Professional Physical Therapy
26471 Crown Valley Parkway, Suite 200
Mission Viejo, California 92691

Date _____ **PATIENT REGISTRATION**

Physician _____ Diagnosis _____

Last Name _____ First Name _____

Middle _____ Nickname _____

Address _____

City _____State _____ Zip _____

Social Security Number _____

Home Phone _____ Cell Phone _____

PLEASE GIVE US YOUR E-MAIL IF YOU WOULD LIKE TO RECEIVE APPOINTMENT REMINDERS

Email _____

Age _____ Date of Birth _____ Sex _____ Date of Onset _____

IS THIS A WORK RELATED INJURY? ☐ **YES** ☐ **NO**

Employer _____Work Phone _____Employer Address_____

How Did You Hear About Us? ◯**Doctor** ◯**Friend** ◯**24Hr Fitness** ◯**Online Other_____**

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1. **<u>Treatment Authorization & Release of Information</u>: I authorize treatment by Professional Physical Therapy. I authorize payment of medical benefits directly to Professional Physical Therapy for services rendered to me. I understand that I am solely responsible for all charges (unless this treatment is for an accepted workers compensation claim). I will make sure that my portions of all claims are paid promptly and all co-pays are paid at the time of service. I also authorize Professional Physical Therapy to furnish information to my insurance carriers and referring physicians concerning this treatment.**

Patient or Guardian Signature _____Date _____

2. **<u>Cancellation Policy & No Shows</u>: I understand any cancellations that are not made 24 hours prior to my scheduled appointment time or no shows are subject to a $75 fee. This fee will be billed to my account.**

Patient or Guardian Signature _____Date _____

Professional Physical Therapy
26471 Crown Valley Parkway, Suite 200
Mission Viejo, California 92691-6302

MEDICAL HISTORY

NAME: _____ Date: _____
Home Phone: _____ Work Phone: _____
Primary (Family) Doctor: _____ Phone # _____

MEDICAL HISTORY - ***Please circle any of the following that apply to you.***

Heart	Diabetes	Metal Implants	Osteoporosis
Smoking	Pacemaker	Kidney	Bladder Control
Lung	Currently Pregnant	Seizures	Gastro Intestinal
Cancer	High Blood Pressure	Anemia	Leg/Ankle Swelling

Other _____

MEDICATIONS: ***Please list any medications that you are currently taking or have recently used.***

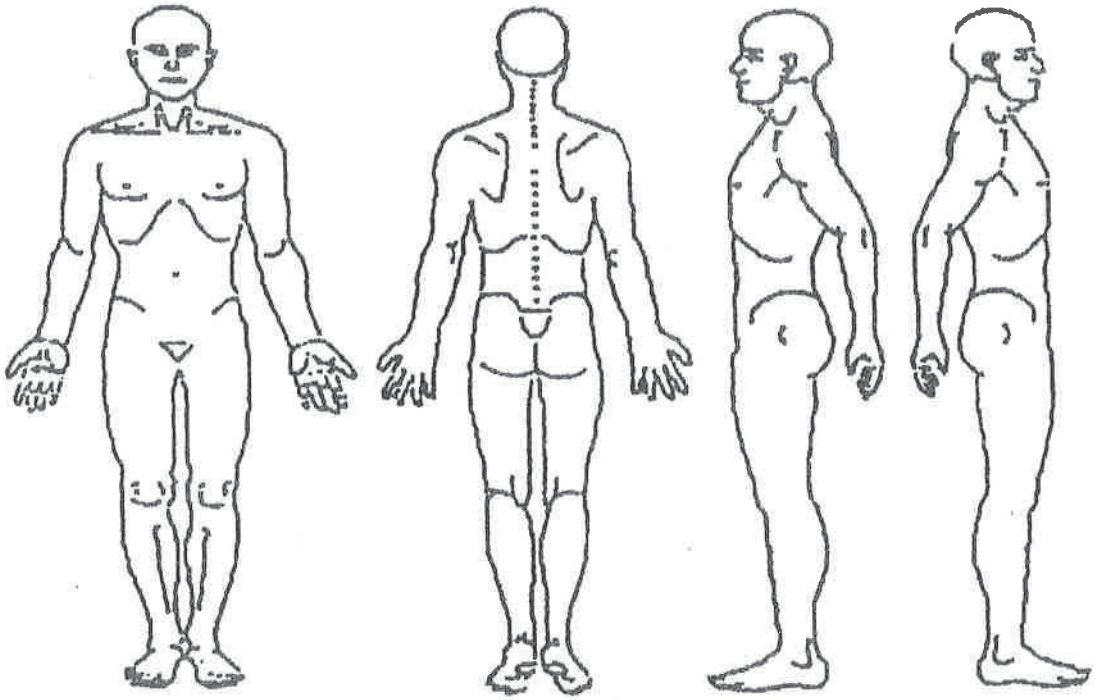
_____

ALLERGIES Please list any known allergies: _____

Using this diagram, please circle your pain level: 0-No Pain 10-Severe Pain

(0 1 2 3 4 5 6 7 8 9 10)

Please write the letter by the body part that pertains to your symptoms:
S-sharp/stabbing pain, **D**-dull/aching pain, **ST**-stiffness, **T**-tingling/pins or needles, **N**-numbness/no sensation.



EMERGENCY NOTIFICATION:
NAME _____ RELATIONSHIP _____ PHONE # _____
NAME _____ RELATIONSHIP _____ PHONE # _____

To the best of my knowledge, all the information that I have provided is true and correct.

Signature: _____

Richards Physical Therapy, Inc.

NOTICE OF PRIVACY PRACTICES

This notice describes how information about you as a patient of this practice, Richards Physical Therapy, Inc., may be used and disclosed, and how to access your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following important information:

The following circumstances may require us to use or disclose your health information:

1. **To provide treatment:** We will use your health information within our office to provide you with the best health care possible. This may include administrative and clinical office procedures to schedule and coordinate care between physician, technician, nurse and business office staff. Richards Physical Therapy, Inc. will report to your prescribing physician and your insurance company.
2. **To obtain payment:** We may include your health information with an invoice used to collect payment for treatment you received in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will make every attempt to work only with the companies with similar commitment to the security of your health information.
3. **To conduct health care operation:** Your health information may be used during performance evaluations of our staff, during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine processes or certification, licensing or credentialing activities.
4. **Communications:** Because we believe regular follow up is very important to your health, we may remind you of a scheduled appointment or to contact us to schedule an appointment. These communications may include telephone, text or email reminders. We may share your health information with those you tell us will be helping you with your home treatment, medications, or payment. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may request that we contact you at home, rather than work. We will try to accommodate reasonable requests.
5. **Required by law:** We may disclose your health information to public health oversight agencies that are authorized by law to collect information, when required to do so by a law enforcement official, lawsuits and similar proceeding in response to a court or administrative order, when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public, for Worker's Compensation and similar programs.

Our patient medical records are kept confidential, secure, and out of reach by unauthorized persons. A written release signed and dated by the patient/guardian must be obtained prior to the release of medical record information, except for Initial Evaluations, Progress Notes, Plan of Care, Daily Notes and Re-Examinations .

You are entitled to receive a copy of this Notice of Privacy Practices.

I _____, have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of protected health information to carry out treatment, payment activities, and health care operations as described in the Privacy Notice.

Signature:_____ Date_____
(Parent/guardian if patient is a minor)

QuickDASH - Initial Patient name:_____ Date:_____

INSTRUCTIONS

This questionnaire asks about your symptoms as well as your ability to perform certain activities.
Please answer every question, based on your condition in the last week, by circling the appropriate number.
If you did not have the opportunity to perform an activity in the past week, please make your best estimate of which response would be the most accurate.
It doesn't matter which hand or arm you use to perform the activity; please answer based on your abilty regardless of how you perform the task.

1. Please rate your pain level with activity: NO PAIN = 0 1 2 3 4 5 6 7 8 9 10 = VERY SEVERE PAIN

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. Open a tight or new jar	1	2	3	4	5
2. Do heavy household chores (e.g., wash walls, floors).	1	2	3	4	5
3. Carry a shopping bag or briefcase.	1	2	3	4	5
4. Wash your back	1	2	3	4	5
5. Use a knife to cut food.	1	2	3	4	5
6. Recreational activities in which you take some force or impact through your arm, shoulder or hand(e.g., golf, hammering, tennis, etc.).	1	2	3	4	5
	NOT AT ALL	SLIGHTLY	MODERATELY	QUITE A BIT	EXTREMELY
7. During the past week, to what extent has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbors or groups?	1	2	3	4	5
	NOT LIMITED AT ALL	SLIGHTLY LIMITED	MODERATELY LIMITED	VERY LIMITED	UNABLE
8. During the past week, were you limited in your work or other regular daily activities as a result of your arm, shoulder or hand problem?	1	2	3	4	5
Please rate the severity of the following symptoms in the last week. (circle number)	NONE	MILD	MODERATE	SEVERE	EXTREME
9. Arm, shoulder or hand pain.	1	2	3	4	5
10. Tingling (pins and needles) in your arm, shoulder or hand.	1	2	3	4	5
	NONE	MILD	MODERATE	SEVERE DIFFICULTY	SO MUCH DIFFFICULTY THAT I CAN'T .SLEEP
11. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand? (circle number)	1	2	3	4	5

Therapist Use Only

Comorbidities:
- ☐Cancer
- ☐Diabetes
- ☐Heart Condition
- ☐High Blood Pressure
- ☐Multiple Treatment Areas
- ☐Neurological Disorders (e.g., Parkinson's, Muscular Dystrophy, Huntington's, CVA, Alzheimer's, TBI)
- ☐Obesity
- ☐Surgery for this Problem
- ☐Systemic Disorders (e.g., Lupus, Rheumatoid Arthritis, Fibromyalgia)

ICD9 Code: