



PATIENT INFORMATION

FIRST NAME	MI	LAST NAME
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ADDRESS

CITY	STATE	ZIP
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SOCIAL SECURITY NUMBER	BIRTHDATE (mm/dd/ccyy)
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MARITAL STATUS	SEX	Emergency contact: (Name and phone #)
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HOME PHONE	CELL PHONE
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SPOUSE'S NAME	SPOUSE'S SOCIAL SECURITY NUMBER
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SPOUSE'S ADDRESS

SPOUSE'S PHONE NUMBER	SPOUSE'S BIRTHDATE
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PHYSICIAN INFORMATION

Name of REFERRING PHYSICIAN:	Phone #
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Name of your PRIMARY CARE DOCTOR:	Phone #
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If WORK COMP, please provide name of work comp MD	Phone #
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When is your next scheduled doctor's appointment?

YOUR EMPLOYMENT INFORMATION

EMPLOYER	WORK PHONE #
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ADDRESS

CITY	STATE	ZIP CODE
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OCCUPATION

Is your PRIMARY INSURANCE plan provided through this employer?

Is your SECONDARY INSURANCE plan provided through this employer?

YOUR SPOUSE'S EMPLOYMENT INFORMATION

EMPLOYER	WORK PHONE #
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ADDRESS

CITY	STATE	ZIP CODE
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OCCUPATION

Is your PRIMARY INSURANCE plan provided through YOUR SPOUSE'S employer?

Is your SECONDARY INSURANCE plan provided through YOUR SPOUSE'S employer?

INSURANCE INFORMATION

PRIMARY INSURANCE

SECONDARY or SUPPLEMENTAL INSURANCE (write SELF if you pay for the insurance, write name if other than self)

WORKERS COMP or AUTO INSURANCE NAME

WORK COMP or AUTO insurance address:

WC or AUTO insurance CITY	STATE	ZIP CODE
WC or AUTO CLAIM #		WC or AUTO phone #
WC or AUTO case worker/adjuster NAME		Case worker or adjuster's phone #

MEDICAL HISTORY

List any SURGERIES (include dates & reason):

List any HOSPITALIZATIONS (include dates & reason):

List any AUTO ACCIDENT INJURIES (include dates):

List any on the JOB INJURIES (include dates):

List any CURRENT OR PAST MAJOR MEDICAL CONDITIONS you have had (cancer, diabetes, heart disease, arthritis, etc.):

List all current over-the-counter and prescription MEDICATIONS used (include reason used):

List any HEALTH CONDITIONS that run in your family (cancer, heart disease, diabetes, arthritis, back problems, etc.)

Have you been under a PHYSICIAN'S CARE in the past year? YES NO (reason)

If female, is there a possibility that you are PREGNANT? YES NO

Do you smoke/use tobacco? YES NO Exercise habits? never occasional frequent

Check any of the following symptoms you have noticed Previously Now

- | | | |
|---------------------------------------------------------|----------------------------------------------------------|------------------------------------------------------------|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Low back pain | <input type="checkbox"/> Sensitive to light or sound |
| <input type="checkbox"/> Dizziness or light-headed | <input type="checkbox"/> Leg/foot numbness/tingling | <input type="checkbox"/> Visual or hearing disturbance |
| <input type="checkbox"/> Jaw pain, clicking, or locking | <input type="checkbox"/> Leg/foot fatigue/weakness | <input type="checkbox"/> Memory loss/problems |
| <input type="checkbox"/> Pain or difficulty swallowing | <input type="checkbox"/> Leg pain with walking | <input type="checkbox"/> Irritability or depression |
| <input type="checkbox"/> Neck pain or stiffness | <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Fatigue or loss of energy |
| <input type="checkbox"/> Shoulder pain | <input type="checkbox"/> Nausea or vomiting | <input type="checkbox"/> Fainting or convulsions |
| <input type="checkbox"/> Mid back pain | <input type="checkbox"/> Diarrhea or constipation | <input type="checkbox"/> Trouble with balance/coordination |
| <input type="checkbox"/> Chest pain or cough | <input type="checkbox"/> Blood in urine or stool | <input type="checkbox"/> Sleep disturbances/problems |
| <input type="checkbox"/> Pain/trouble breathing | <input type="checkbox"/> Difficulty or pain w/ urination | <input type="checkbox"/> Rashes (face, body, limbs) |
| <input type="checkbox"/> Arm/hand numbness/tingling | <input type="checkbox"/> Difficulty with sexual function | <input type="checkbox"/> Joint pain or swelling |
| <input type="checkbox"/> Arm/hand fatigue/weakness | <input type="checkbox"/> Abnormal menstrual periods | <input type="checkbox"/> Pain with exertion (activity) |

Have you had any of the following:

- | | | |
|--------------------------------------------------|---------------------------------------------------------------|---------------------------------------------------|
| <input type="checkbox"/> Pain worse at night | <input type="checkbox"/> Recent bacterial infection (30 days) | <input type="checkbox"/> Urinary discharge |
| <input type="checkbox"/> Constant pain | <input type="checkbox"/> Loss of bowel or bladder control | <input type="checkbox"/> Recent surgery (30 days) |
| <input type="checkbox"/> Unexplained weight loss | | |

CURRENT CONDITION/COMPAINT

What is your PRIMARY COMPLAINT/PROBLEM?

List other SYMPTOMS:

WHEN did your symptoms FIRST BEGIN (give date if possible)?

HOW did your symptoms FIRST BEGIN? Pain is: Constant Intermittent Is your condition getting worse? YES NO

What activities AGGRAVATE your condition? (list)

What activities LESSEN your symptoms? (list)

Have you had: X-RAY MRI or CAT Scan EMG Bone Scan Blood Work

List all home remedies tried for this problem

Is your condition worse at certain times of the day or night?

Does your condition interfere with: (yes/no) work sleep normal daily routine

Have you had symptoms like this before? YES NO (describe)

PAIN SCALE

Regarding your MAIN Complaint: How bad is your Pain?

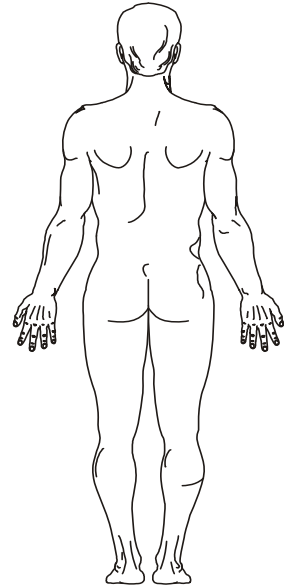
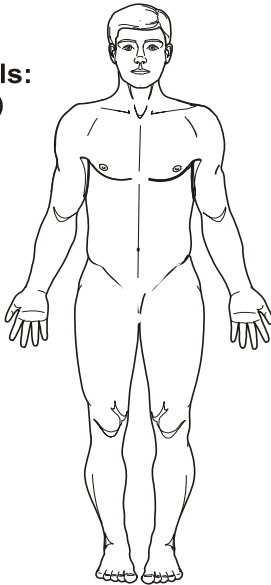
Make a slash on all 3 scales.

	0 - no pain	10 - worst pain imaginable
1. RIGHT NOW	-----	-----
2. AVERAGE	-----	-----
3. AT WORST	-----	-----

Draw Area of Symptoms

Draw the area of your symptoms using these symbols: (mark on the figures)

- XXX = ache
- * = sharp/stab
- ooo = numb/tingle
- > = shooting
- //// = stiff/tight





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.

1) Uses and Disclosures We will use your protected health information (PHI) for the purposes of treatment, payment and health care operations.

Treatment includes the disclosure of health information to other providers who have referred you for services or are involved in your care. This may include doctors, nurses, technicians and other physical therapists. For example, we may feel that a stroke patient we are treating would benefit from an evaluation by a speech-language pathologist to address a swallowing difficulty. The health information we share with the speech-language pathologist would be considered a treatment related disclosure.

Payment includes the disclosure of health information to your insurance company, including Medicare and Medicaid, so payment can be obtained for services rendered. Your insurance company may make a request to review your medical record to determine that your care was necessary.

Health Care Operations includes the utilization of your records to monitor the quality of care being given at our facility or for business planning activities.

Other Special Uses
Our practice may use your PHI to send you an appointment reminder, to inform you of our other health-related products and services, or to request a contribution to our charitable activities.

Uses and Disclosures Required by Law
The federal health information privacy regulations either permit or require us to use or disclose your PHI in the following ways: we may share some of your PHI with a family member or friend involved in your care if you do not object, we may use your PHI in an emergency situation when you may not be able to express yourself, and we may use or disclose your PHI for research purposes if we are provided with very specific assurances that your privacy will be protected. We may also disclose your PHI when we are required to do so by law, for example by court order or subpoena. Disclosures to health oversight agencies are sometimes required by law to report certain diseases or adverse drug reactions.

We may use and disclose health information about you to avert a serious threat to your health or safety or the health or safety of the public or others. If you are in the Armed Forces, we may release health information about you when it is determined to be necessary by the appropriate military command authorities. We may also release information about you for workers' compensation or other similar programs that provide benefits for work-related injury or illness.

Your authorization is required before your PHI may be used or disclosed by us for other purposes.

2) Your Privacy Rights

Restrictions

You have the right to request restrictions on how your PHI is used, however, we are not required to agree with your request. If we do agree, we must abide by your request.

Confidential Communications

You have the right to request confidential communication from us at a location of your choosing. This request must be in writing.

Access to PHI

You have the right to request a copy of your medical record. You must make this request in writing and we may charge a fee to cover the costs of copying and mailing.

Amendments

You have the right to request an amendment be made to your PHI, if you disagree with what it says about you. This request must be made in writing. If we disagree with you, we are not required to make the change. You do have the right to submit a written statement about why you disagree that will become part of your record. We may not amend parts of your medical record that we did not create.

Accounting of Disclosures

After April 14, 2003, you have the right to request an accounting of the disclosures made in the previous six years. These disclosures will not include those made for treatment, payment, or health care operations or for which we have obtained authorization.

Complaints

If you feel that your privacy rights have been violated, you have the right to make a complaint to us in writing without fear of retaliation. Your complaint should contain enough specific information so that we may adequately investigate and respond to your concerns. If you are not satisfied with our response, you may complain directly to the Secretary of Health and Human Services.

Our Duty to Protect Your Privacy

We are required to comply with the federal health information privacy regulations by maintaining the privacy of your PHI. These rules require us to provide you with this document, our Notice of Privacy Practices. We reserve the right to update this notice if required by law. If we do update this notice at any time in the future, you will receive a revised notice when you next seek treatment from us or find it on our website at www.ptfsolutions.com.

Privacy Contact

If you would like more information about our privacy practices or to file a complaint you may contact:

Name: Jon Ruzich
Title: Privacy Officer
Address: 6011 Baptist Road, Suite 100,
Pittsburgh, Pa 15236
Phone: 412-347-0022

Effective Date: April 14, 2003