Exclusively Spine
Physical Therapy, LLC

14050 N. 83rd Ave Suite 230
Peoria, AZ 85381
Tel: 623-776-7577
Fax: 623-776-7597
www.exclusivelyspine.com

Welcome! We appreciate your help in providing this information we need to complete your medical record.

Name: _____
Last First MI

_____
Home Street Address

_____
City State Zip

Phone: _____ _____
Home Work

_____ _____
Cell E-mail

Schedule Reminder: _____ Text _____Email

Date of Birth: _____ **Age:** _____

Social Security #: _____
Required

Driver's License #: _____

Employer Name: _____

Occupation: _____

☐ Full time ☐ Part time ☐ Unemployed ☐ Medical Leave

Physician's Name: _____

Phone number: _____ **City**: _____

Date of next scheduled appointment: _____

In case of emergency, please notify:

Name: _____ **Ph:** _____

Have you ever seen one of our therapists before? ☐ **Yes** ☐ **No**

How did you hear about us? _____
Please be specific

(Please provide insurance card and driver's license to be copied.)

Primary Insurance: _____ **Secondary Insurance:** _____

Insured's Social Security#: _____ **Insured's Date of Birth:** _____

Does your employer consider this a work injury? ☐ Yes ☐ No

Is this injury part of an open car accident case or other personal injury lawsuit? ☐ Yes ☐ No

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I have read and fully understand Exclusively Spine Physical Therapy, LLC's Notice of Privacy Practices. I understand that Exclusively Spine Physical Therapy, LLC may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice in writing. I also understand that Exclusively Spine Physical Therapy, LLC will consider requests for restriction on a case-by-case basis, but does not have to agree to requests for restrictions.

I hereby acknowledge the use and disclosure of my personal health information for purposes as noted in Exclusively Spine Physical Therapy, LLC's Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

Please provide your e-mail address if you would like to receive our one page monthly newsletter about neck and back related health or notification of future announcements or specials. Note: Exclusively Spine Physical Therapy will not sell or distribute this address to any other vendors or companies.

Email address: _____

I attest that the above information is true and correct. **Printed Name:** _____

Signature: _____ **Date:** _____

Revised 11-22-16

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Notice of Privacy Practices (HIPPA)

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review this document carefully.

We are required to abide by the terms of the Notice of Privacy Practices. We reserve the right to change our Notice of Privacy Practices at any time and those changes will apply to any protected health information that we maintain at that time. We will provide you with a revised Notice of Privacy Practice upon request or upon your return for future treatment.

In this notice, "we", "our" or "us" means this FACILITY and our workforce of employees, contractors and volunteers. "You" and "your" refers to each of our patients who are entitled to a copy of this notice. We are required by federal and state law to protect he privacy of your health information. Protected Health Information (PHI) refers to health information that may specifically identify you.

Ways we may use or disclose your Protected Health Information

We use or disclose your PHI for certain activities or health care operations. We will also disclose your PHI as required or permitted by the law.

Treatment: We use and disclose your PHI in the course of your treatment. For example, once we have completed your evaluations or re-evaluations we will send a copy of summary of our report to your referring physician.

Payment: We may disclose your PHI for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your PHI including treatments received, diagnosis, and social security number.

Health Care Operations: We may use your PHI to support business activities of this practice. For example; employee review activities, quality assessment, compliance monitoring, training for therapy students and resolution of a complaint.

Special Services: We may also use or disclose your PHI for appointment reminders, follow up calls, advise of new services or supplies offered. We verbally may share some of your PHI with a family member or friend if they are involved in your care. We may use your PHI in an emergency if you are unable to express yourself.

Other required uses of PHI:

1. When required by law.
2. For public health activities. For example reporting a communicable disease or reporting an adverse reaction to the FDA.
3. To report neglect, abuse or domestic violence.

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4. To the government regulators for purposes such as conducting audits and investigations.
5. To the appropriate military command authorities, If you are a member of the military.
6. To worker's compensation agencies for workers' compensation benefit determination.

Your privacy rights

1. You have the right to request in writing that we do not use or disclose your PHI in a particular way. We are not required to abide by all requests.
2. You have the right to confidential communication if requested in writing. You may request that we us a specific address or phone number or all communication as long as it does not interfere with your method of payment.
3. You have the right to inspect and copy your PHI when requested in writing. We must respond to your request within thirty days. We may charge a reasonable fee for copying and labor time related to copying and we may require an appointment for record inspection.
4. You have the right to make amendments to your PHI if requested in writing. We are not obligated to make all requested amendments. However, if we accept the amendment we must notify you and make efforts to notify others who may have the original record.
5. You have the right to revoke your authorization to disclose your PHI at any time in writing.
6. You have the right to an accounting of certain disclosures that we have made by us regarding your PHI. The request must be in writing.
7. If you have received this notice electronically, and wish to receive a paper copy, you have the right to obtain a paper copy by making a request in writing to the Privacy Officer, Exclusively Spine Physical Therapy, LLC, 14050 N. 83rd Ave, Ste. 230, Peoria, AZ, 85381.
8. You have the right to complain if you feel your privacy rights have been violated. All complaints should be made in writing to the Privacy Officer, Exclusively Spine Physical Therapy, LLC, 14050 N. 83rd Ave, Ste. 230, Peoria, AZ, 85381. You may also submit a written complaint to the U.S. Department of Health and Human Services.

If you have any questions about this notice please contact the Privacy Officer listed below:

Melissa Hourihan, P.T., D.P.T.
Exclusively Spine Physical Therapy, LLC
14050 W. 83rd Ave, Suite 130
Peoria, AZ 85381

Exclusively Spine
Physical Therapy, LLC

Important Company Policies for a Successful Relationship

We appreciate the confidence you have shown in choosing us as your healthcare provider. We strive to provide the highest quality of care to all of our patients. We will make every effort to schedule appointments that are convenient for you, but we ask that you please follow the guidelines below.
Please initial each policy to indicate that you have read and understand it. Thank you.

_____Late Policy "10 minutes"

Being late will require you to either reschedule or wait for the next available opening. There are no guarantees since openings due to cancellations are unpredictable. Showing up late to an appointment can undeservedly compromise the care of another patient.

_____24-Hour Advance Notice Fee

If you wish to change or cancel an appointment we require a minimum *24-hour advance notice.* Anything less will result in a *$20 fee* charged to your account. It costs us money to make appointments available to you. Whether you attend or not we still accrue the expenses (for staff wages, rent, etc.) We don't charge you the actual cost for that appointment but rather a mere *$20 fee.* We do NOT make money with this charge: it's only to act as a deterrent from making last minute changes. Advance notice allows someone else (who needs it) time to reserve it in place of you. Please be courteous and responsible. Thank you.

_____Copay, co-insurance, and deductible payments are due upon arrival

If you happen to forget your wallet or checkbook we may still be able to see you upon completion of an "Extension Request" form. This is a "promise-to-pay" and carries a *$2.50 fee* that allows you to keep your appointment.

_____No-Shows are bad

If you fail to show for an appointment without notice all future appointments will be removed and a *$20 fee* will be added to your account. You may reschedule appointments again on a "first come first serve basis."

_____Cell phones must be shut OFF or silent.

Cell phones/smart phones are a distraction and can be a danger and/or decrease the quality of your care/treatment program. We realize emergencies may arise and therefore allow you to carry your cell phone during your session. However, please be courteous and set to silent mode or turn off. Thank you.

_____Children requiring supervision are NOT allowed to attend sessions with you.

Unless your child does not require supervision, please do not bring them to your appointment. If any disturbance is caused to other patients or staff members you may be asked to terminate your session early and attend to your child.

Please sign your name below indicating that you understand and have read this policy.

_____
Print name

_____ _____
Patient signature Date

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Patient Name: _____ **Date:** _____

CURRENT SYMPTOMS: ***Please describe the symptoms you are seeking treatment for:***

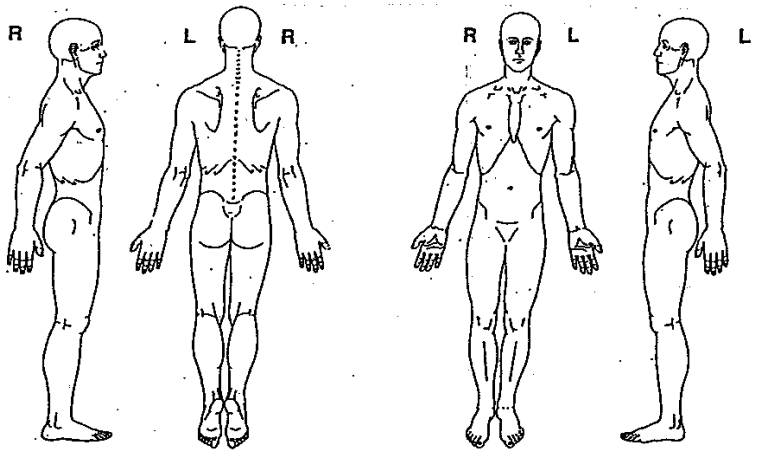
_____

_____

Please use the key below to mark where your symptoms are located and what kind of symptoms you are having.

KEY:

Numbness	-------
Pins & Needles	oooo
Burning Pain	xxxxx
Stabbing Pain	/////



PAIN LEVELS/SYMPTOM HISTORY

- Please ***circle*** the number that describes your pain at ***worst.*** ◯
- Please put a ***box*** around the number that describes your pain at ***best.*** □
- Please **underline** your **current pain level**. ____

Body part _____ best 0 1 2 3 4 5 6 7 8 9 10 worst

Body part _____ best 0 1 2 3 4 5 6 7 8 9 10 worst

Body part _____ best 0 1 2 3 4 5 6 7 8 9 10 worst

Body part _____ best 0 1 2 3 4 5 6 7 8 9 10 worst

Are you currently seeing a physician for these symptoms: ☐ Yes ☐ No

Physician Name: _____ **Next scheduled appointment:** _____

How long have you had these symptoms? _____

Was the onset of your symptoms gradual or sudden? ☐ Gradual ☐ Sudden

Have you had similar symptoms in the past? ☐ Yes ☐ No **More than one episode?** ☐ Yes ☐ No

Since onset are your symptoms getting: ☐ Better ☐ Worse ☐ Not changing

Please check all that apply about your current symptoms:

☐ Work-related injury ☐ Recurrence of previous injury ☐ Injury related to falling
☐ Motor vehicle accident ☐ Injury related to lifting ☐ Other: _____
☐ Cause unknown ☐ Athletic/recreational injury

As the day progresses, do your symptoms: ☐ Increase ☐ Decrease ☐ Stay the same

What position do you sleep? ☐ Back ☐ Stomach ☐ Right side ☐ Left side ☐ Chair/Recliner ☐ Other: _____

Does the pain wake you at night? ☐ Yes ☐ No ***If yes, is it present:*** ☐ While lying still ☐ With position change

Patient Name: _____ **Date:** _____

Do you have pain/stiffness upon getting out of bed in the morning? □ Yes □ No

What *aggravates* your symptoms? ***(check all that apply)***

□ Sitting
□ Standing
□ Walking
□ Squatting
□ Sleeping
□ Bending

□ Lying down
□ Going from sit to stand
□ Up/down stairs
□ Stress

□ Looking up overhead
□ Talking, chewing
□ Swallowing
□ Coughing/sneezing
□ Taking a deep breath

□ Reaching overhead
□ Reaching behind back
□ Reaching in front of body
□ Reaching across body

□ Recreation/sports including _____ _____
□ Housework including _____
□ Yard Work including _____
□ Other _____

What *relieves* your symptoms? ***(check all that apply)***

□ Lying down
□ Sitting
□ Standing
□ Walking
□ Heat
□ Cold

□ Massage
□ Topical Creams
□ Stretching
□ Exercise
□Wearing a splint/orthosis
□ Medication

□ Nothing
□ Other:
_____
_____
_____
_____

PREVIOUS TREATMENTS: ***Describe any previous treatments you have had for these symptoms:***

Treatment: Date: Response to Treatment:

_____
_____
_____
_____

PREVIOUS TESTING: ***Have you had any imaging/testing performed for this condition?***

	Yes	No	Approximately when and where were these images taken?
X-Ray	□	□	_____
MRI	□	□	_____
CT Scan	□	□	_____
Dexascan	□	□	_____
Other	□	□	_____

PAST MEDICAL HISTORY	**Yes**	**No**		**Yes**	**No**
Diabetes	□	□	Anemia	□	□
Osteoporosis/Osteopenia	□	□	Dizziness	□	□
High Blood Pressure	□	□	Depression	□	□
Stroke/CVA	□	□	Anxiety/Panic Disorder	□	□
Pacemaker	□	□	Mental Illness	□	□
Abdominal Aortic Aneurysm	□	□	Headaches	□	□
Elevated Cholesterol	□	□	Ankylosing Spondylitis	□	□
Heart Attack	□	□	Spondylolisthesis	□	□
Angina	□	□	Metal Implants	□	□
Seizures	□	□	Fractures	□	□
Hernia	□	□	Shoulder Injury	□	□
Cancer	□	□	Arthritis	□	□
COPD	□	□	Hepatitis/AIDS	□	□
Peripheral Vascular Disease	□	□	Thyroid Conditions	□	□

Patient Name: _____ **Date:** _____

	Yes	No		Yes	No
Kidney or Bladder Disorder	□	□	Visual Impairment	□	□
Bleeding Disorder	□	□	Hearing Impairments	□	□
Current Fever/Chills	□	□	Unexplained weight change	□	□
Numbness genital/anal area	□	□	Bowel/bladder problems	□	□
Alcohol use	□	□	Drug Use	□	□
If yes how much? _____ *How often?* _____			*If yes what, how often?* _____		
Smoke	□	□	Current Pregnancy	□	□
If yes how many packs per day? _____			*If yes how many months?* _____		

If yes to any of the listed conditions please briefly explain the condition and date of diagnosis:

_____

_____

Is there any other information regarding your past medical history not listed we should know about? □ Yes □ No

_____

Please list any medications prescription and non prescription, vitamins, home remedies, birth control pills, herbs you are taking. Please list dosage and frequency:

Medication: ***Dosage (e.g. mg/pill):*** ***Frequency:*** ***What are you taking medication for:***

_____

_____

_____

_____

_____

_____

_____

Are you allergic to any medications? □ Yes □ No ***If yes, please list:*** _____

Please list all surgeries you have had: ***Surgery:*** ***Date:***

_____

_____

_____

_____

FAMILY MEDICAL HISTORY ***Has anyone in your immediate family ever had any of the following:***

	Yes	No	Relation		Yes	No	Relation
Heart Disease	□	□	_____	Alcohol/Drug Abuse	□	□	_____
Cancer/Type	□	□	_____	Diabetes	□	□	_____
Hypertension	□	□	_____	Elevated Cholesterol	□	□	_____
Stroke	□	□	_____	Asthma	□	□	_____
Mental Illness	□	□	_____	COPD	□	□	_____
Death before 50	□	□	_____	Bleeding disorder	□	□	_____

Please list any other family history that may be important to your care:_____

HOME EVIRONMENT

□ Married □ Single □ Living Alone □ Children Ages: _____

Is help available from spouse/children/roommate with household activities and yard work activities ? □ Yes □ No

Does your home have stairs that you are required to climb? _____

Other relevant information about home environment: _____

Patient Name: _____ Date: _____

WORK EVIRONMENT

□ Employed □ Student □ Retired □ Unemployed □ Homemaker

□ Full time □ Part Time □ Limited Hours _____ □ Restricted Duty _____

□ Employed but presently not working due to my condition

□ Previously employed and receiving disability benefits for my condition

Are you currently seeking disability benefits for this condition? □ Yes □ No □ Short Term □ Long Term

What is/was your occupation? :_____

What are your physical activities at work? (check all that apply)

□ Sitting □ Standing □ Phone Use □ Computer Use □ Heavy Lifting □ Repetitive lifting

□ Heavy equipment operation □ Driving □ Other: _____

PREVIOUS FUNCTIONAL ACTIVITY LEVEL

Prior to this injury…..

- How would you rate your overall health? □ Excellent □ Good □ Average □ Fair □ Poor
- Were you able to perform all self care activities? □ Yes □ No
- Were you able to perform all housework/child care /yard work activities? □ Yes □ No
- Were you able to perform all work duties? □ Yes □ No
- Did you exercise outside of your normal everyday activities? □ Yes □ No
  If yes, how often and what type: _____
- What did your recreational/sport activities consist of: _____

CURRENT FUNCTIONAL ACTIVITY LEVEL

Since the current injury…. ***If you answer no please elaborate on line below***

- Are you able to perform all self care activities? □ Yes □ No
  _____
- Are you able to perform all housework/child care /yard work activities? □ Yes □ No
  _____
- Are you able to perform all work duties? □ Yes □ No
  _____
- Are you able to tolerate your previous exercise activities ? □ Yes □ No
  _____
- Are you able to tolerate your previous recreational/sport activities? □ Yes □ No
  _____
- Are there any other activities that you are unable to do? □ Yes □ No
  _____

  _____

What are your goals for your treatment? _____

_____

Other information you believe is relevant to your treatment: _____

_____

_____

_____

_____

_____

Oswestry Low Back Pain Disability Questionnaire

Exclusively Spine Physical Therapy, LLC

Please read:
This questionnaire has been designed to give the doctor/clinician information as to how your back pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only the ONE sentence which applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just mark the sentence which most closely describes your problem.

NAME:_____ DATE:_____

Section 1 – Pain Intensity
- ☐ I can tolerate the pain I have without having to use pain killers.
- ☐ The pain is bad but I manage without taking pain killers.
- ☐ Pain killers give complete relief from pain.
- ☐ Pain killers give moderate relief from pain.
- ☐ Pain killers give very little relief from pain.
- ☐ Pain killers have no effect on the pain and I do not use them.

Section 2 – Personal Care (Washing, Dressing, etc.)
- ☐ I can look after myself normally without causing extra pain.
- ☐ I can look after myself normally but it causes extra pain.
- ☐ 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 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 me extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., 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 1 mile.
- ☐ Pain prevents me walking more than ½ mile.
- ☐ Pain prevents me walking more than ¼ mile.
- ☐ 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 only sit in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting more than 1 hour.
- ☐ Pain prevents me from sitting more than ½ hour.
- ☐ Pain prevents me from sitting 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 for more than 1 hour.
- ☐ Pain prevents me from standing more than 30 minutes.
- ☐ Pain prevents me from standing more than 10 minutes.
- ☐ Pain prevents me from standing at all.

Section 7 – Sleeping
- ☐ Pain does not prevent me from sleeping well.
- ☐ I can sleep well only by using tablets.
- ☐ Even when I take tablets I have less than six hours sleep.
- ☐ Even when I take tablets I have less than four hours sleep.
- ☐ Even when I take tablets I have less than two hours sleep.
- ☐ Pain prevents me from sleeping at all.

Section 8 – Sex Life
- ☐ 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 gives me no extra pain.
- ☐ My social life is normal but increases the degree of pain.
- ☐ Pain has no significant affect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
- ☐ Pain has restricted my social life and I do not go out as often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have no social life because of pain.

Section 10 – Traveling
- ☐ I can travel anywhere without extra pain.
- ☐ I can travel anywhere but it gives me extra pain.
- ☐ Pain is bad but I manage journeys over two hours.
- ☐ Pain restricts me to journeys of less than one hour.
- ☐ Pain restricts me to short necessary journeys less than 30 minutes.
- ☐ Pain prevents me from traveling except to the doctor or hospital.