Body Wisdom
PHYSICAL THERAPY

A. Maria de la Cruz
Physical Therapist
Licensed Massage Therapist

NYS PT Lic: 013788-1
NYS LMT Lic: 010443-1
NPI #:1346297850

INTAKE FORM

INITIAL EVALUATION SUBJECTIVE REPORT

Date _____ **Date of Birth** _____

Name_____

Address _____

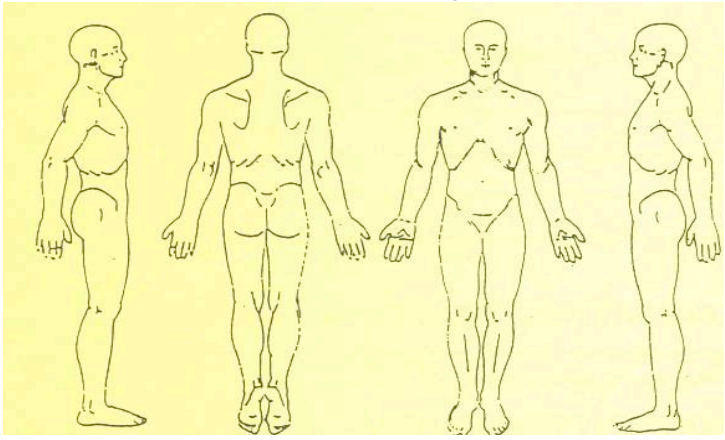
City _____ **State** _____ **Zip** _____

Phone: Home_____ **Cell**_____ **Work**_____

Emergency contact/relation:_____ **Phone:**_____
E-mail:_____
Occupation _____

Insurance Company / type of policy / ID number_____/_____/_____
Contact phone number for Insurance company_____
Primary Care Physician, Referring Physician or therapist
_____
Address _____
Phone _____
How did you hear about me? _____

The following is very important in the evaluation process. Please fill out these forms as specifically as possible to provide me with a clear picture of your present pain and functional status.



Please shade in areas of your symptoms.

1. **What is the primary complaint that brings you here today?**

   On a scale from 0-10 (0=painfree, 10=worst imaginable pain), how would you rate your pain?
   Presently_____ **Best**_____ **Worst**____

   Secondary complaint?

   When and how did your symptom(s) begin? Date: _____

   What makes the symptoms better?

   What makes the symptoms worse?

2. Have you ever received the following treatment for this condition?

	Yes	No	How long?	Helpful?
Physical Therapy	___	___	_____	_____
MFR	___	___	_____	_____
Chiropractic	___	___	_____	_____
Other	___	___	_____	_____

3. Check the box if you have had any of the following medical conditions?

Please place an "M" in front of each item that you experience at least MONTHLY. Place a "W" in front of each item that you experience WEEKLY or more frequently.

___ Diabetes ___ Varicose veins ___ Neurological problems
___ Rheumatic fever ___ Circulatory problems ___ Stroke
___ Heart Trouble ___ Lung disease ___ Broken bones (fracture)
___ High blood pressure ___ Epilepsy/seizures ___ Kidney disease
___ Heart disease/pacemaker ___ Malignancy ___ Liver disease
___ Migraine headaches ___ Arthritis ___ Metal implants
___ Osteoporosis ___ Blackouts ___ Visual Disturbances
___ Ringing ears ___ Weight Change >15 lbs ___ Night pain
___ Constipation ___ Tension headaches ___ Sinusitis
___ Back problems ___ Depression/Anxiety
___ Autoimmune disorder ___Numbness/Tingling ___ Sciatica
___ Sprains/Strains ___ Muscle tear/ruptured tendon ___ Lymph node removal
___ Tendonitis/bursitis ___ Menstrual pain/PMS ___ shortness of breath
___ Abdominal/Stomach disorder ___ Sore, aching muscles
___ Stiff or tender joints ___ Trembling/twitching muscles
___Sweaty palms ___ Cold hands/feet ___ irritability
___ Excessive perspiration ___ Can't keep warm enough ___Blushing/flushed face
___ Heartburn/indigestion ___ Asthma /difficulty breathing ___ Frequent urination
___ Incomplete urination ____Painful urination ___ Urinary leakage
___ Bowel leakage ___ Diarrhea
___ Bowel irregularity ___ Skin rashes ___Grinding of teeth (TMJ)
___ Dry mouth ___ Mouth sores
___ Sleep disturbances ___ Excessive drowsiness during day
___ Breast tenderness ___ Periods of extreme fatigue ___ Hot flashes
___ Feeling faint or dizzy ___ Water retention
Other: explain _____
_____

4. List past medical history and dates of occurrence. Include surgeries, accidents, and other traumas. Please note any scars and their locations.

_____
_____
_____
_____
_____

5. List ALL medications, which you are currently taking, the problem for which you are using them, the dose, and their effectiveness. (Include supplements, herbal, and homeopathic remedies).

Medication	for treatment of	Dose/Amt. per day	Effectiveness

_____
_____
_____
_____
_____

6. Is there a chance you may be pregnant at this time? Yes ___ No____

7. Patient Goals

List the activities that you would like to be able to do as a result of therapy.

Activity	Duration/How Often	By When
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

NOTICE OF ADVICE: As of November 2006 New York State allows direct access to Physical Therapy without a referral from a doctor, dentist or nurse practitioner for up to 30 days or 10 visits, whichever comes first. This notice is to advise you that your health insurance company may not cover PT without a referral, while they may cover PT with a referral.

I understand that my healthcare provider may not reimburse therapy services and services rendered are not contingent on reimbursement.

I, _____, acknowledge that I have received and understand the NOTICE OF PRIVACY PRACTICES from A. Maria de la Cruz, PT, LMT of Body Wisdom Physical Therapy, Pittsford, NY 14534 on _____.
I give permission for Maria de la Cruz/Body Wisdom Therapeutics to communicate with the following people/healthcare providers:
1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Also, be aware that there is a 24-hour cancellation policy. You are responsible for full payment of the missed/cancelled session. This ensures that open appointment times are not left void, while other patients may be on a waiting list to receive treatment. By signing this document you agree to adhere to this policy.

There is a $40 service fee for checks with insufficient funds.

Please sign and date below that you have read understand this advice. Thank you.

Signature:_____ Date:_____

NOTICE OF PRIVACY PRACTICES (MEDICAL)
THIS NOTICE DESCRIBES HOW MEDICALINFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TOTHIS INFORMATION.
PLEASE REVIEW ITCAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your information.

We may use and disclosed your medical records only for each of the following purposes: treatment, payment and health care operations.

· **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.

· **Payment** means such activities as obtained reimbursement for services, confirming coverage, billing or collection activities, and utilizationreview. An example of this would be sending a bill for your visit to your insurance company for payment.

· **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvementactivities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

· The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
· The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
· The right to inspect and copy your protected health information.
· The right to amend your protected health information.
· The right to receive an accounting of disclosures of protected health information.
· The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of December 1st, 2003and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

For more information about HIPAA or to file a complaint:
The U.S. Department of Health & Human
Services Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775