Physical Therapy, P.A. 27180 Bay Landing Drive | Suite 7 | Bonita Springs, FL 34135 | krizpt.com | 239-992-6700

PLEASE PRINT CLEARLY

Name: ______________________________ Today's Date: __________

Current Address: ______________________________

Other Address: ______________________________

Day Phone: __________ Eve. Phone: __________ Mobile Phone: __________

Soc. Sec. #: __________ Date of Birth: __________ Gender: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Employment Status: ☐ Full-Time ☐ Part-Time ☐ Not Employed ☐ Retired

Employer: ______________________________

Referring Physician: __________ Date of LAST & NEXT appointment: __________

In Case of an emergency, Notify: __________ Phone #: __________

Who may we thank for referring you to us? ______________________________

Is the illness/injury for which you are being seen the result of any of the following? (check one)

☐ Auto Accident ☐ Work Injury ☐ Other Illness/injury being litigated ☐ None of these

Primary Health Insurance Company: __________ ☐ Insurance I.D. card copied for chart.

Secondary Health Insurance Company: __________ ☐ Insurance I.D. card copied for chart.

Driver's License # / Photo ID: __________ ☐ Driver's Lic. / Photo ID Copied for Chart.

Consent to Treat and Authorization to Release Information (please initial)

____ I consent to evaluation and treatment by Kriz Physical Therapy, P.A. and realize that I have the right to refuse a procedure after having the risks and benefits explained to me.

____ I authorize the release of information acquired in the course of my treatment, including but now limited to medical records, electronic media, and oral communications, to my insurance company representatives, employer, primary care physician, referring physician, and/or other third party payer.

____ I authorize phone messages regarding my treatment and appointments to be left with persons or machines at the phone numbers I have provided.

____ A copy of this facility's Statement of Privacy Notice has been provided to me.

Patient's Signature: ______________________________ Date: __________

Signature of Responsible Party: __________ Relationship: __________ Date: __________

PHYSICAL THERAPY, P.A. 27180 Bay Landing Drive | Suite 7 | Bonita Springs, FL 34135 | krizpt.com | 239-992-6700

Patient History Questionnaire

To ensure you receive a complete and thorough evaluation, please provide us with the important background information. If you do not understand a question leave it blank and your therapist will assist you. Your therapist will discuss your responses with you during the evaluation. Thank you for completing this information.

PLEASE PRINT CLEARLY

Name: ______________________________

I am currently: ☐ Employed ☐ Employed with restrictions ☐ On Medical Leave ☐ Not Employed

Employer: ______________________________

Is there anyone who can assist you with doing home exercises or activities if needed? ☐ Yes ☐ No

Next Scheduled Dr. Appointment(s): Date: ____________ Physician: ______________________________

Date: ____________ Physician: ______________________________

ALLERGIES: Please list any medication(s) or materials you are allergic to: ______________________________

____

Have you declared the Advanced Clinical Directive of Do Not Resuscitate? ☐ Yes ☐ No

General Health

1. Medical conditions you have or have had. (e.g. high blood pressure, diabetes, etc.)

   Please list: ______________________________

2. Have you ever been diagnosed with any of the following conditions?:

   Cancer ☐ Yes ☐ No If yes, please describe what kind:

High Blood Pressure	☐ Yes	☐ No	Circulatory Problems	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Emphysema/Bronchitis	☐ Yes	☐ No
Multiple Sclerosis	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Rheumatoid Arthritis	☐ Yes	☐ No	Other Arthritic Condition	☐ Yes	☐ No
Depression	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No

3. Have you had any surgical or invasive procedures? ☐ Yes ☐ No If yes, please list: ______________________________

   ____

4. Uncontrolled leakage of urine? ☐ Yes ☐ No
5. Loss of bowel control? ☐ Yes ☐ No

continued on next page

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Patient History Questionnaire *continued*

6. Do you smoke? ☐ Yes ☐ No Packs per day: ________
7. Do you drink alcohol? ☐ Yes ☐ No Drinks per Week: ________
8. Is there any chance you might be pregnant? ☐ Yes ☐ No
9. Are you on a special diet? ☐ Yes ☐ No
10. How much caffeinated coffee or caffeine containing beverages do you drink per day?
11. Which of the following over the counter medications have you taken in the past week?
    ☐ Aspirin ☐ Tylenol ☐ Advil/Motrin/Ibuprofen ☐ Aleve ☐ Laxatives ☐ Decongestants
    ☐ Antihistamines ☐ Antacid ☐ Vitamins/Mineral Supplements ☐ Herbals/Remedies

    Other (please list): ____________________
12. Are you taking any prescription medications? ☐ Yes ☐ No
    If yes, please list or attach separate sheet (including pills, injections, and skin patches)
13. For patients 12 years and younger, is immunization/vaccination status current? ☐ Yes ☐ No
14. Has anyone in your immediate family (parents, brothers, sisters) ever been treated for any of the following?
    ☐ Diabetes ☐ Cancer ☐ Heart disease ☐ Alcoholism ☐ Stroke ☐ Kidney disease
    ☐ Depression ☐ Inflammatory Arthritis (Rheumatoid, Ankylosing)
15. What do you WANT TO achieve from having therapy? Check all that apply.
    ☐ Improve home activities
    ☐ Improve mobility/walking activities decrease or eliminate pain/discomfort
    ☐ Improve leisure/sports activities
    ☐ Return to work: ☐ Current Job ☐ Other Job
    ☐ Improve Self care activities Other:

Patient Signature: ____________________ Date: ____________

Therapist Signature: ____________________ Date: ____________

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Statement of Privacy Notice

Effective September 30, 2008

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information.

- Your protected health information may be released to your insurance provider for the purpose of providing Kriz Physical Therapy, P.A. (Kriz P.T.) receiving payment for providing you with needed physical therapy services. Kriz P.T. might share your health information with your physician for payment activities related to the care you received.
- Your protected health information may be released to public or law enforcement officials in the event of an investigation in which you are a victim of abuse, a crime or domestic violence.
- Your protected health information may be released to other healthcare providers in the event you need emergency care.
- Information regarding your appointment time, presence at our facility, or other general details of your scheduled appointments may be provided over the phone to callers who request so by providing your name.
- Your protected health information may be released only after receiving written authorization from you with the exception of those listed above or for treatment, payment, or healthcare operations. You may revoke your permission to release protected health information at any time. It must be writing with effective date and be specific to the health information being protected. Kriz P.T. is not required to agree to your request.
- You may be contacted by Kriz P.T. by phone or mail (or leave a message on an automated answering device) to remind you of appointments, verify insurance/demographic information, etc. You have the right to request a more confidential way of providing your protected health information or alternate communication method at the time you are seen at Kriz P.T. Kriz P.T. will honor all reasonable requests.
- You have the right to restrict the use of your protected health information. However, Kriz, P.T. may choose to refuse your restriction if it is in conflict with providing you with quality healthcare or in the event of an emergency.
- You have a right to review and photocopy any/all portions of your health information. Kriz P.T. has the right to assess a fee for photocopying of the health information.
- You have the right to request an amendment to your health information. It must be in writing and explain why the information should be amended. Kriz P.T can deny the amendment and if so, a written explanation will be provided.
- You have the right to possess a copy of this Statement of Privacy Notice upon request. This copy can be in the form of an electronic transmission or on paper.
- Kriz P.T. is required by law to protect the privacy of its patients. It will keep protected any and all health information and will provide patients with a list of practices that protect health information upon written request.
- Kriz P.T. will abide by the terms of this notice. Kriz P.T. reserves the right to make changes to this notice and will continue to maintain the confidentiality of all health information. Changes to this notice will be distributed at your next visit to Kriz P.T.
- You have the right to complain to Kriz P.T. if you believe your rights have been violated; please mail your written complaint to: Kriz Physical Therapy, P.A., Attn: Patient Information Privacy Officer, 27180 Bay Landing Drive, Suite 7, Bonita Springs, FL 34135.
- All complaints will be investigated. No personal issue will be raised for filing a complaint with Kriz P.T.
- You may also file a complaint to: Region IV, Office of Civil Rights, US Dept. of Health and Human Services, Atlanta Federal Center, Suite 3B70, 61 Forsythe Street, S.W., Atlanta, GA 30303-8909.

If you would like more information regarding this Privacy Notice, please contact our Privacy Officer at (239) 992-6700.

Patient signature signifying receipt of HIPPA Statement: ______________________________