Medical and Pain History

1. Reason for your visit/main location of pain?

   _____

2. Does your pain radiate (travel)? If so, where?

   _____

3. Approximate date of when symptoms began?

   _____

4. What do you think caused the problem/pain/injury?

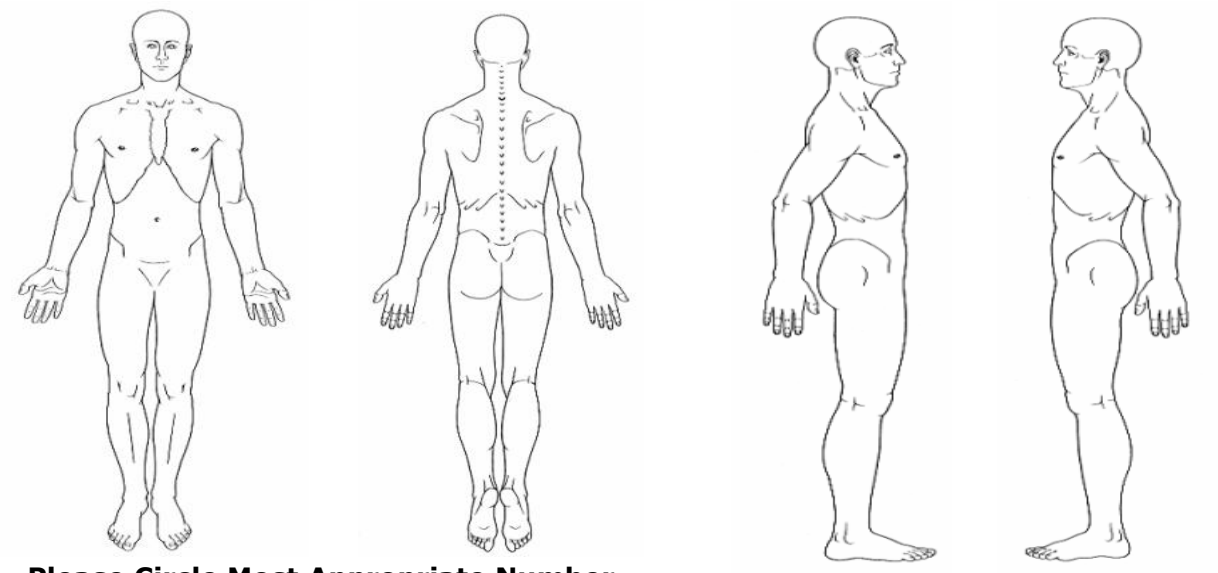
   _____

5. Have you seen a doctor regarding your complaints? Did they order any imaging?

   _____

6. Indicate on body diagram where your pain is located.

Mark the location of symptoms with an "X" and label it as sharp, dull, burning, aching, etc.



Please Circle Most Appropriate Number

7. What is your pain level when it is at its **worst**?

0.....1.....2.....3.....4.....5.....6.....7.....8.....9.....10

Mild: No pain **Moderate: Some Limitations** **Severe: Requires hospitalization**

8. What is the **average** pain level that you experience?

0.....1.....2.....3.....4.....5.....6.....7.....8.....9.....10

Mild: No pain **Moderate: Some Limitations** **Severe: Requires hospitalization**

9. Describe the pain (Aching, Burning, Cramping, Dull, Numbness, Sharp, Shooting, Soreness, Spasm, Stiffness, Throbbing pain, Tightness, Tingling, Weakness, Other)

_____

10. Frequency of Pain Daily <**10% 10-25% 25-50% 50-75% 75-100%** (Circle amount)

11. Are there any activities or movements that alleviate or make the pain better?

_____

12. Are there any activities or movements that aggravate or make the pain worse?

_____

13. Is the pain worse or better during certain times of the day?

_____

14. What are your typical sleeping habits (on back, on sides, on stomach)? _____

15. Are you currently exercising? If yes, how frequently? _____

16. Do you have access to exercise equipment such as a foam roller, swiss ball, free weights, etc.?

_____

17. Current Occupation or Retired: _____

18. Please list all medications, dosage, and purpose.

_____
_____
_____

19. Please list all surgeries and approximate dates.

_____
_____
_____

20. Current or past medical history; **circle all that apply**:

High blood pressure	Heart Disease	Chest pain	Respiratory problems
Lung disease	Heartburn	Upset Stomach	Thyroid condition
Diabetes	Low blood sugar	Cancer	Osteoporosis
Headaches	Joint disease	Swelling	Fractures
Vision Problems	Hearing problems	Arthritis	Hepatitis
Psoriasis	Stroke	Tuberculosis	Dizziness/Fainting
Metal or other implants	Tumor/cyst	Epilepsy/seizures	Pacemaker

Other _____
Additional information _____
_____

21. What are your goals with therapy/treatment? _____

_____
_____

To the best of my knowledge, the information I have provided is accurate and complete.

Patient/Guardian Signature _____ Date _____

Petra A. Eggert Dba Intrahealth

NOTICE OF PRIVACY PRACTICES

This notice describes how our staff will handle and disclose your private medical information. Please review it carefully.

We believe that all medical information is personal and we are committed to protecting it. A record of all care and services you receive from our office and staff is maintained to ensure that you receive the highest quality of care possible. This record is also necessary for us to comply with certain legal requirements.

We are legally required to:

- Keep your medical information private
- Provide you with this form explaining our privacy policies and procedures
- Adhere to the current listed policies and procedures

We have the right to:

- Change our privacy policies and procedures, compliant with legal requirements, at any time.
- Make any changes to our policies and procedures effective for all medical information that we keep including information already on file.

We will not use or disclose your medical information for any purpose not listed below without your specific authorization.

Treatment – Medical information about you may be disclosed to other healthcare providers to assist them in treating you.
Payment – Your medical information may appear on documents accompanying bills sent to you or a third party payer.

Other uses and disclosures that can be made without your consent or authorization:

1. As required during an investigation by law enforcement agencies
2. To avert a serious threat to the public's health or safety
3. As required by military command authorities for their medical records
4. To worker's compensation or similar programs for processing claims
5. In response to a legal proceeding
6. To a coroner or medical examiner for identification of a body
7. If an inmate, to the correction institution or law enforcement official
8. As required by the US Food and Drug Administration (FDA)
9. Other health care treatment providers activities
10. Other covered entities, healthcare operations activities (to the extent covered under HIPAA)

11. Uses and disclosures required by law
12. Health oversight activities
13. Other public health activities

Your individual rights regarding your medical information:

You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however that Intrahealth is not required to agree to the restrictions that you request. You have the right to have your health information received, communicated, or delivered, upon your request.

You have the right to inspect and copy your medical information:
Usually this includes medical and billing records, but does not include information compiled for use in a civil, criminal, or administrative action or processing and PHI to which access is prohibited by law.

Right to amend: You have the right to request that Intrahealth amend your PHI. Please be advised, however, that Intrahealth is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reasons and information about how you can file a statement of disagreement with us.

Change to this Notice of Privacy Practices:

Intrahealth reserves the right to amend this Notice of Practice at any time in the future, and will make a new provisions effected for all information that is maintained. Until such amendment is made, Intrahealth is required by law to comply with this notice.

We at Intrahealth are required by law to maintain the privacy of your health information and to provide you with notice of our legal duties and privacy practices with respect to your health information. If have questions or complaints about any part of this notice, or how Intrahealth has handled your health information please contact Petra Eggert, PT., DC. by calling this office at 408-530-0005 and schedule an appointment.

If you are not satisfied with the manner in which Intrahealth handles your complaints, you may submit a formal complaint to:

Office of Civil Rights, DHHS
90 7th street, ste. 4-100
San Francisco, CA. 94103
Phone - 415-437-8310 Fax - 415-437-8329

I have read and understand this notice of privacy policies and procedures.

Signature _____ Date _____

FINANCIAL POLICY STATEMENT

• We do our best to verify your insurance as a courtesy to you. However, it is not a guarantee of payment. Due to the fact that payment is determined by your insurance carrier at the time the claim is processed, only when payment from your insurance company is received will we know if it is necessary to modify your co-pay or deductible amount. ***All presumed co-pays and deductibles will be collected at the time services are rendered.***

• If your insurance plan requires that you need a doctor's referral prior to treatment***, we must be in receipt of this referral before we can begin your care***. In the event of any unauthorized charges as deemed by your insurance carrier for lack of proper referral, you accept responsibility for payment of those claims.

• It is your responsibility to immediately notify us of changes to your insurance before and during your care. Any treatment provided that is not paid by your insurance because we were unable to obtain prior authorization because we did not have current insurance information is ultimately your financial responsibility.

• Be advised, if you claim worker's compensation benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you.

• If any payment is made directly to you for services billed by us, you recognize your obligation to promptly remit the same amount to IntraHealth.

• If you pay by check and your check is dishonored or returned for any reason, we will expect payment in full plus a returned check fee of $30 within 30 days of the returned check.

• I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs and attorney fees.

• There is a $70.00 fee for all missed, broken or rescheduled appointments without 24 hour advance notice.

Signature _____ Date_____

BENEFIT ASSIGNMENT

I, _____, hereby assign all medical benefits to which I am entitled, including private insurance and third party payers, to IntraHealth for services rendered.
(Have patient sign ONLY when they receive payment from Insurance Company)

Signature _____ Date _____

PATIENT CONSENT

I, _____, authorize the providers of IntraHealth Physical Therapy and Chiropractic to administer any treatment and perform procedures as deemed necessary in the diagnosis and treatment of _____.

I realize that these procedures are to be performed by or under the direction of doctors, associates, or assistants employed by IntraHealth Physical Therapy and Chiropractic.

The nature and purpose of the procedures, possible alternatives and the risks involved, the possible consequences and the possibility of complications have been explained to me by the treating doctor and/or associates and assistants.

I acknowledge that no guarantee or assurance as to the results that may be obtained from procedures and treatment has been given by the treating doctor, associates or assistants.

I authorize IntraHealth Physical Therapy and Chiropractic employees and providers to utilize my home or work numbers and answering machines, and if elected my e-mail or cell phone, for the purpose of disclosing appointment and/or treatment information.

I acknowledge that IntraHealth Physical Therapy and Chiropractic will use reasonable means to protect the security and confidentiality of e-mail communication. However, because of the inherent risks of e-mail communication, IntraHealth Physical Therapy and Chiropractic cannot guarantee the security and confidentiality of e-mail communication and will not be held liable for improper use and/or disclosure of confidential health information that is not caused by IntraHealth Physical Therapy and Chiropractic's intentional misconduct.

_____ Date: _____

Signature of Patient/Parent/Guardian (Must be 18 or older)

For Parents/Guardians: By signing above, I am attesting that as of this date, I have the legal right to select and authorize healthcare services for the minor child named above. If applicable, under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

Disclosure of Information:

If you would like us to be able to discuss and disclose your medical care and/or billing account information with anyone other than yourself, please list the name, relationship and telephone number below.

Name	Relationship	Telephone Number