

Rehabilitation Services
Patient History Questionnaire

Douglass Orthopedic & Spine Rehabilitation, Inc
24820 Burnt Pine Drive Suite 4 • Bonita Springs FL 34134
(239) 947-4184 Fax (239) 947-4171

Patient: _____
MR# _____

Your therapist will discuss your responses with you during the evaluation. Thank you for completing this information.

PERSONAL INFORMATION

I am currently: Employed Employed with restrictions On medical leave Not employed

Employer: _____ Occupation: _____

Interests/hobbies/exercise: _____

Is there anyone who can assist you with doing home exercises or activities if needed? Yes No

Will you have any problems attending therapy sessions? No Yes If yes, please describe:

Next scheduled Dr appointment(s): Date _____ Physician _____
Date _____ Physician _____

KEY QUESTIONS ABOUT YOUR CONDITION

1. What is your MAIN complaint? _____

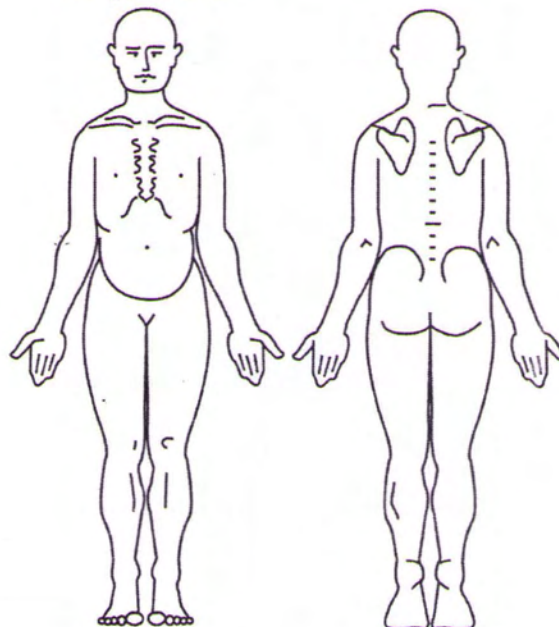
2. Darken the areas on the body where you are having problems.

3. Please mark your level of pain with an X along the following lines:

What is your pain at rest?



What is your pain with activity?



GENERAL HEALTH

4. Are you having trouble sleeping? Yes No Normal hours of sleep _____ hours
Current hours of sleep _____ hours

5. Are you experiencing or have any of the following:

- Apprehension
- Crying episodes
- Low energy or frequent fatigue
- Flushing
- Increased perspiration
- Avoiding or uncomfortable with people
- Less talkative than usual
- Increased negative feelings about injury or future
- Weight loss (10 lbs or more)
- Decreased sexual interest

Please complete 2nd page of form.

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GENERAL HEALTH (cont)

6. Medical conditions you have or have had. (check all that apply)

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Stroke | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Cancer: <input type="checkbox"/> In remission | <input type="checkbox"/> Stomach Disorders (<i>ulcers, etc.</i>) | <input type="checkbox"/> Visual problems | <input type="checkbox"/> Parkinson's disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Hearing problems | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Depression | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Panic Attacks | <input type="checkbox"/> Other _____ | |
| <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Gland Problems (<i>thyroid</i>) | | |

7. Have you had any surgical or invasive procedures? Yes No If yes, please list:

8. Uncontrolled leakage of urine? Yes No
9. Loss of bowel control? Yes No
10. Do you smoke? Yes No Packs per day _____
11. Do you drink alcohol? Yes No Drinks per week _____
12. Is there any chance you might be pregnant? Yes No
13. Are you on a special diet? Yes No Specify _____
14. Are you taking any medications (prescription, over the counter, herbal preparations)? Yes No If yes, please list or see attached

15. Do you have any allergies (eg. adhesives, latex, cortizone)? Yes No If yes, please list with any reactions/treatments:
 _____ Reaction/Treatment: _____
 _____ Reaction/Treatment: _____
 _____ Reaction/Treatment: _____

16. For patients 12 years and younger, is immunization/vaccination status current? Yes No

PERSONAL GOALS FOR THERAPY

17. What do you **WANT TO** achieve from having therapy? Check all that apply:
- | | | |
|--|--|--|
| <input type="checkbox"/> Improve home activities | <input type="checkbox"/> Improve mobility/walking activities | <input type="checkbox"/> Decrease or eliminate pain/discomfort |
| <input type="checkbox"/> Improve leisure/sports activities | <input type="checkbox"/> Improve ability to communicate | <input type="checkbox"/> Return to work: <input type="checkbox"/> Current job <input type="checkbox"/> Other job |
| <input type="checkbox"/> Improve self care activities | <input type="checkbox"/> Improve swallowing | <input type="checkbox"/> Other _____ |

18. Please include any additional information you feel would help us provide your care (ie. what you think would help, any apprehensions about treatment, special communication, language, spiritual or cultural needs).

To the best of my knowledge, the above information is complete and factual.

Patient Signature _____
Date



Douglass Orthopedic & Spine Rehabilitation, Inc. Statement of Privacy Notice

Effective April 14, 2003

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information.

Please review the information carefully.

- Your protected health information may be released to your insurance provider for the purpose of Douglass Orthopedic & Spine Rehabilitation, Inc. (DOSR inc.) receiving payment for providing you with needed physical therapy services. DOSR inc. might share your health information with your physician for payment activities related to the care you received.
- Your protected health information may be released to public or law enforcement officials in the event of an investigation in which you are a victim of abuse, a crime or domestic violence.
- Your protected health information may be released to other healthcare providers in the event you need emergency care.
- Information regarding your appointment time, presence at our facility, or other general details of your scheduled appointments may be provided over the phone to callers who request so by providing your name.
- Your protected health information may be released only after receiving written authorization from you with the exception of those listed above or for treatment, payment, or healthcare operations. You may revoke your permission to release protected health information at any time. It must be in writing with effective date and be specific to the health information being protected. DOSR inc. is not required to agree to your request.
- You may be contacted by DOSR inc. by phone or mail (or leave a message on an automated answering device) to remind you of appointments, verify insurance/demographic information, etc. You have the right to request a more confidential way of providing your protected health information or alternative communication method at the time you are seen at DOSR inc. DOSR inc. will honor all reasonable requests.
- You have the right to restrict the use of your protected health information. However, DOSR inc. may choose to refuse your restriction if it is in conflict with providing you with quality healthcare or in the event of an emergency situation.
- You have the right to review and photocopy any/all portions of your health information. DOSR inc. has the right to assess a fee for the photocopying of the health information.
- You have the right to request an amendment to your health information. It must be in writing and explain why the information should be amended. DOSR inc. can deny the amendment and if so, a written explanation will be provided.
- You have the right to possess a copy of this Statement of Privacy Notice upon request. This copy can be in the form of an electronic transmission or on paper.
- DOSR inc. is required by law to protect the privacy of its patients. It will keep protected any and all patient health information and will provide patients with a list of practices that protect health information upon written request.
- DOSR inc. will abide by the terms of this notice. DOSR inc. reserves the right to make changes to this notice and will continue to maintain the confidentiality of all health information. Changes to this notice will be redistributed at your next visit to DOSR inc.
- You have the right to complain to DOSR inc. if you believe your rights to privacy have been violated. If you feel your privacy rights have been violated, please mail your written complaint to:
Douglass Orthopedic & Spine Rehabilitation, Inc.
ATTN: Patient Information Privacy Officer
24820 Burnt Pine Drive Suite 4
Bonita Springs FL 34134
- All complaints will be investigated. No personal issue will be raised for filing a complaint with DOSR inc.
- You may also file a complaint to:
Region IV, Office of Civil Rights
US Dept. of Health and Human Services
Atlanta Federal Center, Suite 3B70
61 Forsyth Street, S.W.
Atlanta GA 30303-8909
- If you would like more information regarding this Privacy Notice, please contact our Privacy Officer at (249) 947-4184.