# Notice of Privacy Practices Talyored Physical Therapy and Fitness LLC

**Patient Signature** _____ _____

**Date**

**Effective Date of this Notice: January 1, 2015**

This notice is a summary of how medical information about you may be used and disclosed and how you can get access to this information. You may view a full version of the Notice of Privacy Practices at the front desk before signing this consent form. **Please review it carefully.**

**When it comes to your health information, you have certain rights:** You may get an electric or paper copy of your medical record, ask us to correct your medical record, request confidential communications, ask us to limit what we use or share, get a list of those with whom we've shared information, and get a copy of this privacy notice.

**You may choose someone to act for you.** If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

**You may file a complaint if you feel your rights are violated**

- You can file a complaint if you feel we have violated your rights by contacting therapytaylored@gmail.com

**For certain health information, you can tell us your choices about what we share.** If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. We will never share your information unless you give us written permission.

**Our Uses and Disclosures** We typically use or share your health information in the following ways: to treat you, run our organization, and bill for your services. We may also use your health information to help with health and safety issues, comply with the law, address workers compensation, law enforcement, and other government requests.

**Respond to lawsuits and legal actions**

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities: We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

**Changes to the Terms of this Notice -** We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

TAYLORED PHYSICAL THERAPY
TAYLOREDPT.COM 610-601-4580
5442 PERKIOMEN AVENUE READING PA 19606

Medical History Questionnaire

Name: _____ Date: _____

Date of Birth: _____ Onset Date: _____

Address: _____ Emergency Contact: _____

City/Zip: _____ Emergency Contact Number: _____

Phone: _____ Email: _____

**Do you have a history of any of the following?**

| | | | | | |
|---|---|---|---|---|---|
| High Blood Pressure | __Yes __No | Diabetes | __Yes __No | Hepatitis/HIV | __Yes __No |
| Chest Pain | __Yes __No | Osteoporosis | __Yes __No | Seizures | __Yes __No |
| Heart Disease | __Yes __No | Arthritis | __Yes __No | Headaches | __Yes __No |
| Stroke | __Yes __No | Cancer | __Yes __No | Depression | __Yes __No |

**In the past 3 months have you experienced any of the following?**

| | | | |
|---|---|---|---|
| Change in your health | __Yes __No | Nausea/Vomiting | __Yes __No |
| Shortness of breath | __Yes __No | Unexplained weight change | __Yes __No |
| Dizziness | __Yes __No | Change in appetite | __Yes __No |
| Fever/Chills/Sweats | __Yes __No | Change in bowel/bladder | __Yes __No |
| Numbness/Tingling | __Yes __No | Upper respiratory infection | __Yes __No |

**If you answered "Yes" please describe** _____

Are you currently pregnant? __Yes __No Do you drink alcohol regularly? __Yes __No

Do you smoke tobacco? __Yes __No

**Have you had 2 or more falls in the past year or any fall with injury in the past year?** __Yes __No

**Please answer the following questions regarding your current condition.**

**Have you had any previous treatment for your current condition?**

__ Chiropractic __ Physical Therapy __ Injections __ Other _____

**Have you had any diagnostic tests for your current condition?**

__ MRI __ X-Ray __ CT Scan __ Bone Scan __EMG __ Other _____

**My symptoms are:** __ Getting Worse __ Staying the same __ Getting Better

TAYLORED PHYSICAL THERAPY
TAYLOREDPT.COM 610-601-4580
5442 PERKIOMEN AVENUE READING PA 19606

PLEASE LIST ALL MEDICATIONS, VITAMINS AND SUPPLEMENTS YOU ARE CURRENTLY TAKING. PLEASE CIRCLE THE METHOD, LIST THE DOSAGE AND CIRCLE THE FREQUENCY BY WHICH YOU TAKE THEM. IF YOU HAVE A LIST OF YOUR MEDICATIONS, WE WILL GLADLY MAKE A COPY RATHER THAN COMPLETING THIS FORM.

| Medications, Vitamins, Supplements | Method (Circle One) | Dosage | Frequency |
|---|---|---|---|
| | Oral Patch Inhaler Injection Other: | | 1x/day 2x/day 3x/day Other: |
| | Oral Patch Inhaler Injection Other: | | 1x/day 2x/day 3x/day Other: |
| | Oral Patch Inhaler Injection Other: | | 1x/day 2x/day 3x/day Other: |
| | Oral Patch Inhaler Injection Other: | | 1x/day 2x/day 3x/day Other: |
| | Oral Patch Inhaler Injection Other: | | 1x/day 2x/day 3x/day Other: |
| | Oral Patch Inhaler Injection Other: | | 1x/day 2x/day 3x/day Other: |
| | Oral Patch Inhaler Injection Other: | | 1x/day 2x/day 3x/day Other: |

**BODY MASS INDEX (BMI) – PLEASE LIST YOUR WEIGHT AND HEIGHT (Medicare Patients Only):**

*Weight*: _____ *Height*: _____ *Calculated BMI* (For Internal Use Only): _____

Normal Parameters: *Age 65 years and older – BMI ≥ 23 and < 30* *Age 18-64 years – BMI ≥ 18.5 and < 25*

*I hereby consent to evaluation and/or treatment of my condition by a licensed physical therapist employed by or under contract with Taylored Physical Therapy and Fitness, LLC. I am aware that the physical therapist will inform me of the expected benefits and possible discomfort, which may result from skilled physical therapy care.*

*I am aware that there is not a guarantee that the proposed course of treatment will improve my condition and that it is possible, although unlikely, that the course of treatment may cause additional pain or discomfort or aggravate my condition. I confirm that I have read and fully understand this consent form.*

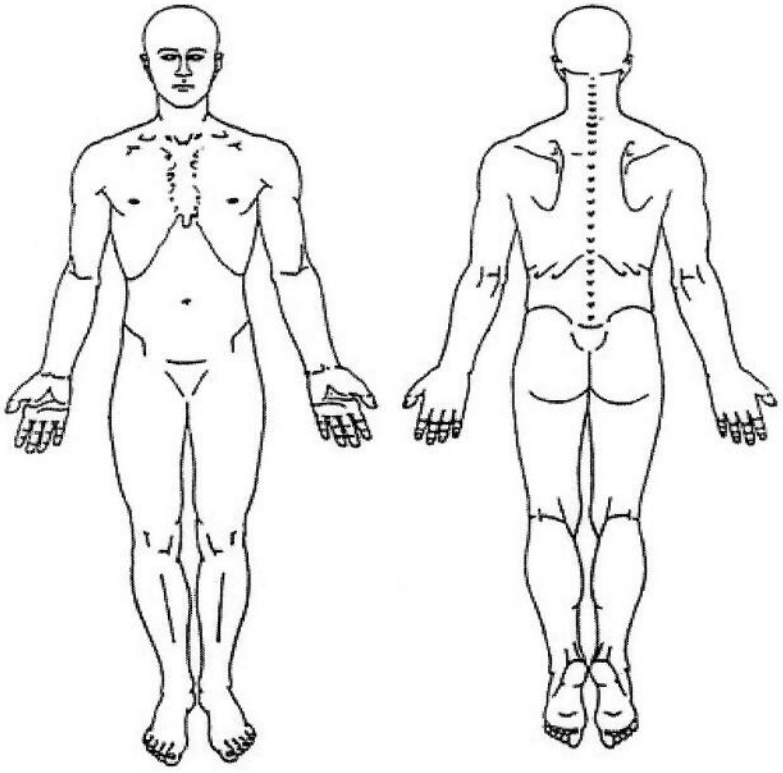
PATIENT SIGNATURE: _____ DATE: _____

FORM HAS BEEN READ AND REVIEWED BY THERAPIST: PT INITIALS: _____

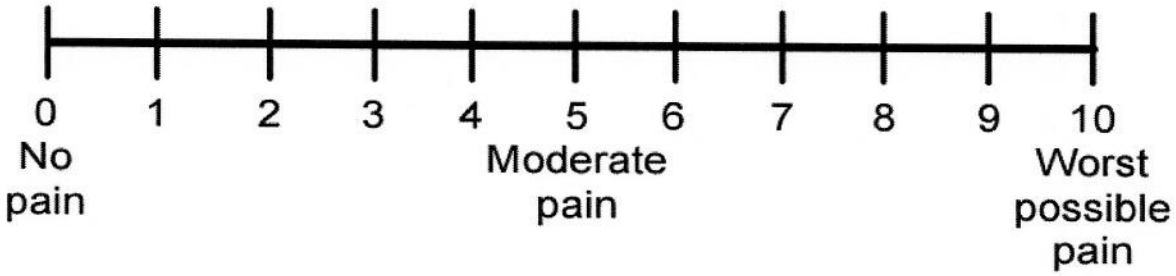
TAYLORED PHYSICAL THERAPY
TAYLOREDPT.COM 610-601-4580
5442 PERKIOMEN AVENUE READING PA 19606

**USE THE FOLLOWING DRAWING AND SYMBOLS SHOWN TO INDICATE THE LOCATION AND TYPE OF SYMPTOMS YOU ARE EXPERIENCING AT THE PRESENT TIME:**

| SHARP PAIN | ACHINESS | BURNING | PINS & NEEDLES | NUMBNESS |
|---|---|---|---|---|
| ///// | XXXXX | !!!!! | 00000 | +++++ |



**PLEASE USE THE FOLLOWING SCALE TO RATE YOUR PAIN**




**RATING OF PAIN CURRENTLY: _____/10**

**RATING OF PAIN AT BEST: _____/10**

**RATING OF PAIN AT WORST: _____/10**