Thygesen
Physical Therapy

Acct #:_____ Date/Time of Evaluation: _____

PATIENT INFORMATION

Name _____ Home # _____Work #_____Cell #_____

E-Mail _____ SSN# _____ DOB _____ Marital Status_____

Address_____
Street Apt # City State Zip

Employer Name/Address _____

Primary Care Physician _____ Referring Physician _____

Diagnosis or Chief Complaint _____

INSURANCE INFORMATION/VERIFICATION

Policy Holder Information

Name _____ Home # _____Work #_____Cell #_____

Relationship to Patient _____ SSN# _____ DOB _____

Address_____
Street Apt # City State Zip

Employer Name/Address _____
Employer Street City State / Zip

Primary Insurance

Insurance Name _____ Policy / Group # _____

Insurance Address _____ Insurance Phone # _____
Street City State / Zip

Policy Holder _____ Relationship to Policy Holder _____

Policy Holder DOB _____ Policy Holder SSN #_____

Secondary Insurance

Insurance Name _____ Policy / Group # _____

Insurance Address _____ Insurance Phone # _____
Street City State / Zip

Policy Holder _____ Relationship to Policy Holder _____

Policy Holder DOB _____ Policy Holder SSN #_____

Emergency Contact

Name _____ Home # _____Work #_____Cell #_____

Relationship _____

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Authorization for Treatment
I hereby consent to and authorize all physical therapy treatments at Thygesen Physical Therapy.

Signature _____ Date: _____
(Must be 18 years or older to sign)

Parent/Guardian

Signature _____ Date:_____ Relationship _____

Financial Agreement
I understand and agree that I am responsible for payment for services performed at Thygesen Physical Therapy. I will pay upon demand, all charges that are my responsibility. I authorize all payments be made from my insurance company to Thygesen Physical Therapy and I am responsible for all charges not paid by my insurance company. I authorize Thygesen Physical Therapy to provide information necessary to secure payment of benefits. Please initial _____

Use of Protected Health Information
I have been provided with a Notice of Privacy Practices. I understand that Thygesen Physical Therapy may disclose my personal health information for the purpose of carrying out treatment and obtaining payment. I hereby consent to the use and disclosure of my person health information as described in the Notice of Privacy Practices. I understand that I can revoke this consent by notifying the practice in writing at any time. Please initial _____

Cancellation/No Show Policy
It is the policy of this clinic that after four (4) rescheduled or missed appointments, you will be asked to go to the “same day scheduling”. Same day scheduling requires you to call our office the day you wish to come in, with the understanding that you will only be seen if there is an appointment time available. If no appointment times are available that day, you may call again on another day; however, no appointments will be scheduled further out than the day you call in. Failure to keep same day appointments will be an automatic discharge from our office and a letter will be sent to your referring physician. Please initial _____

Patient Signature _____ Date _____

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In order to provide you with the best care, we would like you to complete the following:

Name _____ Age_____ Date _____

Occupation:_____

What are we seeing you for:_____

When did your current problem begin (date of related accident/onset):_____

Previous and/or Current Treatment (Physical Therapy / Chiropractor / Massage, other):

_____

Tests performed (X-rays, MRI, CT scan, blood tests):_____

When/Where:_____ Results:_____

Date of last physical examination _____ Date of next physician follow up _____

Other existing/previous injuries:_____

Have you or any immediate family member ever been told you have:

	Self		Family			Self		Family	
Cancer	Yes	No	Yes	No	Stroke	Yes	No	Yes	No
Diabetes	Yes	No	Yes	No	Osteoporosis	Yes	No	Yes	No
High blood pressure	Yes	No	Yes	No	Osteoarthritis	Yes	No	Yes	No
Heart disease	Yes	No	Yes	No	Rheumatoid arthritis	Yes	No	Yes	No
Angina/chest pain	Yes	No	Yes	No	Seizures	Yes	No	Yes	No
Chronic headache	Yes	No	Yes	No	Pacemaker	Yes	No	Yes	No

In the past 3 months have you had or do you experience:

A change in your health	Yes	No	Numbness or tingling	Yes	No
Nausea/Vomiting	Yes	No	Difficulty swallowing	Yes	No
Fever/chills/sweats	Yes	No	Shortness of breath	Yes	No
Unexplained weight change	Yes	No	Dizziness	Yes	No
Changes in appetite	Yes	No	Urinary tract infection	Yes	No
Changes in bowel/bladder function	Yes	No	Upper respiratory infection	Yes	No

Do you have a history of:

Allergies/Asthma	Yes	No	Seizures	Yes	No
Headaches	Yes	No	Ulcers	Yes	No
Kidney disease	Yes	No	Bronchitis	Yes	No
Rheumatic fever	Yes	No	Sexually transmitted disease	Yes	No

Are you currently:

Pregnant	Yes	No, if yes due date: _____
Depressed	Yes	No
Under Stress	Yes	No

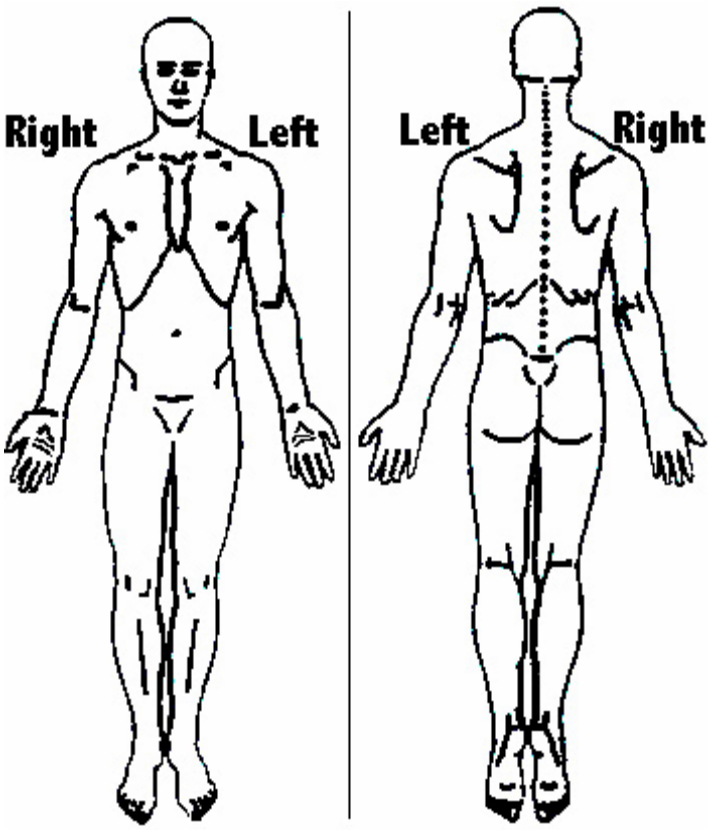
Are your symptoms: (circle one)

Getting worse The same Improving

How are you able to sleep at night? (circle one)

Fine Moderate difficulty Only with medication

Please draw your area of pain:



On a scale of 0 to 10 with 0 being no pain and 10 being severe pain

How would you rate your pain today?

0 1 2 3 4 5 6 7 8 9 10

How would you rate your pain on average?

1 2 3 4 5 6 7 8 9 10

What aggravates your pain?_____

_____

What relieves your pain? _____

_____

List all medications and supplements you are currently using: _____

_____

Any other information you would like to provide to your therapist _____

_____

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Patient Functional Questionnaire

Patient Name _____ Today's Date _____

Please choose the answer in each section that best describes your condition.

Pain Intensity
- I have no pain at the moment.
- Pain is very mild at the moment.
- Pain is very moderate at the moment.
- Pain is fairly severe at the moment
- Pain is very severe at the moment.
- Pain is the worst imaginable at the moment.

Personal Care (washing, dressing, etc.)
- I can look after myself normally without causing increased pain
- I can look after myself normally, but it is very painful.
- 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, I wash with difficulty, and I stay in bed.

Work
- I can do as much work as I want to.
- I can only do my usual work, but no more.
- I can do most of my usual work, but no more.
- I cannot do my usual work.
- I can hardly do any work at all (only light duty).
- I cannot do any work at all.

Sleeping
- I have no trouble sleeping.
- My sleep is slightly disturbed
- My sleep is mildly disturbed (1-2 hrs. sleepless).
- My sleep is moderately disturbed (2-3 hrs. sleeplessness).
- My sleep is greatly disturbed (3-5 hrs. sleeplessness).
- My sleep is severely disturbed (5-7 hrs. sleeplessness).

Headaches
- I have no headaches at all.
- I have slight headaches which come less than 3 per week.
- I have moderate headaches which come infrequently.
- I have moderate headaches which come 4 or more per week.
- I have severe headaches which come frequently.
- I have headaches almost all of the time.

Eating
- I can eat whatever I want without pain.
- I can eat whatever I want but it gives me extra pain.
- Pain prevents me from chewing anything other than soft foods
- I cannot chew food and I am on a liquid diet.

Walking
- Symptoms do not prevent me walking any distance.
- Symptoms prevent me walking more than 1 mile.
- Symptoms prevent me walking more than 1/2 mile.
- Symptoms prevent me walking more than 1/4 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.

Stairs
- I can walk stairs comfortably without a rail.
- I can walk stairs comfortably, but with a crutch, cane, or rail.
- I can walk more than 1 flight of stairs, but with increased symptoms.
- I can walk less than 1 flight of stairs.
- I can manage only a single step or curb.
- I am unable to manage even a step or curb.

Standing
- I can stand as long as I want without increased symptoms.
- I can stand as long as I want, but it gives me extra symptoms.
- Symptoms prevent me from standing for more than 1 hour.
- Symptoms prevent me from standing for more than 30 minutes.
- Symptoms prevent me from standing for more than 10 minutes.
- Symptoms prevent me from standing at all.

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.
- My symptoms prevent me from sitting more than 1 hour.
- My symptoms prevent me from sitting more than 1⁄2 hour.
- My symptoms prevent me from sitting more than 10 minutes.
- My symptoms prevent me from sitting at all.

Reaching
- I can reach to a high shelf to place an empty cup without increased symptoms.
- I can reach to a high shelf to place an empty cup with some increased symptoms.
- I can reach to a high shelf to place an empty cup with a moderate increase in symptoms.
- I cannot reach to a high shelf to place an empty cup, but I can reach up to a lower shelf without increased symptoms.
- I cannot reach up to a lower shelf without increased symptoms, but I can reach counter height to place an empty cup.
- I cannot reach my hand above waist level without increased symptoms.

Lifting
- I can lift heavy weights without extra symptoms.
- I can lift heavy weights but it gives extra symptoms.
- My symptoms prevent me from lifting heavy weights, but I manage if they are conveniently positioned. (e.g. on a table)
- My symptoms prevent me from lifting heavy weights, but I 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.

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Physical Therapy

Privacy Policy

Notice of Privacy Practices

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.

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 health information.

We may use and disclose 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 obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. 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 improvement activities, 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 the 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 legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003, and 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 the office.

We have recourse if you feel that your privacy protections have been violated. You have the right to file 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.

Please contact us for more information:
Paul Thygesen, President
Paul Thygesen, HIPAA Administrator
402-423-7878

For more information about HIPAA or to file a complaint:
The U.S. Dept of Health and Human Services,
Office of Civil Rights
200 Independence Ave. S.W.
Washington, DC 20201
202-619-0257
877-696-6775