



MEDICAL PROFILE QUESTIONNAIRE

Please fill out the following questionnaire as completely as possible. This will assist your physical therapist to establish a safe and effective therapy program.

Name: _____ **Age:** _____ **Occupation:** _____

Do your symptoms interfere with your work NO YES, because _____

Which physicians are involved in your care: _____

Has your doctor ever said you have (check all the boxes that apply):

- | | | |
|---|---------------------------------------|--|
| <input type="checkbox"/> Cancer / tumors | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Heart trouble | <input type="checkbox"/> Asthma | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Poor Circulation | <input type="checkbox"/> OTHER: _____ | |

Does your family have a history of (check all boxes that apply):

- | | | |
|---|---------------------------------------|--|
| <input type="checkbox"/> Cancer / tumors | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Asthma | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Poor Circulation | <input type="checkbox"/> OTHER: _____ | |

What medications do you use, or have you recently used (check all boxes that apply):

- | | | |
|--|--|---------------------------------------|
| <input type="checkbox"/> Steroids | <input type="checkbox"/> Anti-inflammatory | <input type="checkbox"/> Pain killers |
| <input type="checkbox"/> Muscle relaxants | <input type="checkbox"/> Blood thinners | <input type="checkbox"/> Insulin |
| <input type="checkbox"/> Blood pressure meds | <input type="checkbox"/> Heart medications | <input type="checkbox"/> Other _____ |

Do you suffer or have you suffered from (check all boxes that apply):

- | | | |
|--|--|---|
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Pain in your chest | <input type="checkbox"/> Angina |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Epilepsy / seizures | <input type="checkbox"/> Black outs |
| <input type="checkbox"/> Frequent falls | <input type="checkbox"/> Severe pain at night | <input type="checkbox"/> Bladder Problems |
| <input type="checkbox"/> Night sweats | <input type="checkbox"/> Concentration problem | <input type="checkbox"/> Decreased appetite |

Please list all your surgeries, major injuries and fractures: _____

- | | | |
|----------------------------|-----------------------------|---|
| Do you smoke | <input type="checkbox"/> no | <input type="checkbox"/> yes, _____ per day |
| Do you drink alcohol | <input type="checkbox"/> no | <input type="checkbox"/> yes, _____ glasses per week |
| Do you use drugs | <input type="checkbox"/> no | <input type="checkbox"/> yes |
| Do you have metal implants | <input type="checkbox"/> no | <input type="checkbox"/> yes |
| Do you exercise regularly | <input type="checkbox"/> no | <input type="checkbox"/> yes, _____ sessions per week |

How would you rate the level of stress in your life: high medium low

Women only:

- | | | |
|--|-----------------------------|---|
| I have had a recent pelvic exam | <input type="checkbox"/> no | <input type="checkbox"/> yes |
| Is there any chance you may be pregnant | <input type="checkbox"/> no | <input type="checkbox"/> yes |
| I have had a recent mammogram or breast exam | <input type="checkbox"/> no | <input type="checkbox"/> yes |
| I have had a full physical exam | <input type="checkbox"/> no | <input type="checkbox"/> yes, date: _____ |

Men only:

- | | | |
|-----------------------------------|-----------------------------|---|
| I have had a recent prostate exam | <input type="checkbox"/> no | <input type="checkbox"/> yes |
| I have had a full physical exam | <input type="checkbox"/> no | <input type="checkbox"/> yes, date: _____ |



Name: _____

Briefly describe your problems: _____

Please rate your pain 1-10 in the following chart, 0 is no pain and 10 is excruciating pain.

	0	1	2	3	4	5	6	7	8	9	10
Night											
Morning											
Afternoon											
Evening											
Working											
Recreational activities											
Rest											
Moving around											

Spine Patients only:

Coughing/Sneezing											
Bowel movement											
Sitting											
Standing											
Walking more than 15 min											

How would you describe your pain (check all boxes that apply)

- constant
 intermittent
 pounding
 shooting
 sharp
 dull

Please draw on the body chart where you feel pain and/or symptoms:

Pain /////

Shooting pain -----

Numbness oooo

What are your functional limitations

(for example: I can not bend forward, etc.):

What would you like to gain from physical therapy? : _____

Is there anything else your physical therapist should be aware of? :

PRIVACY PRACTICES



THIS NOTICE DESCRIBES HOW MEDICAL AND PERSONAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS FORM CAREFULLY.

This notice covers services provided to you by Willem Verweij Physical Therapy, LLC and the members of its medical staff together as an organized health care arrangement pursuant to the Federal Privacy Rule. It applies to medical and payment records for all services provided to you in the clinically integrated care setting, regardless of whether specific services are provided by employees, providers under contract, or independent members of our medical staff.

OUR LEGAL DUTY

Willem Verweij Physical Therapy, LLC is required by law to protect the privacy of your personal and health information, provide notice about our information management practices, and follow the information protocols described below.

USES AND DISCLOSURES OF HEALTH INFORMATION

Willem Verweij Physical Therapy, LLC uses your personal and health information primarily for treatment, obtaining payment for treatment, conducting internal administrative activities, and assessing the quality of care we are proud to provide. We use your personal information to contact you to arrange an appointment with us and to properly bill your insurance carrier(s) for the services we provide you with. In addition, we may, from time to time, disclose your health information without prior authorization for public health purposes, auditing tracking, and research studies. In any other situation, Willem Verweij Physical Therapy, LLC will obtain your written permission and 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 cease future disclosures at any time. If and when any changes are made in our privacy and confidentiality policies, a new Notice of Information Practices will be posted in the same area for public view. You may request a copy of our Privacy Practice at any time. Our HIPAA Compliance Officer is Jacki Pepin. She can be reached at the office by calling (603) 335-4700.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct inaccurate or incomplete information in your records. You also have the right to request a list of instances where we disclosed your personal health information for reasons other than for treatment, payment or other related administrative purposes. You may request in writing that we not use or disclose

your personal health information for treatment, payment, or administrative purposes except when specifically authorized by you, when required by law, or in an emergency. Willem Verweij Physical Therapy, LLC will consider all such requests on a case-by-case basis. The company is not legally required to accept the requests.

OUR RESPONSIBILITIES

This organization is required to:

- ❖ Maintain the privacy of your health information
- ❖ Provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you; and
- ❖ Abide by the terms of this notice while it is in effect.

If you believe your privacy rights have been violated, you can file a written complaint with our HIPAA Compliance Officer, Jacki Pepin, at our office address listed below or with the Office of Civil Rights, Department of Health and Human Services, Washington, DC 20201. There will be no retaliation for filing a complaint.

EVERY PATIENT MUST RECEIVE A COPY OF THIS FORM

**36 Industrial Way, Suite 1 ♦ Rochester, NH 03867 ♦ voice
603-335-4700 ♦ fax 603-335-4704**



Acknowledgement of Receipt of Notice

I have received the Notice of Privacy Practices provided by Willem Verweij Physical Therapy, LLC. I understand that the terms of this notice may change and I may receive a copy of a revised notice by contacting Willem Verweij Physical Therapy, LLC located at 36 Industrial Way, Suite 1, Rochester, NH 03867.

Patient Name

Patient Signature Date



I authorize _____
(spouse, parent etc please print their full name)

**To receive my medical and billing information from
Willem Verweij Physical Therapy, LLC.**

Patient Signature Date