MARIN PHYSICAL THERAPY

165 N. Redwood Dr., Suite #120
San Rafael, CA 94903
(415) 499-0278 phone
(415) 499-0297 fax
www.marinphysicaltherapy.com

New Patient Form

Date: _____

Name (Last): _____ (First): _____ (MI): _____

Birth Date: _____ Social Security: _____ - _____ - _____ Age _____ Sex ☐ M ☐ F

Home Address: _____

City: _____ State: _____ Zip: _____

Complaint / Area to be treated: _____ Injury Date: _____

Home Phone: ( ) _____ Other Phone: ( ) _____ Work Phone: ( ) _____

Email Address: _____ Fax: ( ) _____

Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed Student: ☐ Full-time ☐ Part-time

Employment: ☐ Full-time ☐ Part-time ☐ Not Working ☐ Retired Employer: _____

Emergency Contact: _____ Relation: _____ Phone: ( ) _____

Referring Physician: _____ Phone: ( ) _____

Whom may we thank for your referral other than your Doctor? _____

Injury Type: ☐ Work ☐ Auto ☐ Home ☐ Other Lawyer Involved? ☐ Yes ☐ No

Attorney Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: ( ) _____

Patient Signature: _____ Date: _____

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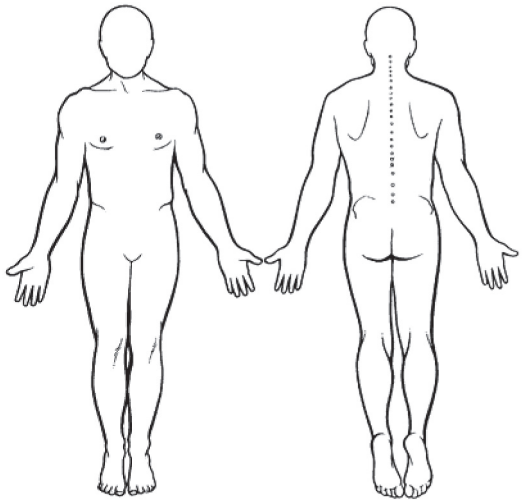
Medical Intake Form

Date: _____

Name (Last): _____ (First): _____ (MI): _____

Have you EVER been diagnosed as having the following conditions?

- ☐ Cancer. If YES, describe what kind: _____
- ☐ Heart Problems
- ☐ High blood pressure
- ☐ Circulation problems
- ☐ Asthma
- ☐ Emphysema / Bronchitis
- ☐ Chemical dependency (alcoholism, etc)
- ☐ Thyroid problems
- ☐ Diabetes
- ☐ Rheumatoid arthritis
- ☐ Multiple sclerosis
- ☐ Surgeries: _____
- ☐ Osteoporosis / Osteopenia
- ☐ Epilepsy
- ☐ Anemia
- ☐ Kidney disease
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Hepatitis
- ☐ Depression
- ☐ Other arthritic conditions
- ☐ Other: _____



Please mark the areas of concern on the BODY CHART

Which of the following OVER-THE-COUNTER medications have you taken in the last week?

- ☐ Aspirin
- ☐ Tylenol
- ☐ Advil/Motrin/Ibuprofen
- ☐ Antihistamines
- ☐ Antacid
- ☐ Vitamins / mineral supplements
- ☐ Decongestants
- ☐ Laxatives
- ☐ Other: _____

Please list any PRESCRIPTION medication you are currently taking (INCLUDING pills, injections and / or skin patches):

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

Have you recently noted:

- ☐ Unintentional weight loss / gain
- ☐ Nausea / vomiting
- ☐ Night pain
- ☐ Numbness / tingling
- ☐ Poor Balance / Falls
- ☐ Fever / chills / sweats
- ☐ Dizziness
- ☐ Fatigue
- ☐ Changes in bowel or bladder
- ☐ Weakness

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Notice of Privacy Practice

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.

USES AND DISCLOSES OF YOUR MEDICAL INFORMATION

For Treatment: *We may use medical information about you to provide you with medical treatment or services.* ***For Payment:*** *We may use and disclose medical information about you so that the treatment and services you receive at our practice may be billed to and payment may be collected from you, an insurance company, or a third party.* ***For Health Care Operations:*** *We may use and disclose health information about you for operations of our health care practice.* ***For Individuals Involved in Your Care or Payment for Your Care:*** *We may release medical information about you to a friend or family member who is involved in your medical care.* ***For Health-Related Services and Treatment Alternatives:*** *We may use and disclose health information to tell you about health-related services or recommend possible treatment options or alternatives that may be of interest to you.* ***As Required By Law:*** *We will disclose medical information about you when required to do so by federal, state, or local law.* ***To Avert a Serious Threat to Health or Safety:*** *We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.* ***For Military and Veterans:*** *If you are a member of the armed forces, we may release medical information about you as required by military command authorities.* ***For Worker's Compensation:*** *We may release medical information about you for workers' compensation or similar programs.* ***For Public Health Risks:*** *We may disclose medical information about you for public health activities.* ***For Health Oversight Activities:*** *We may disclose medical information to a health oversight agency for activities authorized by law.* ***For Lawsuits and Disputes:*** *If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order.* ***For Law Enforcement:*** *We may release medical information if asked to do so by law enforcement officials.* ***For Coroners, Medical Examiners, and Funeral Directors:*** *We may release medical information to a coroner or medical examiner.* ***For National Security and Intelligence Activities:*** *We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.* ***For Protective Services for the President and Others:*** *We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons of foreign heads of state or conduct special investigations.* ***For Inmates:*** *If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official.*

YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION

Your Right to Inspect and Copy: *To inspect and copy your medical information, you must submit your request in writing. We may deny your request to inspect and copy, in limited circumstances. If you are denied access to medical information, you may request in writing, that the denial be reviewed.* ***Your Right to Amend:*** *If you feel that medical information we have about you is incorrect or incomplete, you may request an amendment in writing. Your request may be denied if you do not include a reason to support the request.* ***Your Right to an Accounting of Disclosures:*** *You have the right to request in writing, a list of accounting for any disclosures of your medical information we have made, except for uses and disclosures for treatment, payment, and health care operations, as previously described.* ***Your Right to Request Restrictions:*** *You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. We are not required to agree to your request.* ***Your Right to Request Confidential Communications:*** *You have the right to request in writing that we communicate with you about medical matters in a certain way or at a certain location.* ***Your Right to a Paper Copy of This Notice:*** *You have the right to a paper copy of this notice at any time.*

Changes to this Notice: *We reserve the right to change this notice, and will post the current notice in our facility.*

Complaints: *If you believe your privacy rights have been violated, you may file a complaint with the practice or with the Security of the Department of Health and Human Services.*

Other uses of Medical Information: *Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.*

By my signature below I acknowledge receipt of a copy of the Notice of Privacy Practices.

Patient or Personal Representative Signature: _____ *Date* _____