New Episode/Case Form (Please print)

First Name: _____Last Name:_____DOB: _____Age: _____ .

Medical Information for this episode of care:

Referring Physician:_____ Primary Care Physician:_____.

Are you scheduled for a follow up visit with your doctor? No___Yes___If yes, then when? _____.

What part of your body will we be treating?_____.

When did your symptoms start, or date of injury? _____.

How did your injury occur? _____.

If you've had surgery for this, what was the date of your most recent surgery? _____.

Have you seen any other provider within the last 30 days for this condition? (i.e. massage therapist, chiropractor, athletic trainer or acupuncturist) _____.

Are you working? Yes_____No_____ If working, has this injury restricted you from employment? Yes____ No___.

If yes, Restricted_____ or Off work_____.

What is your occupation? _____.

Please list any medications or supplements hat you are currently taking_____.

_____.

_____.

Have you had any diagnostic tests completed? MRI_____ X-Ray _____Please list any other tests_____.

Condition Related To: Employment_____Automobile Accident_____State of Accident _____.

Worker's Comp Accident____State of Accident _____.

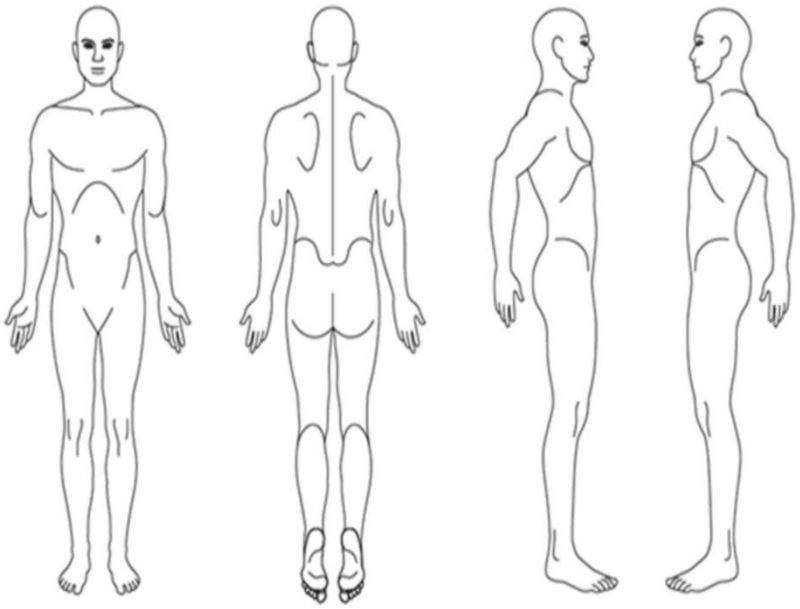
If unable to work, list last full work date _____.

Pain, when did pain first start?_____.

At present time, would you say that your health is: Excellent_____Very good _____Fair_____Poor_____.

Medical History – Please check Yes or No for conditions that apply to you

	Yes	No		Yes	No
Vascular Disorder			Smoker		
Rheumatoid Arthritis			Are you pregnant?		
Osteoarthritis			Autoimmune Disorder		
Heart Trouble			Hepatitis		
Pain or tightness in chest			Neck Pain		
Low Blood Pressure			Back Pain		
High Blood Pressure			TMJ (Jaw Problems)		
Fainting Spells			History of Seizures		
Bruise Easily			Allergies		
Diabetes			Pacemaker/Implant		
Low Blood Sugar			Stroke		
Shortness of breath			Asthma		
Hard to Remember			Other:		
Cancer					
History of Substance Abuse					



***Please indicate the areas of your symptoms as they are at this moment**

Please rate your pain at rest:

0	1	2	3	4	5	6	7	8	9	10

Please rate your pain at worst:

0	1	2	3	4	5	6	7	8	9	10

Function Therapy Specialists

CONSENT TO TREATMENT:

I hereby give written consent to be evaluated for my current diagnosis by a licensed physical or occupational therapist and treated by same therapist and/or his/her supervised physical or occupational assistant or technician employed by Function Therapy Specialists. _____**Initials** _____**Date**

EMERGENCY CONTACT:

Name:_____ Relationship:_____ Phone:_____.

RELEASE OF INFORMATION:

Please check each line that you are authorizing us to release information to the people you listed below.

Make changes to my scheduled appointments _____Call & obtain scheduled appointments times _____.

Call & inquire about and/or obtain my billing information_____Pick up requested documents_____.

List Names_____.

_____.

Consent to Email or Test Usage for Appointment Reminders and Other Healthcare Communications

Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, to provide general health reminders/information, and to send you statements. If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointments reminders and other healthcare communications/information at that email or text address from the Practice.

The practice does not charge for this service, but standard text messaging rate may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

_____(Patient initials) I consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all further appointment reminders/feedback/health information unless I request a change in writing.

The cell phone number that I authorize to receive text messages for appointment reminders, feedback, and general health reminders/information is_____.

The email that I authorize to receive email messages for appointment reminders and general health reminders/feedback/information is_____.

HIPAA Compliance Patient Consent Form

Our notice of privacy practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain by your signature that you have reviewed our notice before signing this consent. The terms of the notice may changes, if so, you will be notified at your next visits to update your signature/date. You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement.

The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

Your rights:

- Get a copy of your health claims records
- Ask us to correct health and claims records
- Request confidential communications
- Ask us to limit what we use or share
- Get a list of those with whom we've shared information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you feel your rights are violated

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

By initialing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not retroactive.

_____ _____

Signature Date