Therapy One
physical therapy

NEW PATIENT INFORMATION

Patient Name: _____ Today's Date: _____

Address: _____ City _____ State _____ Zip _____

Social Security No. _____ Date of Birth: _____ Home Phone: _____

Cell Phone: _____ Cell Carrier: (to enable texting) _____

Employer: _____ Work Phone: _____ E-Mail: _____

Primary Care Physician: _____ ☐ Married ☐ Single Children # _____

Any Previous Chiropractic Care? ☐ Yes ☐ No If yes, Who? _____

INSURANCE INFORMATION

Primary Insurance:

Insurance Company: _____

Policy ID#: _____ Group Plan #: _____

Insured Name: _____ DOB: _____ Social Security #: _____

Insured's Employer: _____ Relationship to Insured: _____

Secondary Insurance: *(if applicable)*

Insurance Company: _____ Address: _____

Policy ID#: _____ Group Plan #: _____

Insured Name: _____ DOB: _____ Social Security #: _____

Insured's Employer: _____ Relationship to Insured: _____

AUTO INSURANCE INFORMATION
(IF APPLICABLE)

Auto Insurance Co.: _____ Phone: _____

Insurance Co. Address: _____

Policy Holder Name & Address (if other than yourself): _____

Relationship to Patient: _____ Did you report your accident? ☐ Yes ☐ No

Policy# _____ Claim# _____ Date of Accident: _____

Insurance Adjuster Handling Claim: _____ Phone/Ext: _____

Patient/Guardian Signature: _____ Date: _____

Therapy One
physical therapy

Date: _____

Name: _____

Social Security #: __ __ __ - __ __ - __ __ __ __

Gender: M F Age:

Smoker: Y N Pregnant: Y N

Occupation:

Describe your regular exercise routine:

Past Surgical History (list all &date):

_____

_____

_____

Please List All Current Medications:

_____

_____

Have you had an x-ray, MRI, or other imaging study?

Past Medical History: Please circle each condition that you have been told you have (or had).

Cancer	Diabetes	Kidney Disease	Liver Disease	Stroke
High Blood Pressure	Heart Disease	Angina/Chest Pain	Ulcers	Fibromyalgia
Osteoporosis	Osteoarthritis	Rheumatoid Arthritis	Sexually Transmitted Disease	
Allergies/Asthma	Lung Disease	Have you had a recent illness (explain if yes)? _____		

Do you take blood thinners? YES NO Are you allergic to latex? YES NO Other:

During the past month, have you often been bothered by feeling down, depressed, or hopeless? YES NO
During the past month, have you often been bothered by little interest or pleasure in doing things? YES NO

Currently I am experiencing (circle all that apply):

Fever/chills/sweats	Poor balance (falls)		
Unexplained weight loss	Numbness or Tingling	Changes in appetite	Difficulty swallowing
Depression	Shortness of breath	Dizziness	Headaches
Changes in bowel or bladder function		Nausea /Vomiting	Increased pain at night

CURRENT SYMPTOMS

Where are you currently having symptoms? _____

What date (approximately) did your present pain start? _____

How (gradually, suddenly, injury)? _____

My symptoms are currently: **Getting better / About the same / Getting worse**

Have you received any treatment for this problem? _____

Have you ever had this problem before: **YES / NO**

If so, how was the problem treated? _____

How long did it take for you to feel better? _____

How are you able to sleep at night? ☐ Fine ☐ Moderate Difficulty ☐ Only with medication

What is your personal goal for therapy? _____

Do you have any barriers to learning, if so list?

CONSENT: I understand that my diagnosis & treatment plan will be discussed during my appointment and that I have the right to question and/or refuse any treatment offered. _____ (Sign)

On the scales below, please circle the number which best represents the severity of your pain is.

Average for the last 48 hours:

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Worst Pain Imaginable**

Best for the last 48 hours:

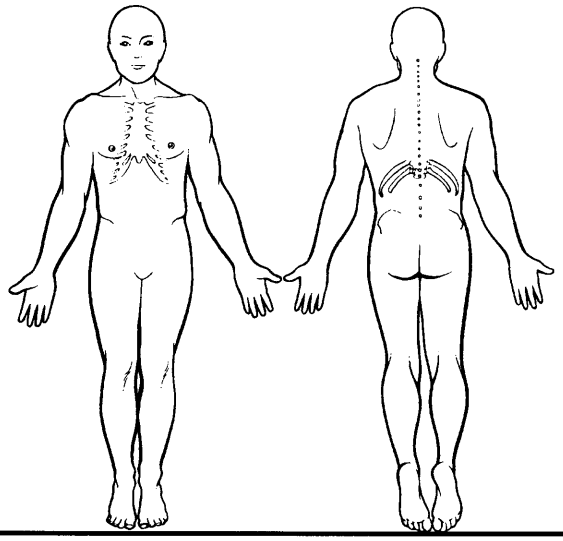
No Pain 0 1 2 3 4 5 6 7 8 9 10 **Worst Pain Imaginable**

Worst for the last 48 hours:

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Worst Pain Imaginable**

Body Chart:

Please mark the areas where you feel pain on the chart to the right



For the therapist

+ / - Cough/Sneeze
+ / - Saddle Anesth.
+ / - Bwl/Bldder Chnge
+ / - Numb/Ting.

Please circle the number below which best represents your overall average level of function.

Cannot do anything 0 1 2 3 4 5 6 7 8 9 10 **Able to do everything**

What makes your symptoms better? _____

_____

Please circle the activities which make your pain worse:

lying down standing walking stress sitting

Any other activities that make your pain worse?:

Please list the best and worst time of day for your symptoms } Best - Worst -

Aggravating Factors: Identify up to 3 important activities that you are unable to do or are having difficulty with as a result of your problem. List them below:

1) _____

2) _____

3) _____

Below for the Therapist:

Rating: _____

Rating: _____

Rating: _____

AVG: _____

Therapist Use

Unable to perform activity 0 1 2 3 4 5 6 7 8 9 10 **Able to perform activity at same level as before your (injury or problem)**

Patient Name:_____DOB:_____

Oswestry Disability Index

Section 1 – Pain Intensity

- ❑ I have no pain at the moment.
- ❑ The pain is very mild at the moment.
- ❑ The pain is moderate at the moment.
- ❑ The pain is fairly severe at the moment.
- ❑ The pain is very severe at the moment.
- ❑ The pain is the worst imaginable at the moment.

Section 2 – Personal Care (washing, dressing, etc.)

- ❑ I can look after myself normally but it is very painful.
- ❑ I can look after myself normally but it is very painful.
- ❑ It is painful to look after myself and I am slow and careful.
- ❑ I need some help but manage most of my personal care.
- ❑ I need help every day in most aspects of my personal care.
- ❑ I need help every day in most aspects of self-care.
- ❑ I do not get dressed, wash with difficulty, and stay in bed.

Section 3 - Lifting

- ❑ I can lift heavy weights without extra pain.
- ❑ I can lift heavy weights but it gives extra pain.
- ❑ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (i.e. on a table).
- ❑ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ❑ I can lift only very light weights.
- ❑ I cannot lift or carry anything at all.

Section 4 – Walking

- ❑ Pain does not prevent me walking any distance.
- ❑ Pain prevents me walking more than 1mile.
- ❑ Pain prevents me walking more than ¼ of a mile.
- ❑ Pain prevents me walking more than 100 yards.
- ❑ I can only walk using a stick or crutches.
- ❑ I am in bed most of the time and have to crawl to the toilet.

Section 5 – Sitting

- ❑ I can sit in any chair as long as I like.
- ❑ I can sit in my favorite chair as long as I like.
- ❑ Pain prevents me from sitting for more than 1 hour.
- ❑ Pain prevents me from sitting for more than ½ hour.
- ❑ Pain prevents me from sitting for more than 10 minutes.
- ❑ Pain prevents me from sitting at all.

Section 6 – Standing

- ❑ I can stand as long as I want without extra pain.
- ❑ I can stand as long as I want but it gives me extra pain.
- ❑ Pain prevents me from standing more than 1 hour.
- ❑ Pain prevents me from standing for more than ½ an hour.
- ❑ Pain prevents me from standing for more than 10 minutes.
- ❑ Pain prevents me from standing at all.

Section 7 – Sleeping

- ❑ My sleep is never disturbed by pain.
- ❑ My sleep is occasionally disturbed by pain.
- ❑ Because of pain, I have less than 6 hours sleep.
- ❑ Because of pain, I have less than 4 hours sleep.
- ❑ Because of pain, I have less than 2 hours sleep.
- ❑ Pain prevents me from sleeping at all.

Section 8 – Sex life (if applicable)

- ❑ My sex life is normal and causes no extra pain.
- ❑ My sex life is normal but causes some extra pain.
- ❑ My sex life is nearly normal but is very painful.
- ❑ My sex life is severely restricted by pain.
- ❑ My sex life is nearly absent because of pain.
- ❑ Pain prevents any sex life at all.

Section 9 – Social Life

- ❑ My social life is normal and cause me no extra pain.
- ❑ My social life is normal but increases the degree of pain.
- ❑ Pain has no significant effect on my social life apart from limitingmy more energetic interests, i.e. sports.
- ❑ Pain has restricted my social life and I do not go out as often.
- ❑ Pain has restricted social life to my home.
- ❑ I have no social life because of pain.

Section 10 – Traveling

- ❑ I can travel anywhere without pain.
- ❑ I can travel anywhere but it gives extra pain.
- ❑ Pain is bad but I manage journeys of over two hours.
- ❑ Pain restricts me to short necessary journeys under 30 minutes.
- ❑ Pain prevents me from traveling except to receive treatment.

Section 11 - Previous Treatment

Over the past three months have you received treatment, tablets or medicines of any kind for your back or leg pain? Please check the appropriate box.

- ❑ No
- ❑ Yes (if yes, please state the type of treatment you have received)

Patient Signature:_____Date:_____Time:_____

Clinician Signature:_____Date:_____Time:_____

Therapy One
physical therapy

1701 New Road, Northfield, NJ 08225
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET TO THAT INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

This Physical Therapy Practice, Therapy One Center, in accordance with the federal Privacy Rule, 45 CFR parts 160 & 164 (the Privacy Rule) and applicable state law, is committed to maintaining the privacy of your protected health information (PHI). PHI includes information about your health condition and the care and treatment you receive from the Practice and is often referred to as your health care or medical record. This notice explains how your PHI may be used and disclosed to third parties. This notice also details your rights regarding your PHI.

HOW THE PRACTICE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION (PHI)

The practice, in accordance with this notice and without asking your express consent or authorization may use and disclose your PHI for the purpose of:

A. **TREATMENT** – For coordination, planning and management of your health care.
B. **PAYMENT** – To get paid for services directly through you, billing service, and insurance company or health plans.
C. **HEALTHCARE OPERATIONS** – To evaluate performance of the Practice's personnel providing care to you.
D. **ADVISE OF APPOINTMENT SERVICES** – Following appointment reminders may be used by the practice:
   1. Postcards
   2. Telephoning home
   3. Email
   4. Telephoning cell phone and/or texting
E. **DIRECTORY/SIGN-IN LOG** – Practice maintains a sign-in log at the reception area where staff can readily see. Others seeking services/care at the Practice may see this information.
F. **FAMILY/FRIENDS** – Disclose PHI to family member, other relative, friend or other person identified by you for involvement in care or payment of care.
G. **USE OF NAME** – Your name may be used in a verbal or written manner when requesting information over the phone or between staff members or when using a social media that you have agreed to by "liking or following", such as FACEBOOK, TWITTER or INSTAGRAM. This in no way implies your PHI has been disclosed.
H. **EMAIL/TEXTING** - You may be contacted thru email and/or text to convey information/correspondence regarding you and this practice.

OTHER USE & DISCLOSURES WHICH MAY BE PERMITTED OR REQUIRED BY LAW

A. **DE-IDENTIFIED INFORMATION** – Disclose PHI, for sake of your care, which cannot identify you.
B. **BUSINESS ASSOCIATE (BA)** – BA includes entity that assists the Practice in some essential function.
C. **TCPA** - Telephone Consumer Protection Act - our office and/or our agents may contact you by telephone, including wireless numbers by call or text, which could result in charges from your wireless carrier. Methods may include pre-recorded voice messages or an automatic dialing device. We may also contact through email.
D. **PERSONAL REPRESENTATIVE** – A person who has the authority to represent your decisions.
E. **EMERGENCY SITUATIONS**
F. **PUBLIC HEALTH EMERGENCY** – To prevent or control disease.
G. **ABUSE, NEGLECT OR DOMESTIC VIOLENCE**
H. **HEALTH OVERSIGHT ACTIVITIES** – PHI for criminal investigation, disciplinary actions or relating to community's health care system.
I. **JUDICIAL & ADMINISTRATING PROCEEDING** – For court order or lawfully issued subpoena.
J. **LAW ENFORCEMENT PURPOSES** – Use PHI when authorized to Law Enforcement official.
K. **CORONER OR MEDICAL EXAMINER**
K. **ORGAN, EYE, OR TISSUE DONATION** – May disclose your PHI if you are a tissue or organ donor.
L. **RESEARCH** – May disclose PHI subject to legal requirements if the Practice is involved in research.
M. **AVERT THREAT TO HEALTH AND SAFETY** – Disclose PHI necessary to prevent serious threat to health or safety.
N. **FINANCIAL HARDSHIP** - Financial agreements are available for those who qualify at time of service & who are unable to meet their total financial obligation.
O. **SPECIALIZED GOVERNMENT FUNCTION** – Use PHI, authorized by law, for military and veteran activity.
P. **WORKERS COMPENSATION OR MVA**
Q. **NATIONAL SECURITY AND INTELLIGENCE ACTIVITES**
R. **MILITARY AND VETERANS** – Disclose PHI, if member of armed forces, required by military command authorities.
S. **TIME OF SERVICE PAYMENT –** All patients are eligible for a discount if payment for services rendered are made at time of service. If payment is not made at the time of service the patient is responsible for full charges incurred.

PRACTICE REQUIRMENTS

A. Is required by federal law to maintain the privacy or your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.
B. Maybe required by State Law to maintain greater restrictions on the use or release of your PHI than that which is provided for under Federal Law.
C. Is required to abide by the terms of this Privacy notice.
D. Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for your entire PHI that it maintains.
E. Will distribute any revised Privacy Notice to you prior to implementation.
F. Will not retaliate against you for filing a complaint.

YOUR RIGHTS

A. Revoke any authorization or consent given to the Practice in a written request.
B. Request restrictions on certain uses & disclosures of your PHI in written form.
C. Inspect & copy your PHI. Practice can charge fee for copying, mailing or other supplies associated with request.
D. Amend your PHI as provided by federal Law. You must submit written request to the Practices Privacy Officer (PPO).
E. Receive accounting disclosures or PHI as provided by the Federal Law. Time period may be no longer than six (6) years and may not include dates before April 14, 2003. The first list within a 12-month period is free. Practice may charge for additional lists.
F. Receive paper copy of Privacy Notice from Practice.
G. Complain to Practice or Secretary of HHS if you believe your rights have been violated.

To file a complaint with the Practice or to obtain more information about your rights contact the Practice's Privacy Officer.
Name: Christi Murphy *Address*: 1701 New Road, Northfield, NJ 08225 *Telephone*: 609.867.9353

AUTHORIZATION

Uses and/or disclosures other than those described above will be made only with your written request.
This notice is in effect as of 4.1.2021