Confidential Patient Information

Name _____DOB _____ Age _____
Address _____ Apt _____ Phone _____
City _____ State _____ Zip _____ Gender _____
Permanent Address _____ Phone _____
City _____ State _____ Zip _____ E-mail _____
Social Security # _____ Driver's License # _____ State _____
If a minor, parent/guardian name _____
Social Security # _____ DOB _____

Emergency Contact _____ Relationship _____
Address _____ Phone _____
City _____ State _____ Zip _____

Referring Physician _____ Next visit _____
Primary Care Physician _____ Next visit _____

I hereby authorize the release of any medical information necessary for processing insurance claims and payment of medical benefits for myself or the party who accepts assignments of benefits.

Signature _____ Date _____

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Consent for Care and Treatment

I, the undersigned, do hereby agree and give my consent for MechanoTherapy to furnish medical care and treatment, which is considered necessary and proper in the diagnosing or treating of my physical condition.

Signature _____ Date _____
Patient/Guardian

BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

I, the undersigned, hereby assign all medical benefits, i.e.: Medicare, private insurance, major medical benefits, Worker's Compensation, automobile insurance, and any other health plans to which I'm entitled to MechanoTherapy. A photocopy is to be considered as valid as the original. I hereby authorize MechanoTherapy to release all medical records necessary to secure payment for services rendered.

Signature _____ Date _____
Patient/Guardian

FINANCIAL POLICY STATEMENT

It is our policy to bill your insurance carrier or other provider of medical benefits as a courtesy to you, although you are responsible for the entire bill when the services are rendered. Required co-payments and estimated co-insurances are to be made as services are rendered and arrangements are to be made for payments of all amounts not covered by your medical benefits or estimated co-insurances as soon as those amounts are known. If your medical benefits are not paid within sixty (60) days, the balance will be due in full from you.
All co-insurance percentages paid at time of service are estimated. Your actual liability may be more. You are responsible for any difference between the estimated and actual co-insurance due.

If any payments of medical benefits are made directly to you for services rendered by MechanoTherapy, you must promptly remit such payment directly to MechanoTherapy.

If you are a Worker's Compensation patient the above policy does not apply to you. Be advised, however, that you maybe responsible for your charges if your Worker's Compensation claim is successfully controverted.

If you fail to make timely payment for any amount for which you are responsible, you will be responsible for all costs of collection, including court costs, collection agency fees and/or a reasonable attorney fee.

I have read the above information and/or it has been explained to me and I accept the terms and conditions above and will be responsible for the payment of my account.

Signature _____ Date _____
Patient/Guardian

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Privacy Policy and Procedure Statement

Dear Patient,

MechanoTherapy maintains compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy regulations passed into law on December 20, 2000.

We obtain your voluntary consent to provide treatment, release medical records to the appropriate entities and those who you designate to provide health care treatment, payment, and daily operations of the facility.

Our clinical and front office staff uses patient information to ensure quality care and appropriate billing for services.

You may correct, amend, access, and request a copy of your medical record and access history by signing a letter for release of your medical information. The cost for copies of medical records is in accordance with state law.

We protect all patient information within the guidelines provided by federal, state, and local government.

If you have any grievance pertaining to the privacy of medical records or wish to enquire further about how our facility manages patient information, please contact our privacy officer at (503)567-5771.

MechanoTherapy reserves the right to amend, change, and/or revise our privacy policy at any time in accordance with federal, state, and local rules, regulations, and guidelines.

Thank you for choosing our health care facility.

Signature _____ Date _____

Patient/Guardian

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Name: _____ Date: _____ Date of Birth: _____ Age: _____

Nickname: _____

Preferred Pronoun: _____ Gender: _____

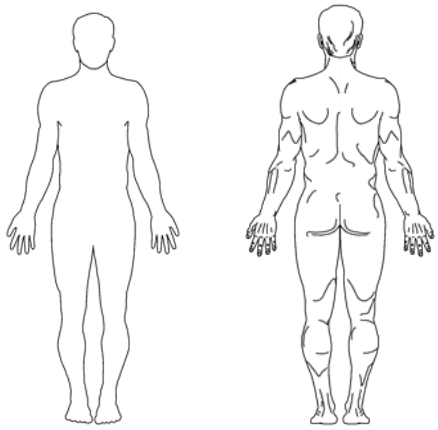
To ensure you receive a complete and thorough evaluation, please provide us with important background information on the following form. If you do not understand the question, your Physical Therapist can assist you. Thank you for your time.

1) Reason for Visit?

_____

_____

Shade in region(s) of pain or abnormal sensation:



2) When did your symptoms begin?

_____

3) Surgery Performed? ❑ Yes ❑ No

Type:_____

Date of Surgery:_____

4) Was the onset/time of this episode:

❑ Gradual ❑ Sudden

Any previous episodes? ❑ Yes ❑ No

5) How did your injury occur?

- ❑ Unknown
- ❑ Car Accident
- ❑ Trauma
- ❑ Overuse
- ❑ Degenerative Process
- ❑ During recreation/sports
- ❑ Other_____
- ❑ While lifting
- ❑ A fall
- ❑ At work
- ❑ Dental

6) Since the onset, are your symptoms getting:

❑ Better ❑ Worse ❑ Staying the Same

7) Nature of pain/symptoms:

- ❑ Sharp ❑ Aching ❑ Dull
- ❑ Throbbing ❑ Periodic ❑ Constant
- ❑ Occasional
- ❑ Other: _____

8) Rate your pain on scale of 0-10 below. Place 3 circles: (**Best, Current, Worst**)

0 1 2 3 4 5 6 7 8 9 10

No Pain…… **……Worst Pain Imaginable**

9) As the day progresses, do your symptoms:

❑ Increase ❑ Decrease ❑ Stay the Same

10) Does your pain wake you at night:

- ❑ Yes ❑ No
- ❑ While lying down
- ❑ Only with changing positions

11) What Position do you sleep?

- ❑ Back ❑ Stomach ❑ Chair/recliner
- ❑ Right side ❑ Left side

12) Average amount of sleep per night? _____

13) Do you wake with stiffness in the morning?

❑ Yes ❑ No

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Name: _____ Date: _____ Date of Birth: _____ Age: _____

14) **Previous** Functional Level:

- ❑ Independent in all activities
- ❑ Independent in all self-care
- ❑ Difficulty performing self-care activities
- ❑ Need assistance with self-care activities
- ❑ Difficulty performing household chores
- ❑ Need assistance with activities in community outside of home

15) **Current** Functional Level: What specific activities are you unable to do because of your symptoms?

_____

_____

16) What positions, activities, and time of day **aggravate** your symptoms?

_____

_____

17) What positions, activities, and time of day **relieve** your symptoms?

_____

_____

18) Have you had similar symptoms in the past?

_____

_____

19) Occupation:_____

❑ Full-time ❑ Part-time ❑ Self-Employed
❑ Student ❑ Retired ❑ Unemployed

20) Have you had previous treatment for this condition?

❑ Medication ❑ Injection
❑ Manipulation DC/DO ❑ Exercise
❑ Physical Therapy ❑ Traction
❑ Naturopathic Doctor ❑ Acupuncture
❑ Injection ❑ Bracing/Taping
❑ Massage Therapy ❑ Oriental Medicine
❑ Other _____

21) Have you had any tests done relating to your condition?

❑ X-ray ❑ MRI ❑ CT Scan
❑ Bone Scan ❑ Arthrogram ❑ Lab Tests
Results: _____

22) Are you currently taking any medications or supplements, either prescription or over the counter? Please List.

_____

_____

23) Do you have any allergies to food or medications?

_____

_____

24) How would you rate your general health?

❑ Excellent ❑ Good ❑ Average
❑ Fair ❑ Poor

25) Do you have a prior or current history of smoking?

❑ No ❑ Yes;
How many packs a day? _____

26) How frequently do you exercise outside of normal daily activities?

❑ 5+ days/wk ❑ 3-4 days/wk ❑ 1-2 days/wk
❑ Occasionally ❑ Zero
What type of exercise/sports?

_____

27) What are your goals coming to Physical Therapy?

_____

_____

28) Please indicate your activity level due to your present condition as compared to your previous level before injury.

Inactive…… ……**Normal**
On A Good Day:
0%------20%------40%------60%------80%-----100%
On A Bad Day:
0%------20%------40%------60%------80%-----100%

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Name: _____ Date:_____ Date of Birth:_____ Age:_____

MEDICAL HISTORY

As you review the following list, please check any problems or conditions that you are currently experiencing or have experienced.

General Health
- ❑ Good General Health
- ❑ Recent weight change
- ❑ Loss of appetite
- ❑ Fatigue
- ❑ Chronic Fatigue Syndrome
- ❑ Fever/Chills
- ❑ Other:_____

Spine/Orthopedic/Bone
- ❑ Back Pain
- ❑ Neck Pain
- ❑ Joint Pain
- ❑ Muscle Pain/Stiffness
- ❑ Difficulty Walking
- ❑ Fractures
- ❑ Dislocations
- ❑ Swelling
- ❑ Other:_____

Ears, Eyes, Nose, Mouth, Throat
- ❑ Change in Taste/Smell
- ❑ Change in swallow/chewing
- ❑ Ringing in Ears
- ❑ Sinus Infection
- ❑ Recent dental work
- ❑ Change in Vision
- ❑ Other:_____

Gastrointestinal
- ❑ Constipation/Diarrhea
- ❑ Nausea/Vomiting
- ❑ Painful Bowel Movements
- ❑ SIBO
- ❑ Stomach/Abdominal Pain
- ❑ Ulcer
- ❑ Crohns
- ❑ Bowel Incontinence
- ❑ Other:_____

Rheumatologic
- ❑ Rheumatoid Arthritis
- ❑ Fibromyalgia
- ❑ Auto-Immune Disorders
- ❑ Psoriatic Arthritis
- ❑ Ankylosing Spondylitis
- ❑ Other:_____

Urinary
- ❑ Kidney Stones/Infection
- ❑ Frequent UTI/Bladder Infections
- ❑ Urinary Incontinence/Urgency
- ❑ Urinary Retention
- ❑ Painful Urination
- ❑ Other:_____

Reproduction
- ❑ Testicle Pain
- ❑ Prostate Disease
- ❑ Sexual Difficulty
- ❑ Irregular Periods
- ❑ # Pregnancies:_____
- ❑ Currently Pregnant
  # of weeks:_____
- ❑ Currently Breastfeeding
- ❑ STD
- ❑ Endometriosis
- ❑ Oral Birth Control Pills
- ❑ Ovarian Cysts
- ❑ PCOS
- ❑ Pelvic Pain
- ❑ Other:_____

Blood
- ❑ Deep Vein Thrombosis
- ❑ Arteriosclerosis
- ❑ Artery Bypass Surgery
- ❑ Calf pain
- ❑ HIV/AIDS
- ❑ Cancers
- ❑ Other:_____

Cardiac
- ❑ History of Heart Attack
- ❑ Angina
- ❑ Implantable Defibrillator
- ❑ Pacemaker
- ❑ Congestive Heart Failure
- ❑ High Blood Pressure
- ❑ Irregular Heart Beat
- ❑ Bypass surgery
- ❑ Other:_____

Neurologic
- ❑ Seizure
- ❑ Concussion
- ❑ Traumatic Brain Injury
- ❑ Stroke
- ❑ Disc Bulge/Herniation
- ❑ Dizziness/Vertigo
- ❑ Memory Loss
- ❑ Migraine Headaches
- ❑ Balance Difficulties
- ❑ Other:_____

Skin
- ❑ Cellulitis
- ❑ Psoriasis
- ❑ Hives
- ❑ Rash/Itching
- ❑ Other:_____

Psychiatric
- ❑ Severe Depression
- ❑ Panic Attack
- ❑ Psychotic Disorder
- ❑ Borderline Disorder
- ❑ Suicide Attempt
- ❑ Other:_____

Cancer
- ❑ History of Cancer
  Type:_____
  Treatment:_____
- ❑ Blood Disorder
- ❑ Other:_____

Surgical History
- ❑ Types of Surgery and Surgical
  Dates:_____
  _____
  _____
  _____
  _____

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BFR Precautions and Contraindications Precautions:

<u>Please circle any of the following conditions that are part of your medical history</u>:

- Poor circulatory system
- Obesity or with limb tissue that is loose (The risk of tourniquet shifting may be increased)
- Varicose veins
- Arterial calcification
- Abnormal clotting times
- Diabetes
- Sickle cell trait
- Tumor
- General Infection
- Hypertension
- Cardiopulmonary conditions
- Renal Compromise
- Clinically significant acid---base imbalance
- Atherosclerotic vessels (McEwan 2014, Wakai 2001)
- Anti-hypertensives
- Creatine supplements (Gupta 2008, Sheth 2006)

Contraindications:
Possible contraindications for BFR use include:
Venous thromboembolism
Impaired circulation or peripheral vascular compromise
Previous revascularization of the extremity
Extremities with dialysis access
Acidosis
Sickle cell anemia
Extremity infection
Tumor distal to the tourniquet
Medications and supplements known to increase clotting risk
Open fracture
Increased intracranial pressure
Open soft tissue injuries
Post---traumatic lengthy hand reconstructions
Severe crushing injuries
Severe hypertension
Elbow surgery (where there is concomitant excess swelling)
Skin grafts in which all bleeding points must be readily distinguished
Secondary or delayed procedures after immobilization
Vascular grafting
Lymphectomies
Cancer

Signature _____ Date _____