Integrated Therapeutic Healing, LLC

New Patient Information Sheet

Welcome to our practice!
Please help us serve you better by taking a few minutes to provide the following information.

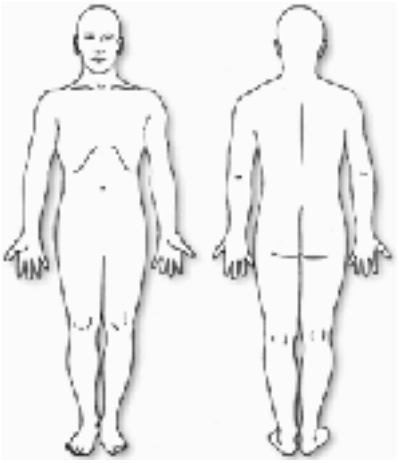
Name:	Last Name	First Name		Today's date:					
Address:									
City / State / ZIP:									
Phone #	MOBILE		HOME		WORK				
DOB:		Age:		Marital status:	M	S	W	D	
Email:									
Occupation:		Employer:							
Emergency Contact	Name:		Phone:						
Primary Care Physician	Name:		Date of next visit						
Specialist Physician	Name:		Date of next visit						

How did you hear about our practice?	
Who can we thank for referring you to our practice?	

The following is very important in our evaluation process.
Please fill out these forms as specifically as possible to provide us with a clear picture of your present pain and functional status.

What is the primary issue/problem that brings you in today?
Secondary concern/problem?
As a result, I am now having difficulty with:
Are you currently experiencing pain as a result of these symptoms? If yes, what is it like?
When did your symptom(s) begin? (Date):

Please shade in areas where you have pain, discomfort, or tension.



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Please rate your pain in the last 24-72 hours **Using the "0 -10" scale where 0 is no pain and 10 is the worst possible pain.**	At its worst	
	At its best	
	At present	
	Night (sleeping)	

At what time of day are your symptoms the worst?	
At what time of day are your symptoms the best?	
What activities increase your pain?	
What activities decrease your pain?	

What other types of treatment have you had for this problem?											
	Massage		Bodywork		Physical Therapy		Myofascial Release		Chiropractic		Surgery
Other Medical Treatment: (Please Describe)											

Check the box if you have had any of the following medical conditions?											
	Diabetes		Lung disease		Weight change		Varicose veins		Neurological problems		Pregnancy
	Rheumatic fever		Osteoporosis		Migraine headaches		Epilepsy / seizures		Stroke		Blackouts
	Heart Murmur		Malignancy		Arthritis		Broken bones (fracture		Metal implants		High blood pressure
	Circulatory problems		Liver disease		Heart disease / pacemaker		Kidney disease		**Others (explain below)**		

List past medical history and dates of occurrence. Include surgeries, accidents and other traumas.

List ALL medications which you are currently taking, the condition for which you are using them, the dose, and their effectiveness. (Include supplements, herbal and homeopathic remedies).			
Medication	For treatment of	Dose / Amount per day	Effectiveness

Do you smoke?	Yes	No	If "Yes" – How much?	
When did you quit?			If not, Would you like to quit?	

Is there a chance you may be pregnant at this time?	Yes	No

Do you engage in regular exercise?					Yes	No
What type and how often?						
Are you able to exercise now?					Yes	No

Do you have discomfort, shortness of breath, or pain with exercise?					Yes	No
Please Describe:						
In general, your lifestyle is:	1	2	3	4	5	
	Active		Average		Inactive	

If sleep is a problem, answer these questions:

Do you have trouble falling asleep?	Yes	No	Do you find it difficult to change positions in bed?	
Is your sleep restful?	Yes	No	How many times do you wake in the night?	
Do you find it difficult to lie down?	Yes	No	How long before you fall back to sleep?	

List all the Tasks / Activities that you have difficulty performing and your tolerance (minutes/hours).
If you are no longer able to perform an activity, your tolerance would be "0".

Task / Activity	Tolerance (minutes/hours)

I walk for		**minutes before needing to rest**
I stand for		**minutes before needing to sit**
I sit for		**minutes before needing to change positions/get up**

Do you have trouble getting up from a chair?	Yes	No
Do you have trouble putting on your shoes and socks?	Yes	No
Do you have difficulty climbing stairs?	Yes	No

Patient Goals
Please list the activities that you would like to be able to do as a result of therapy.

Task / Activity	Duration / How Often	By When
Other Goals?		

Informed Consent

I understand that Integrated Therapeutic Healing will maintain my privacy to the highest standards and may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment.

Photographs taken during initial evaluation, progress evaluation and discharge summary will be used for postural comparison purposes and as

educational tools. By signing below I consent to the use of these photographs in a professional manner.

I do hereby agree and give my consent for Integrated Therapeutic Healing to furnish care and treatment that is considered necessary and proper in the diagnosing or treating of my physical condition.

I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.
I hereby certify that all the above information is true to the best of my knowledge.

Patient/Parent/Guardian Signature:_____

Date:_____

NOTICE OF PRIVACY PRACTICES (MEDICAL)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your information. We may use and disclosed your medical records only for each of the following purposes: treatment, payment and health care operations.

Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
Payment means such activities as obtained reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization. You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of **April 14th, 2003** and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information.
Integrated Therapeutic Healing, LLC
integratedtherapeutichealing@gmail.com
419-677-0922

For more information about HIPAA or to file a complaint:
The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

_____
Patient's Signature

_____
Patient's Full Name

_____
Date