Problems

During the past 5 years have you

Been admitted to the hospital or had surgery?

Date:______ Reason: ______________________

Date:______ Reason: ______________________

Had any previous orthopedic problems or injuries?

Date:______ Explain: ______________________

Date:______ Explain: ______________________

During the last year have you

Received any physical therapy treatments?

For what condition(s)?: ________ Amount of sessions: ____________

Patient Signature: ______________________ Date: ____________

452 E. El Camino Real; Sunnyvale, CA 94087
Phone: (408) 245-3575 Fax: (408) 245-3576

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NOTICE OF PRIVACY PRACTICES

This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully.

At Diaz-Olson Physical Therapy, we have always kept your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice.

The law permits us to use or disclose your health information to those involved in your treatment. For example, we will send regular progress notes to your referring doctor.

We may use or disclose your health information for payment of your services. For example, we may send your evaluation and daily charts notes as requested, to your insurance company.

We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer.

We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy.

We may use your information to contact you. For example, we may call to make or change appointments.

We may also want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone.

In an emergency, we may disclose your health information to a family member or another person responsible for your care.

We may release some or all of your health information when required by law.

If this practice is sold, your information will become the property of the new owner.

Except as described above, this practice will not use or disclose your health information without your prior written authorization.

You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.

You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.

As we will need to contact you from time to time, we will use whatever address or telephone number you prefer.

You have the right to transfer copies of your health information to another practice. We will mail your files for you.

You have the right to see and receive a copy of your health information, with a few exceptions. Please give us a written request regarding the information you want to see. If you also want a copy of your records, we may charge you a reasonable fee for the copies.

You have the right to request an amendment or change to your health information. Please give us a written statement requesting the changes you desire. We may or may not make the changes you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information.

You have the right to receive a copy of this notice.

If we change any of the details of this notice, we will notify you of the changes in writing.

You may file a complaint with the Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, Washington, DC 20201. You will not be retaliated against for filing a complaint.

However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our Privacy Officer, Michael Olson at 408-245-3575.

This notice goes into effect as of July 1, 2004.

Acknowledgement: I have received a copy of the Notice of Privacy Practices.

Print Name ____

Signed ________________________________ Date _____________

If signing as a parent or guardian, please note the name of the patient

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