Transform Physical Therapy & Pilates Health History Intake Form

CLIENT INFORMATION

Name:_____Date:_____

Address:_____

Home Telephone:_____Cell Phone:_____

Email Address:_____

Age: _____Date of Birth: _____Occupation:_____

Emergency Contact:_____Emergency Contact Phone:_____

How did you hear about Transform:_____

REASON FOR TODAY'S VISIT:

Describe your pain, limitation or dysfunction:

_____
_____
_____

Onset/cause of condition?

_____
_____
_____

Symptoms aggravated by *check all that apply*:

☐sitting ☐transfer out of chair ☐standing ☐walking ☐sleeping ☐changing positions in bed ☐squatting ☐lifting ☐bending ☐kneeling ☐reaching ☐pushing/pulling ☐taking a deep breath ☐coughing/sneezing ☐other_____

Relieved by *check all that apply*:

☐lying ☐sitting ☐standing ☐walking ☐exercise ☐rest ☐cold ☐heat ☐changing positions ☐stretching ☐massage ☐medication ☐other_____

What previous treatment have you had for this issue?

_____
_____
_____

Date and results of X-ray, MRI, CT scan, EMG or other tests:

_____
_____
_____
_____

Dates & descriptions of past surgeries/injuries:

_____
_____
_____
_____

Check if you currently have or previously had the following medical conditions:

☐Asthma	☐Epilepsy	☐High cholesterol	☐Osteoporosis/Osteopenia
☐Heart conditions	☐Arthritis	☐Allergies	☐Bowel or bladder problems
☐Pace Maker	☐Current pregnancy	☐Cancer	☐Incontinence
☐Chest pain	☐Dizzy spells or vertigo	☐Hernia	☐Smoker
☐Stroke	☐History of seizures	☐Bleeding disorders	☐Poor balance/falls
☐Diabetes	☐Joint replacement	☐Blood clots	☐Fibromyalgia
☐Bone/joint disorder	☐High/low blood pressure	☐Ulcer	☐ Covid-19 (coronavirus)

Other:_____
_____
_____
_____

Medication:_____ Condition:_____
Medication:_____ Condition:_____
Medication:_____ Condition:_____

Describe your current exercise.

_____
_____
_____

Are there any activities or exercise you can't do now as a result of injury/condition?

_____
_____
_____

What are your goals?

_____
_____
_____

Transform Physical Therapy & Pilates LLC

Statement of Privacy Notice

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.

We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations.

We may disclose your health information to your insurance provider for the purpose of payment or health care operations.

We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

We may disclose your health information in the course of any administrative or judicial proceeding.

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

We may disclose your health information to coroners or medical examiners.

We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

We may disclose your health information for military, national security, prisoner and government benefits purposes.

We may leave a message on an automated answering device or person answering the phone for the purposes of scheduling appointments. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment."

We may contact you by phone, mail, or email. "It is our practice to participate in charitable and marketing events to raise awareness, food donations, gifts, money, etc. During these times, we may send you a letter, post card, invitation or call your home to invite you to participate in the charitable activity.

In the event that we are sold or merged with another organization, your health information/record will become the property of the new owner.

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that we are not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.
- You have a right to request that we amend your protected health information. Please be advised, however, that we are not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by us.
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

We reserve the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, we are required by law to comply with this Notice.

We are required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact us by calling this office at (305) 528-1795. If our Privacy Officer is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

Complaints about your Privacy rights, or how we have handled your health information should be directed to our Privacy Officer by calling this office at (305) 528-1795. If our Privacy Officer is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide Transform Physical Therapy & Pilates LLC with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice

_____
Patient's Name (print)

_____
Patient's Signature Date

_____
Authorized Facility Signature Date

HIPAA CONSENT FORM

I give Transform Physical Therapy & Pilates LLC my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for healthcare operations like quality reviews.

I have been informed that I may review Transform Physical Therapy & Pilates LLC's Notice of Privacy Practices (for a more complete description of uses and disclosures) before signing this consent.

I understand that Transform Physical Therapy & Pilates has the right to change their privacy practices and that I may obtain any revised notices at the practice.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that Transform Physical Therapy & Pilates LLC is not required to agree to the request. If Transform Physical Therapy & Pilates LLC agrees to my requested restriction, they must follow the restriction(s).

I also understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.

_____

Name of Patient or Authorized Representative

_____ _____

Signature of Patient or Authorized Representative Date

_____ _____

Authorized Signature of Facility Date