PATIENT HEALTH HISTORY INFORMATION -PLEASE PRINT CLEARLY

Legal Name _____ **Preferred Name/Nickname** _____

Birth Sex □ Male □ Female (required for Insurance) **Birth Date** _____

Preferred Pronoun _____ **Language** □ English □ Other _____

Home Address _____ **Apt/Unit**_____

City _____ **State** _____ **Zip** _____

Email Address (Correspondence and E-statements) _____

Cell Phone _____ **Home Phone** _____ **Work Phone** _____

Resides at □ Home □ Residential Care Facility _____ □ Intermediate Care Facility _____

Do you have an ID WAIVER? □ Yes □ No If **YES**, please see Front Desk Staff

Do you have Medicare? □ Yes □ No **If yes, are you receiving home health services?** □ Yes □ No

Preferred method of contact □ Cell □ Home □ Work **May we leave a message?** □ Yes □ No

Would you like to receive text or email appointment reminders □ Text □ Email □ No Thanks

Emergency Contact

Name _____ Relation _____

Address _____ Phone _____

Please let the Front Desk Staff know if there are any Holiday's you or your family do not celebrate.

EMS CONSENT:

Please specify below by checking ONE box only: I request Unified Therapy Services to:

□ PROVIDE (RESUSCITATE REQUESTED) rescue breathing or CPR if I am in their care during a time of crisis

□ DECLINE (DO NOT RESUSCITATE) or use rescue breathing or CPR if I am in their care during a time of crisis.

REASON FOR VISIT:

☐ Back Pain ☐ Neck Pain ☐ Shoulder/Arm Problems ☐ Hand Problems

☐ Leg/Foot Problems ☐ Balance Problems ☐ Other

Date condition began _____ Date of next doctor appointment for this condition _____

Date of Surgery (if applicable) _____ Type of surgery _____

Have you EVER been diagnosed with any of the following conditions:					
□ **Y** □ **N**	Angina	□ **Y** □ **N**	Depression	□ **Y** □ **N**	Joint pain
□ **Y** □ **N**	Anxiety	□ **Y** □ **N**	Diabetes Type I	□ **Y** □ **N**	Lymphedema
□ **Y** □ **N**	Arrythmia	□ **Y** □ **N**	Diabetes Type II	□ **Y** □ **N**	Migraine Headaches
□ **Y** □ **N**	Asthma	□ **Y** □ **N**	Fibromyalgia	□ **Y** □ **N**	MRSA
□ **Y** □ **N**	Blood Clotting Disorder	□ **Y** □ **N**	Frequent UTI	□ **Y** □ **N**	PVD
□ **Y** □ **N**	Bowel Incontinence	□ **Y** □ **N**	GERD	□ **Y** □ **N**	Multiple Sclerosis
□ **Y** □ **N**	Cancer	□ **Y** □ **N**	Glaucoma	□ **Y** □ **N**	MI/Heart Attack
□ **Y** □ **N**	Carpal Tunnel Syndrome	□ **Y** □ **N**	DVT	□ **Y** □ **N**	Osteoarthritis
□ **Y** □ **N**	Cellulitis	□ **Y** □ **N**	High Cholesterol	□ **Y** □ **N**	Osteoporosis
□ **Y** □ **N**	Chronic Back Pain	□ **Y** □ **N**	Gout	□ **Y** □ **N**	Psoriatic Arthritis
□ **Y** □ **N**	Chronic Neck Pain	□ **Y** □ **N**	Heart Disease	□ **Y** □ **N**	Rheumatoid Arthritis
□ **Y** □ **N**	Crohn's Disease	□ **Y** □ **N**	Hepatitis B	□ **Y** □ **N**	Scoliosis
□ **Y** □ **N**	Degenerative Disc Disease	□ **Y** □ **N**	Hepatitis C	□ **Y** □ **N**	Seizure Disorder
□ **Y** □ **N**	Close Head Injury	□ **Y** □ **N**	Hiatal Hernia	□ **Y** □ **N**	Shortness of Breath
□ **Y** □ **N**	Colitis	□ **Y** □ **N**	HIV/AIDS	□ **Y** □ **N**	Sleeping Disorder
□ **Y** □ **N**	Congestive Heart Failure	□ **Y** □ **N**	Hypertension	□ **Y** □ **N**	TB
□ **Y** □ **N**	COPD	□ **Y** □ **N**	Hypothyroidism	□ **Y** □ **N**	Do you Smoke
□ **Y** □ **N**	CVA (Stroke)	□ **Y** □ **N**	IBS		

□ **Yes** □ **No** During the Past Month have you been feeling down, depressed or hopeless?

□ **Yes** □ **No** During the Past Month have you been bothered by having little interest or pleasure in doing things?

□ **Yes** □ **No** If yes to either, is this something with which you would like more resources from UTHS?

□ **Yes** □ **No** Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way?

□ **Yes** □ **No** FOR WOMEN: Are you currently pregnant or do you think you might be pregnant?

Do you have a pacemaker, transplanted organ, joint replacement, or other metal implants? □ Yes □ No

Explain _____

Please list any surgeries or other conditions for which you have been hospitalized, including dates:

_____

_____

_____

Please list any special tests performed for this problem (x-ray, MRI, labs, etc)

_____

_____

_____

CURRENT MEDICAL CARE:

Please check any of the following whose care you have been under in the past 3 months:

☐ Physician (MD, DO) ☐ Podiatrist (DPM) ☐ Psychiatrist/Psychologist/Dentist

☐ Physical Therapist ☐ Chiropractor (DC) ☐ Other:_____

If you have seen any of the above professionals during the last 3 months, please describe the reason (illness, medical, routine visit,etc_____

_____

_____

ALLERGIES:

Allergies: Please list any medications you are allergic to: _____

Any other allergies?_____ Are you latex sensitive? □ **Yes** □ **No**

MEDICATIONS:

Please list any medications including pills, injections, and/or skin patches, etc you are currently taking.

(You may choose to provide a medication list to our Front Desk Staff to scan into your medical history, if easier)

_____

_____

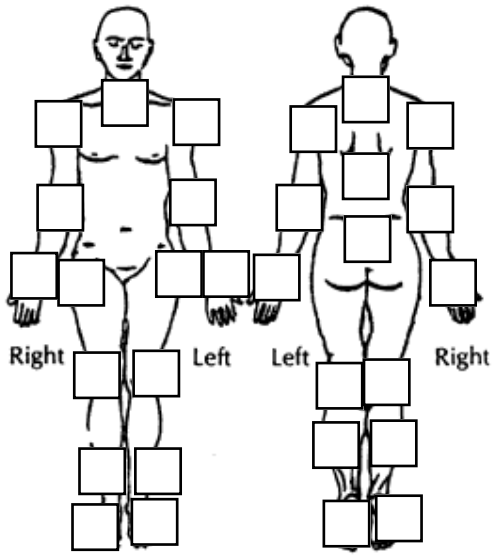
Please note that **ALL sharps must be disposed of at home- NO SHARPS CONTAINER AT UNIFIED THERAPY!

Have you ever taken steroid medications for any medical conditions? □ **Yes** □ **No**

If Yes, please explain _____

Have you ever taken blood thinning or anticoagulant medications for any medical conditions? □ **Yes** □ **No**

Body Chart



Please mark the body chart where your current symptoms are located

My symptoms currently:

☐ Come and go
☐ Are constant
☐ Are constant, but change with activity

Using the 0 to 10 pain scale, with 0 being "no pain" and 10 being the worst pain imaginable please describe:

Choose your **current level of pain** while completing this survey:

Choose the **least amount of pain** you have had in the past 24 hours:

Choose the **worst your pain** has been in the past 24 hours:

Please list 3 activities that you are unable to do or have moderate to extreme difficulty doing as a result of you injury or pain level. For each activity you list, rate the level of difficulty you have performing the activity on the 0-10 scale.

0 = unable to perform activity 10= able to perform activity at the same level as before injury/pain

Activity #1 _____

Activity #2 _____

Activity #3 _____

How are you currently able to sleep at night due to your symptoms?

☐ No problem sleeping ☐ Difficulty sleeping ☐ Awakened by pain ☐ Sleep only with medication

When are your symptoms **worst**? ☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ After Activity

When are your symptoms the **best?** ☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ After Activity

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BILLING/FINANCIAL: Please provide the front desk staff with all insurance cards.

Unified Therapy Services Inc. **requires** a payment method (credit, debit, or HSA card) to be on file. Please see our Financial and Reimbursement Policy form for more information.

INFORMATION RELEASE FORM:

I hereby give Unified Therapy Services permission to receive and release all medical and/or financial information to/from the following individuals/groups/organizations during my care at Unified Therapy Services.

☐ Non-referring Physician _____ ☐ Medical Vendors _____

☐ Dept of Health Services _____ ☐ Spouse/Partner/Parent _____

☐ School/Employer _____ ☐ Other _____

MARKETING:

Please tell us how you learned of our services or whom we may thank: _____

Upon discharge, may we send follow up postcards to your mailing address?: □ **Yes** □ **No**

PUBLIC RELEASE:

Occasionally, Unified Therapy Services will photograph or videotape for educational and/or marketing purposes. We will always verbally discuss with the patient/parents/guardians before anything is printed for marketing purposes.

☐ I **ALLOW** photos/videos to be taken.

☐ I **DECLINE** the use of photos/videos to be taken.

*I hereby **give my permission** to use _____'s first name and last initial to be used by **Unified Therapy Services** to identify accomplishments, birthdays, artwork, etc.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow –up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand the *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you agree then you are bound to abide by such restrictions.

CONSENT FOR CARE/ASSIGNMENT OF BENEFITS/LIABILITY WAIVER

I authorize Unified Therapy Services to release information from my medical records as may be necessary for the completion of the clinic's claims for reimbursement to third party payers. This authorization may include copies of my medical records to be sent to my insurance carrier.

In consideration of the services received or to be received by Unified Therapy services, I assign all insurance, Medicare, or Medicaid due me to Unified Therapy Services. I authorize Unified Therapy Services, Inc to run my card on file for the purpose(s) stated above and per the terms of this agreement. This authorization will remain in effect until I give written notice to Unified Therapy to change or terminate this authorization.

I willingly agree to comply with the stated and customary terms and conditions for participation in therapy services and other clinic operations including protection against and possible exposure to/illness from infectious diseases and I knowingly and freely assume all such risks.

I, for myself, assigns, personal representative and next of kin, hereby release, defend and hold harmless Unified Therapy Services and their employees used to conduct therapy services and clinic operations ("releases"), with respect to any and all illness, disability, death, or loss or damage to person or property arising out of participation in therapy services or clinic operations, whether arising from the negligence of releases or otherwise, to the fullest extent permitted by law.

I APPROVE OF THE NOTED DIAGNOSTIC/REHABILITATIVE SERVICES.

Authorized Signature_____ **Date**_____

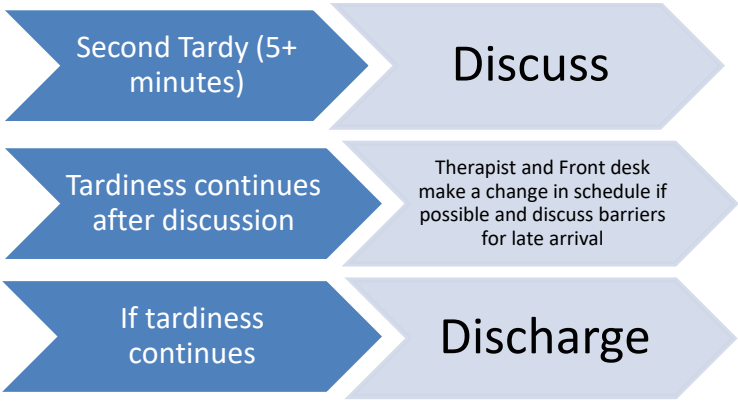
By signing above, I certify that the previous pages of the new patient paperwork information are true and accurate to the best of my knowledge.

UNIFIED THERAPY SERVICES ADULT PATIENT ATTENDANCE POLICY

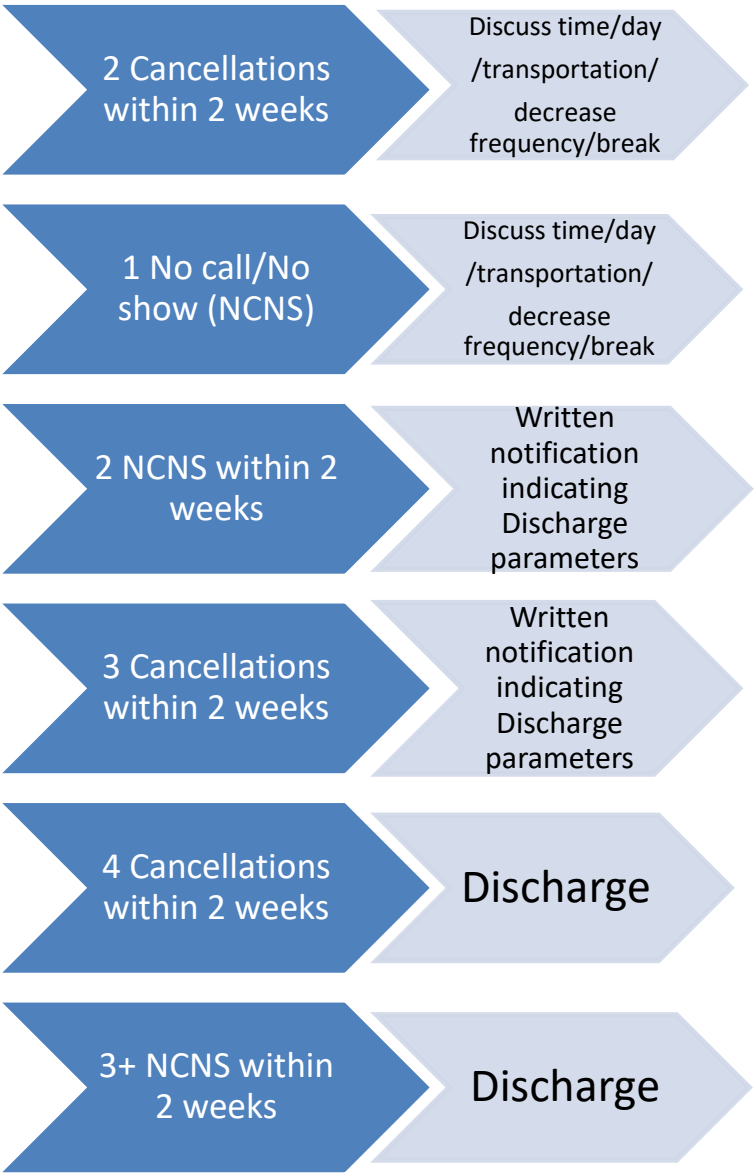
I understand that it is my responsibility to attend all scheduled therapy appointments or to *call and cancel at least 2 hours in advance.* Messages may be left after hours and will be received the next business day.

- I understand that if I don't attend the scheduled appointments and the staff of UTS must call me, this will be considered a **No Call/No Show (NC/NS)** visit. **This will result in a $10 charge**. _____Initial
- I understand that I may be discharged from Aqua Therapy if I have a combination of 2 NC/NS or cancellations.
- I understand there may be extended excused absences related to hospitalizations, surgery, injuries, illness, and extended vacations.
- I understand my employer will receive attendance reports if payment for therapy is via worker's compensation.
- I understand that transportation information is available.
- I understand any exclusion will be at the discretion of Unified Therapy Services.
- I understand that I may see different therapists for my sessions.

ARRIVAL TARDINESS



ATTENDANCE GUIDELINES



I have read & understand the above-mentioned Attendance Policy _____(initials)