Therapist:

Patient I.D. Verified _____
M.D. License Verified_____

SCHAACK PHYSICAL THERAPY

PATIENT INFORMATION SHEET

DATE_____

NAME_____ **SSN#**_____

ADDRESS _____

CITY_____ **STATE**_____ **ZIP**_____

HOME PHONE_____ **EMERGENCY CONTACT NAME**_____

CELL PHONE_____ **EMERGENCY CONTACT PHONE**_____

EMAIL_____ **HOW DID YOU HEAR ABOUT US?** _____

DATE OF BIRTH_____ **AGE**_____ **SEX: M F** **MARITAL STATUS: M S D W**

IF MINOR, NAME OF PARENT/GUARDIAN_____ **PHONE**_____

EMPLOYER_____ **JOB TITLE**_____

BUSINESS ADDRESS_____

CITY_____ **STATE**_____ **ZIP**_____

WORK PHONE_____ **EXT**_____ **SUPERVISOR**_____

PRIMARY INSURANCE COMPANY_____

ADJUSTOR_____ **CLAIM#**_____

ADDRESS _____ **PHONE**_____

CITY_____ **STATE**_____ **ZIP**_____

WORK RELATED: Y N **MOTOR VEHICLE ACCIDENT: Y N** **PERSONAL INJURY CLAIM: Y N**

REFERRING PHYSICIAN: _____ **DATE OF INJURY:** _____

IF THIS IS A PERSONAL INJURY OR IF YOU WERE IN A MOTOR VEHICLE ACCIDENT, HAVE YOU RETAINED AN ATTORNEY? Y N

IF SO, PLEASE PROVIDE THE FOLLOWING INFORMATION:

ATTORNEY NAME: _____ **PHONE:** _____

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PATIENT HISTORY INFORMATION

Patient Name: _____

Have you had previous Physical Therapy for your present condition? Y N

Where_____ **When**_____

Do you have/or have you had any of the following:

☐ **DIABETES I or II**
☐ **HIGH BLOOD PRESSURE**
☐ **HEART DISEASE / CHF /ANGINA**
☐ **HEART ATTACK**
☐ **STROKE OR TIA**
☐ **COPD/ARDS OR EMPHYSEMA**
☐ **ASTHMA**
☐ **PROSTHESIS/METAL IMPLANTS**
☐ **PREVIOUS SURGERY**
☐ **KIDNEY/BLADDER PROBLEMS**
☐ **OSTEOPOROSIS/OSTEOPENIA**
☐ **ARTHRITIS (RA OR OA)**
☐ **RECEIVED COVID VACCINE**

☐ **PACEMAKER**
☐ **NEUROLOGICAL DISEASE (MS or Parkinson's)**
☐ **PREGNANT (now)**
☐ **HEADACHES**
☐ **HISTORY OF CANCER**
☐ **GI DISEASE (Ulcer/Reflux/Bowel/Liver/Gall Bladder)**
☐ **VISUAL / ☐ HEARING IMPAIRMENT**
☐ **HERNIA**
☐ **ALLERGIES (Meds) (Heat/Ice)**
☐ **ANXIETY/PANIC DISORDERS/DEPRESSION**
☐ **SEIZURES**
☐ **HEPATITIS/TB/HIV/AIDS**
☐ **RECENT COVID EXPOSURE**

TOBACCO USE: ☐NONE ☐CIGARETTES/CIGARS ☐SMOKELESS/VAPE

HEIGHT: _____ **WEIGHT:** _____

Please list medication(s) and for what conditions(s) they are being taken:

_____
_____
_____

CONSENT TO TREAT

I understand that I am under the care and control of my physician(s) and that Schaack Physical Therapy is not liable to any act or omission when providing treatment in accordance with my physician's instructions. I consent to have Schaack Physical Therapy provide the treatment and care prescribed by my physician. I understand this consent may be revoked by me at any time**.**

Patient Signature_____**Date**_____

1620 Lead Hill Blvd., Suite 200 ◆ Roseville, CA 95661 ◆ (916) 789-1111 ◆ Fax (916) 789-1304
801 Sterling Parkway, Suite 150 ◆ Lincoln, CA 95648 ◆ (916) 543-7900 ◆ Fax (916) 543-7910

Patient Name_____ **Date**_____

Depression Scale

Instructions:

Circle the answer that best describes how you felt over the past week.

1.	Are you basically satisfied with your life?	Yes	**No**
2.	Have you dropped activities and interests due to Depression?	**Yes**	No
3.	Do you feel that your life is empty?	**Yes**	No
4.	Do you often get bored?	**Yes**	No
5.	Are you in good spirits most of the time?	Yes	**No**
6.	Are you afraid that something bad is going to happen to you?	**Yes**	No
7.	Do you feel happy most of the time?	Yes	**No**
8.	Do you often feel helpless?	**Yes**	No
9.	Do you prefer to stay at home, rather than going out and doing things?	**Yes**	No
10.	Do you feel that you have more problems with memory than most?	**Yes**	No
11.	Do you think it is wonderful to be alive now?	Yes	**No**
12.	Do you feel worthless the way you are now?	**Yes**	No
13.	Do you feel full of energy?	Yes	**No**
14.	Do you feel that your situation is hopeless?	**Yes**	No
15.	Do you think that most people are better off than you are?	**Yes**	No

Patient Name _____ Date _____

EASI Form			
1) Have you relied on people for any of the following: bathing, dressing, shopping, banking, or meals?	YES	NO	Did not answer
2) Has anyone prevented you from getting food, clothes, medication, glasses, hearing aides or medical care, or from being with people you wanted to be with?	YES	NO	Did not answer
3) Have you been upset because someone talked to you in a way that made you feel shamed or threatened?	YES	NO	Did not answer
4) Has anyone tried to force you to sign papers or to use your money against your will?	YES	NO	Did not answer
5) Has anyone made you afraid, touched you in ways that you did not want, or hurt you physically?	YES	NO	Did not answer

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PATIENT GUIDELINES

Patient Name: _____

Please NO PERFUMES/COLOGNES Prior to Physical Therapy.

1. You should be seeing your doctor regularly while attending physical therapy. Please keep us informed **AHEAD OF TIME** of the dates you will be seeing your doctor so that we may prepare a letter to keep him/her informed on your progress.

2. Illness and/or emergencies sometimes occur. We have set aside time for you, please be prompt and consistent in keeping your appointments. **We require notification 24 hours in advance if you are unable to attend a scheduled appointment. If you fail to cancel your appointment within our cancellation guidelines, you will be subject to a "Cancellation/No Show" charge of $50.00. As Work Comp does not allow us to charge a cancellation fee for work comp patients, three (3) missed appointments without 24-hour notice will conclude your physical therapy sessions.**

3. If your yearly deductible has not been met, as a courtesy, we will estimate your visit payments and the balance remaining can be paid in installments arranged with the front office.

4. If you are a worker's compensation patient, please note that we are obligated to inform your insurance carrier with regard to your consistency of attendance. For your health and quick recovery, please keep your scheduled appointments. **Work Comp patients please be advised that we are required to report cancellations & no shows to your adjustor.**

5. Please be consistent in following through with any instruction given regarding home care or home exercise programs.

Initials _____ Date _____

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INDIVIDUAL PATIENT'S AUTHORIZATION

THIS FORM IS TO CONFIRM YOUR AUTHORIZATION TO USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION FOR A SPECIAL PURPOSE.

Psychotherapy Notes: ___ Check here if this authorization is for psychotherapy notes.
If this authorization is for psychotherapy notes, it may not authorize the use or disclosure of any other type of protected information.

1. INDIVIDUAL PATIENT (OR PERSONAL REPRESENTATIVE) CONFIRMING THE AUTHORIZATION

I give my authorization to use or disclose my protected health information as described in Section 2 below. I give my authorization voluntarily.

Individual Patient's Name: _____

Your Address: _____

_____

Your Telephone Number: _____

Your Email Address: _____

2. THE USE AND/OR DISCLOSURE AUTHORIZED

Describe in detail the protected health information you are authorizing to be used and/or disclosed (if this authorization is for psychotherapy notes, no other type of protected health information may be listed here):

PHYSICAL THERAPY

_____

_____

Name the people and/or organizations (or the kinds of people and/or organizations) that you are authorizing to use and/or disclose the protected health information described above.

SCHAACK PHYSICAL THERAPY/ SCHAACK PT BILLING/COLLECTION SERVICE

_____

Name the people and/or organizations (or the kinds of people and/or organizations) that you are authorizing to receive and use your protected health information.

BILLING SERVICE, DOCTOR, INSURANCE COMPANY, SPOUSE, PARENT

_____

Describe each purpose for which you are authorizing your protected health information to be used and/or disclosed.

TREATMENT AND BILLING

_____

3. ENDING THIS AUTHORIZATION

Select one of the following two choices.

___ This authorization will stay in effect until revoked.

__X__ This authorization will end when the following event happens. The event must relate to the individual or the purpose of the authorized use and/or disclosure. Describe the event below.

WHEN NOTIFIED BY PATIENT

4. CHANGING YOUR MIND ABOUT THIS AUTHORIZATION

I understand that I may revoke this authorization at any time by giving written notice to the Privacy Officer at your office. However, I understand that I may not revoke this authorization for any actions taken before receipt of my written notice to revoke this authorization. In addition, I understand that if I am giving this authorization as a condition of obtaining insurance coverage, and I revoke this authorization, the insurance company has a right to contest my claims und the insurance policy.

5. SIGNING THIS AUTHORIZATION IS NOT A CONDITION OF TREATMENT

I understand that under most circumstances a healthcare provider may not condition treatment, payment, enrollment, or eligibility for benefits on my signing this authorization. However, I understand that signing an authorization that permits the use and/or disclosure of my protected health information for research purposes may be a condition of my treatment if I am undergoing research-related treatment. Also, I may be required to sign an authorization if my treatment is provided solely for the purpose of creating protected health information for disclosure to a third party. And under some circumstances, a health plan may condition my enrollment in a health plan or my eligibility for benefits on my providing an authorization permitting the health plan to make enrollment and eligibility determinations.

6. POSSIBILITY OF REDICLOSURE

I understand that information disclosed under this authorization may be disclosed by the recipient. Federal privacy rules may not protect the privacy of my health information once the recipient rediscloses my health information.

7. INDIVIDUAL PATIENT'S SIGNATURE

I have had the chance to read and think about the content of this authorization form and I agree with all statements made in this authorization. I understand that, by signing this form, I am confirming my authorization for use and/or disclosure of the protected health information described in this form with the people and/or organizations named in this form.

Signature: _____ Date: _____

Personal Representative's Name: _____

Signature: _____

Relationship to Individual Patient: _____

YOU HAVE A RIGHT TO HAVE A COPY OF THIS FORM AFTER YOU SIGN IT.

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

We are legally required to give you this Notice and to get a signed statement that you received it. By signing this form, you are saying that you have received Schaack Physical Therapy's Notice of Privacy Practices.

Schaack Physical Therapy's Notice of Privacy Practices tells you how we can use and disclose your health information. It also describes certain rights you have about your health information kept by us. Please review the Notice of Privacy Practices carefully.

The undersigned hereby acknowledges receipt of Notice of Privacy Practices for Schaack Physical Therapy.

_____
Patient's Printed Name

_____ _____
Patient Signature Date

_____ _____
Parent/Guardian Signature Relationship to Patient

If the patient did not sign an acknowledgement of receipt of the Notice of Privacy Practices, complete the following:

List efforts taken to get patient's acknowledgement and reasons acknowledgement was not signed:

_____

_____

_____

_____ _____
Signature of Staff Member Location

_____ _____
Printed Name of Staff Member Date