Patient Intake Sheet

Patient Name: _____ Sex: ☐ Male ☐ Female
Date of Birth: _____ Social Security Number: _____
Address: _____ City: _____ State: ___ Zip: _____
Home Phone: _____ Email: _____

Emergency Contact Name: _____ Relation to patient: _____
Emergency Contact Phone #: _____

Insured's Name: _____ Relation to Patient: _____
Social Security Number of Insured (If different from above): _____
Insured's Date of Birth (If different from above): _____
Insured's Address: _____ City: _____ State: ___ Zip: _____
Insured's Employer: _____ Employer's Phone: _____

Primary Insurance Company: _____ Phone: _____
Member I.D. or Subscriber Number: _____
Group #: _____ Policy # (if different from Member ID):_____

Secondary Insurance Company: _____ Phone: _____
Member I.D. or Subscriber Number: _____
Group #: _____ Policy # (if different from Member ID):_____

Referring Physician: _____ Primary Care Physician: _____
Next Scheduled visit with Dr. for this condition: _____ With Dr.:_____

Have you been a patient at our facility before? ☐ Yes ☐ No
What part of your body is going to be treated? _____
When did your symptoms start? _____
If you had surgery for this, when was the most recent surgery? _____

Are you currently receiving any health related services at your home (including a health nurse of aide)? ☐ Yes ☐ No

Distinctly different from a "Living Will" or "Advanced Directive" – Do you have a "DNR – Do Not Resuscitate" order? This must be written orders by **YOUR PHYSICIAN** to not attempt resuscitation in any event? ☐ Yes ☐ No
If yes, which physician _____
Office Use Only: Verbal Confirmation received _____ Written Copy received _____
I have been offered the Department of Health's information card regarding abuse, neglect, and exploitation. ☐ Yes ☐ No
I acknowledge that all of the information provided factual and accurate.

_____ _____
Signature of Patient of Guardian **Date**

Exhibit C – Acknowledgement of Receipt of Privacy Notice

Purpose of this Acknowledgement

This Acknowledgement, which allows the practice to use and/or disclose personally identifiable health information for treatment, payment, or healthcare operations, is made pursuant to the requirements of 45 CFR §164.520(c)(2)(ii), part of the federal privacy regulations for the Health Insurance Privacy Accountability Act of 1996 (the "Privacy Regulations").

Please read the following information carefully:

1. I understand and acknowledge that I am consenting to the use and/or disclosure of personally identifiable health information about me by New Mexico Sports Fitness and Physical Therapy (the 'practice') for the purposes of treating me, obtaining payment for treatment of me, and as necessary in order to carry out any healthcare operations that are permitted in the Privacy Regulations.

2. I am aware that the "Practice" maintains a Privacy Notice which sets forth the types of uses and disclosures that the "Practice" is permitted to make under the Privacy Regulations and sets forth in detail the way in which the "Practice" will make such use or disclosure. By signing this acknowledgement, I understand and acknowledge that I have received a copy of the Privacy Notice.

3. I understand and acknowledge that in its Privacy Notice, the "Practice" has reserved the right to change its Privacy Notice as it sees fit from time to time. If I wish to receive a revised Privacy Notice, I need to send a written request for a revised Privacy Notice to the office of the "Practice" at the following address **2954 Rodeo Park Drive West, Santa Fe, NM 87505 Attn: Compliance Officer**

4. I understand and acknowledge that I have the right to request that the "Practice" restrict how my information is used or disclosed to carry out treatment, payment, or healthcare operations. I understand and acknowledge that the "Practice" is not required to agree to restrictions requested by me except in very limited circumstances as described in the Privacy Notice, but if the "Practice" agrees to such a requested restriction it will be bound by that restriction until I notify it otherwise in writing.

   I request the following restrictions be placed on the "Practice's" use and/or disclosure of my health information (leave blank if no restrictions): _____
   _____
   _____

   I understand the foregoing provisions, and I wish to sign this Acknowledgement authorizing the use of my personally identifiable health information for the purposes of treatment, payment, and healthcare operations.

BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE REVIEWED AN EXECUTED COPY OF THIS ACKNOWLEDGEMENT AND A COPY OF THE "PRACTICE'S" PRIVACY NOTICE AND AGREE TO THE "PRACTICES'S" USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS.

_____ _____
Signature of Patient or Representative **Date**

_____ _____ _____
Patient's Name Date of Birth Social Security Number

_____ _____
Name of Personal Representative (If Applicable) Relationship to Patient

To be completed by the "Practice"
The requested restrictions on the use and/or disclosure of the patient's health information set forth above are:
☐ Accepted ☐ Denied ☐ Not Applicable
☐ Other (Explain) _____

_____ _____
Signature of Authorized Representative **Date**

New Mexico Sports Fitness and Physical Therapy

Patient Medical History

Chief Complaint

1. Reason for seeing Physical or Occupational Therapist today:

   _____

   _____

   _____

History of Present Illness

2. When did your problem, pain, or injury begin? _____

3. How did your problem start? Suddenly ☐ Slowly over time ☐ During Sports ☐ At work ☐
   (Please check all that apply) Fall ☐ Lifting ☐ Pulling ☐ Auto Accident ☐ No Cause ☐

4. What are your symptoms? Pain ☐ Swelling ☐ Redness ☐ Bruising ☐ Spasm ☐
   (Please check all that apply) Weakness ☐ Tingling ☐ Locking ☐ Catching ☐ Give-way ☐

5. If you have pain, describe it. Constant ☐ Intermittent ☐ While at rest ☐ At night ☐
   (Please check all that apply) With activity ☐ Burning ☐ Aching ☐ Sharp ☐ Dull ☐

6. On average, how severe is your pain? 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 4 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐
   No Pain **Worst Pain**

7. What reduces your symptoms? Sitting ☐ Lying Down ☐ Stopping Activities ☐ Standing ☐
   (Please check all the apply) Walking ☐ Medication ☐ Physical Therapy ☐ Ice ☐ Heat ☐

8. What increases your symptoms? Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Cough/Sneeze ☐
   (Please Check all the apply) Exercise (During) ☐ Exercise (After) ☐ Other _____

9. Have you had any diagnostic X-Rays ☐ CT Scan ☐ MRI ☐ Injections ☐
   tests for this problem? Arthrogram (dye injection) ☐ Electromyogram/Nerve Study ☐
   Dates: _____ Location: _____
   Do you have the results: Yes ☐ No ☐

10. Were you seen in the emergency room for this problem? Yes ☐ If so, when? _____ No ☐

Review of Systems

11. Have you, the patient, ever been diagnosed with any of the following conditions? (Check all the apply)

- ☐ Vision or hearing Problems
- ☐ High Blood Pressure
- ☐ Blood Clots
- ☐ Kidney Disease/failure
- ☐ Arthritis or Rheumatism
- ☐ Osteoporosis
- ☐ Seizures or Epilepsy
- ☐ Contagious Conditions
  - ☐ HIV
  - ☐ TB
  - ☐ Hepatitis ☐ Other
- ☐ Thyroid Problems
- ☐ Heart Problems
- ☐ Stomach Problems/ulcers/reflux
- ☐ Diabetes
- ☐ Depression
- ☐ Cancer
- ☐ Stroke
- ☐ Asthma or Emphysema
- ☐ Bleeding Problems
- ☐ Bone or Joint Problems
- ☐ Gout
- ☐ Skin Disorders
- ☐ Balance Problems
- ☐ None of the above

Past Medical History

12. Please list **ALL** previous surgeries, hospitalizations, and/or broken bones.

_____Date_____
_____Date_____
_____Date_____
_____Date_____
_____Date_____

13. Please list **ALL** your current medications and their doses. Include "Over-the-Counter" meds and herbals.

Medication	Dose	Medication	Dose
kjkj			

14. Are you allergic to any medications? Yes ☐ No ☐ Please list: _____
_____
_____

15. **Women Only:** Are you, or could you be, pregnant? Yes ☐ No ☐ Due Date:_____

Family History

16. Does any blood relative have a history of any of the following medical problems? (Check all the apply)

☐ Rheumatoid Arthritis or Osteoarthritis ☐ Osteoporosis ☐ Cancer
☐ Diabetes ☐ High Blood Pressure ☐ Problems with Anesthesia
☐ Blood Clots ☐ Stroke ☐ Heart Disease
☐ None of the Above ☐ Other (Please list) _____

Social History

17. What is your occupation? _____ Employer _____
18. What are your daily activities? _____
19. Do/Did you use tobacco? ☐ Yes ☐ No How much and how often?: _____
20. Do you drink alcoholic beverages? ☐ Yes ☐ No How many drinks per day? _____
21. Have you ever been addicted to prescription or non-prescription drugs? ☐ Yes ☐ No Which? _____
22. Do you live alone? ☐ Yes ☐ No
23. How often do you exercise? ☐ Never ☐ Rarely ☐ Monthly ☐ Weekly ☐ Daily
    What type of exercise? _____
24. Which is your dominant hand? ☐ Right ☐ Left ☐ Ambidextrous

Miscellaneous

25. Were you referred here by a physician? ☐ Yes ☐ No Name of Physician _____
26. Who is your primary care physician? _____
27. Is there any legal action pending that pertains to your visit or condition? ☐ Yes ☐ No
    If yes, explain: _____
    _____
    _____

_____ _____

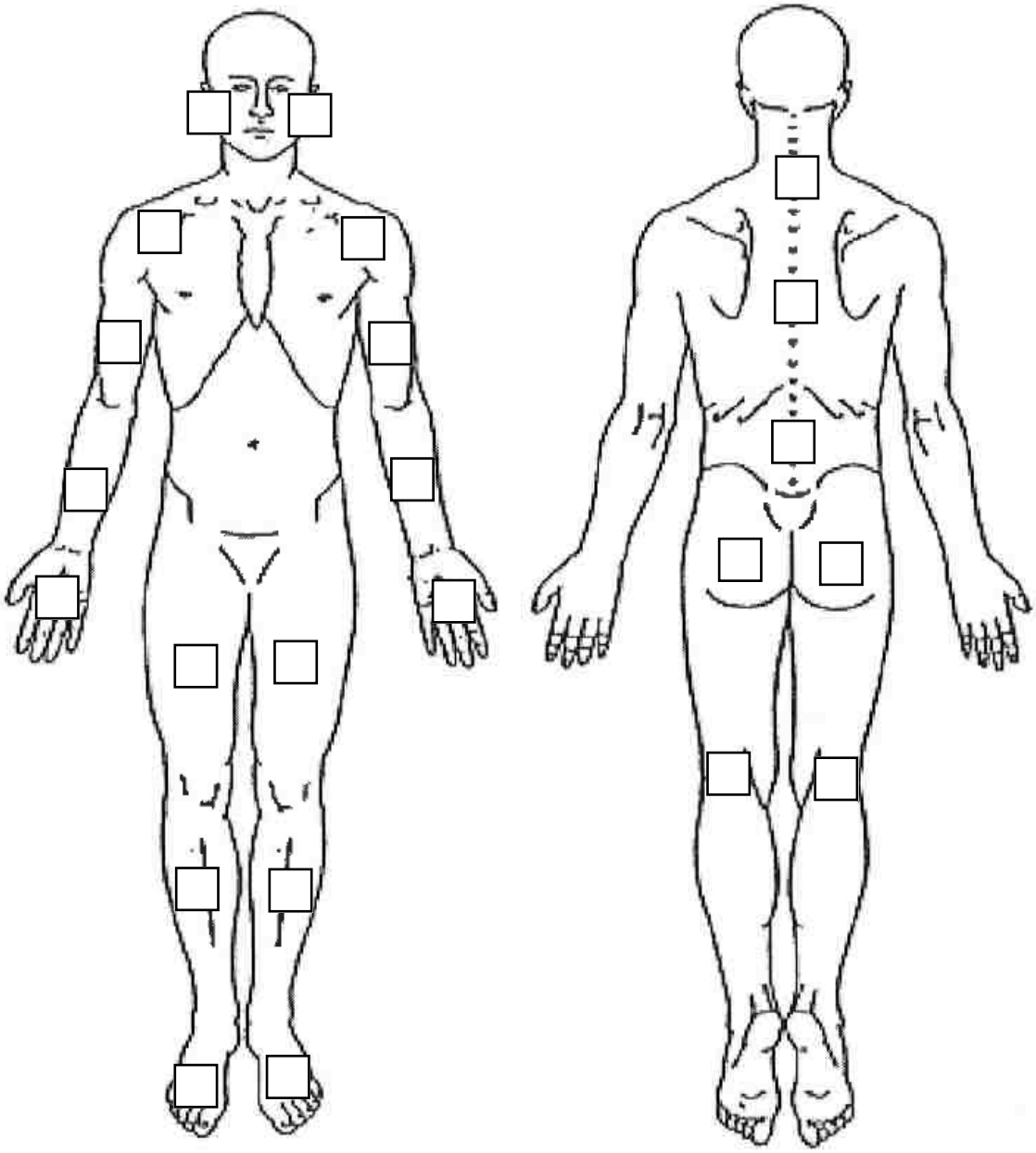
Signature of Patient, Representative, or Parent of Minor **Date**

What would you like to accomplish with Physical Therapy / Occupational Therapy? (Check all the apply)

28. ☐ Return to hobby/recreation/sport
☐ Return to work
☐ Improve strength and motion
☐ Decrease Pain
☐ Improve daily function
☐ Other (Specify): _____

29. When do you return to the Doctor? _____

30. **Please Shade the area(s) below where your symptoms are located:**



If you have pain, please write the intensity between 0-10 next to the shaded area.
(0=No pain, 5=Moderate Pain, 10=Severe Pain)

_____ _____

Signature of Patient, Representative, or Parent of Minor **Date**