Date_____

Patient Information

Patient Name (Last, First, Initial):_____

Address:_____City/State_____Zip_____

Birth date:_____Age_____Sex (M/F):_____Height:_____Weight:_____Social Security#:_____

Driver's Lic:_____Work phone:_____Home Phone:_____Cell Phone:_____

Employer:_____Occupation:_____email:_____

Responsible Party (if other than patient/minor):_____

Responsible Party Address and Phone:_____

Who Referred You:_____Family Physician:_____

Insurance Information

Primary Insurance:_____Insurance Phone:_____

Name of Insured: _____Insured's Date of Birth:_____Insurance Address:_____

Insured's Social Security#:_____ Policy/ID #:_____Group #:_____

Secondary Insurance:_____Insurance Phone:_____

Insurance Address:_____

Emergency Contact: _____ Phone number:_____

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to Keith Mahler Physical Therapist & Associates. I understand that I am financially responsible to any balance. I also authorize Keith Mahler Physical Therapist & Associates or my insurance company to release any information required to process my claims.

Patient/Guardian Signature:_____ Date:_____

Cancellation Policy and Consent to Treat

Cancellation and Late Policy

We at Keith Mahler Physical Therapist & Associates want to provide the best possible care for our patients as well as attending to your scheduled appointments. **If there is not notice of cancellation given within 24 hours before the scheduled appointment, a twenty dollar charge will be billed directly to the patient for each cancellation. Initials: _____**

We at Keith Mahler Physical Therapist & Associates will strive to see our patients at their appointed times. However, in the event we are running behind schedule, we will notify you as quickly as possible. **We reserve the right to reschedule patient who show up late to their appointments. Initials: _____**

By Signing below, you acknowledge you have read, understood and agree to abide by our cancellation and late policy as described above.

Consent to treat

I grant permission for the staff of Mahler Physical Therapist & Associates to perform physical therapy evaluation, treatment, procedures and use of physical therapy modalities in accordance with the laws governing physical therapy. I understand there may be risks as well as benefits associated with evaluation and treatment. These risks and benefits will be explained to me during my initial evaluation and/or prior to any changes in treatment.

If I become ill while undergoing treatment, I give permission to the staff to administer treatments which they consider necessary to my well-being. My signature below indicates that I understand and give consent to be treated as explained above.

Patient or guardian signature _____

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Notice of patient information practices

This notice describes how medical information about you may be used or disclosed and how you can obtain access to information. Please read carefully.

Mahler Physical Therapist & Associates is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

Keith Mahler Physical Therapist & Associates uses your personal health information primarily for treatment, obtaining payment for treatment, conducting internal administrative activities and evaluating the quality of care provided. For example, Keith Mahler Physical Therapist & Associates may use your information to contact you to provide appointment reminders, inform about treatment alternatives or other health related benefits that could be of interest to you.

Keith Mahler Physical Therapist & Associates may also use or disclose your personal health information without your prior authorization for public health purposes, during emergencies and when required by Law.

In any other situation, Keith Mahler Physical Therapist & Associate's policy is to obtain your written authorization before disclosing your personal health information. If you provide us with written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosure at any time.

Keith Mahler Physical Therapist & Associates may change policies at any time. When changes are made, a new "Notice of patient information practices" will be posted in the waiting room and will be provided to you upon request.

Patient's Individual Rights

You have the right to review or obtain a copy of your personal health information at any time (copy charge of twenty dollars may apply). You also have the right to request we correct any inaccurate or incomplete information in your records. You have the right to request a list of where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes **except** when specifically authorized by

you, when required by law or in emergency circumstances. Keith Mahler Physical Therapist & Associates will consider all requests listed above on a case by case basis.

Concerns and complaints

If you are concerned that Keith Mahler Physical Therapist & Associates or its employees may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our office manager at the address listed below. You may also send a written complaint to the United States Department of Health and Human Services. For further information on Keith Mahler Physical Therapist & Associates health information practices or if you have a complaint, please contact the following person:

Compliance Officer

7801 Mission Center Court, Suite 430

San Diego, CA 92108

Phone (619)296-5780

Patient or guardian signature_____

Patient Questionnaire

Name: _____ **Date____/____/____**

Your therapist will review this questionnaire to better address your needs. If you do not understand a question, simply leave it unanswered.

1. Describe what you are being treated for: _____
_____

2. When did your symptoms start? What was the date of your surgery?
_____

3. How often do you experience your symptoms during the day?
   - ❑ Constantly (76-100% of the day)
   - ❑ Frequently (51-75% of the day)
   - ❑ Occasionally (26-50% of the day)
   - ❑ Intermittently (0-25% of the day)

4. Are you worse in the:
   ❑ Morning ❑ Afternoon ❑ Evening ❑ Doesn't matter

5. What activities increase your symptoms? (i.e. sitting for fifteen minutes, walking driving)
_____
_____

6. What eases your symptoms? (i.e. ice, rest, lying on your side) _____
_____

7. Do your symptoms interrupt your sleep?
   ❑ Yes ❑ No

8. How are your symptoms changing?
   ❑ Getting Better ❑ No change ❑ Getting worse

9. What treatment have you had for this injury/symptoms?
   ❑ None ❑ Doctor ❑ Physical Therapist ❑ Chiropractor
   ❑ Other_____

10. Have you had any falls within the last year? If yes, please explain _____
_____

11. Do you have any conditions that would place you at risk for falls?
   ❑ Getting dressed/undressed ❑ Taking bath/shower
   ❑ Getting in/out of chair ❑ Going up/downstairs
   ❑ Reaching for item above head ❑ Other: _____

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12. Have you had any diagnostic tests?

❑ X-rays ❑ MRI ❑ CT scan ❑ EMG ❑ Other_____

13. What medications are you currently taking? (Please list all medications with dosage)

_____

_____

14. Please list any major illness, injury, or surgery that has occurred in the past.

_____

_____

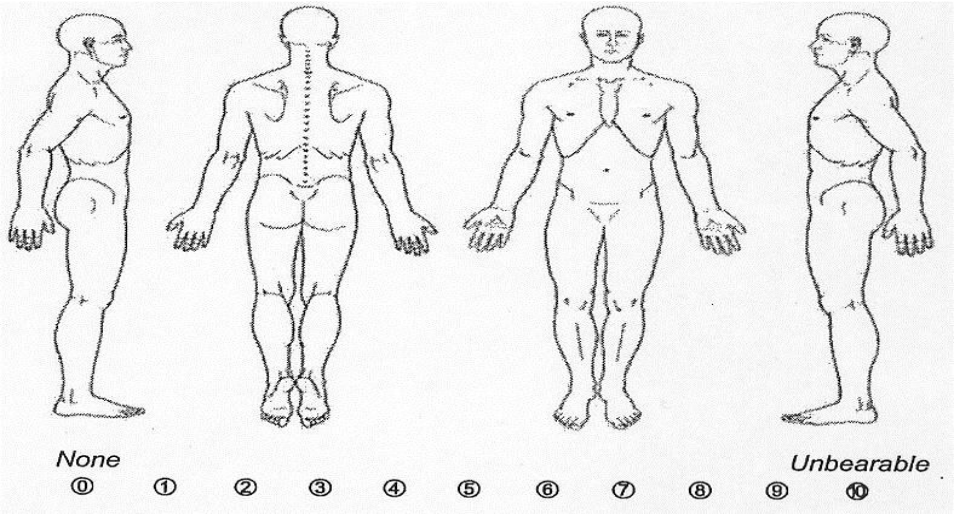
15. Do you have any of the following:

❑ High blood pressure
❑ Heart disease
❑ Pacemaker
❑ Diabetes
❑ Allergies
❑ Sensitivity to Heat or cold
❑ Seizures
❑ Headaches
❑ Kidney disorders
❑ Recent weight loss
❑ Are you pregnant
❑ Cancer
❑ Thyroid disease
❑ Stroke/ CVA
❑ Metal implants
❑ Osteoporosis
❑ Rheumatoid arthritis
❑ Gout
❑ Vision problems
❑ Hearing problems
❑ Balance problems
❑ Nervous disorders
❑ Other_____

16. What goals or activities do you want to achieve with therapy? _____

_____

17. Indicate where you have pain or symptoms on the chart below and indicate your current level of pain.



I affirm the above information is correct to the best of my knowledge.

Signature_____ Date_____