

Richard Farnham P.T., L.M.T.
 Integrative Medicine Center
 301 W. State St. Ithaca NY 14850
 (607) 275-9697

PATIENT HEALTH QUESTIONNAIRE

Name: _____ Birth Date _____ Today's Date: ____/____/____

Please describe your current complaint or limitation: _____

How and when did you problem begin: _____

Specific Date (if possible): ____/____/____

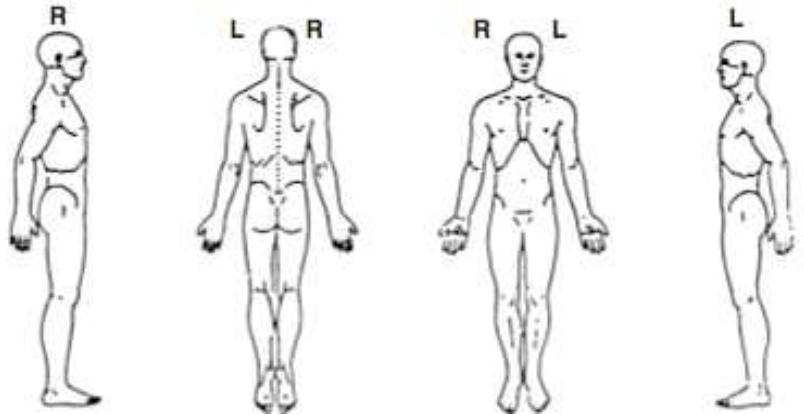
Did you have surgery for this condition?

No Yes Date: ____/____/____

Please describe the nature of your pain:

- | | |
|---|---|
| <input type="checkbox"/> Sharp Pain | <input type="checkbox"/> Constant (76-100%) |
| <input type="checkbox"/> Dull (Pain) Ache | <input type="checkbox"/> Frequent (51-75%) |
| <input type="checkbox"/> Throbbing | <input type="checkbox"/> Occasional (26-50%) |
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Intermittent (25% or less) |
| <input type="checkbox"/> Shooting | |
| <input type="checkbox"/> Burning | |

⇔⇔⇔ **MARK ON PICTURE HERE**
YOU HAVE PAIN OR OTHER SYMPTOMS



Indicate the intensity of your **pain at rest**: (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable Pain)

Indicate the intensity of your **pain with movement**: (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable Pain)

Since this condition began your symptoms have: decreased not changed increased

Your symptoms are worse in: morning afternoon night increased during the day same all day

What worsen the symptoms: _____

In the past, have you been treated for the same problem? No Yes

If yes, who did you see for that condition? MD Physical Therapist Occupational Therapist Chiropractor Other

When and what treatment did you receive? _____

Occupation: _____ Has your work status changed because of this condition? No Yes

Medical History:

PAST PRESENT

- | | |
|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> High Blood Pressure (401.9) |
| <input type="checkbox"/> | <input type="checkbox"/> Angina (413.9) |
| <input type="checkbox"/> | <input type="checkbox"/> Heart Attack (410.9) |
| <input type="checkbox"/> | <input type="checkbox"/> Stroke (436) |
| <input type="checkbox"/> | <input type="checkbox"/> Asthma (493.9) |
| <input type="checkbox"/> | <input type="checkbox"/> HIV/AIDS (042) |
| <input type="checkbox"/> | <input type="checkbox"/> Cancer (199.1) Location: _____ Date: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> Systemic Lupus (710.0) |
| <input type="checkbox"/> | <input type="checkbox"/> Hepatitis (573.3) |
| <input type="checkbox"/> | <input type="checkbox"/> Epilepsy (349.5) |
| <input type="checkbox"/> | <input type="checkbox"/> Diabetes (250.0) |
| <input type="checkbox"/> | <input type="checkbox"/> Rheumatoid Arthritis (714.0) |
| <input type="checkbox"/> | <input type="checkbox"/> Arthritis (716.9) |
| <input type="checkbox"/> | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> | <input type="checkbox"/> Tobacco packs/day _____ |
| <input type="checkbox"/> | <input type="checkbox"/> Drug or Alcohol Dependence |

Hospitalization/Surgical Procedures/Conditions:
 (list if not described elsewhere)

Medications: _____

Present: Weight _____ Height _____ (Feet) _____ (Inches)

 Signature of Patient or Legal Guardian

 Date

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Name _____ Age _____ Birth Date _____
 LAST FIRST MI

Address _____
 STREET OR P.O. BOX CITY, STATE, ZIP CODE

Contact Number (_____) _____ (_____) _____ SS# _____ - _____ - _____
 HOME WORK/CELL

Referred by _____ Diagnosis _____

Is this a work related injury? Y / N

Is this injury due to a motor vehicle accident? Y / N

MEDICAL INSURANCE

This office does not bill directly any insurance companies, including Medicare and Medicaid. Payment is due at the time the service is rendered. Statements will be provided twice each month, so that you can contact your insurance company for reimbursement.

TO ALL PATIENTS

If you need to cancel an appointment, we ask that you please give us at least 24 hours notice so that we may fill any empty spots. We reserve the right to charge for appointments cancelled or broken without 24 hours notice.

I understand that I am responsible for any outstanding bills that my insurance company does not honor. I also understand that I am responsible for any court fees which may be necessary in order to procure payment.

Signature of Patient or Legal Guardian _____

Date _____

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NOTICE OF PRIVACY PRACTICES:

Right to Notice – As a patient, you have the right to adequate notice of the uses and disclosures of your protected health information. Under the Health Insurance Portability and Accessibility Act (HIPAA), Richard Farnham P.T., L.M.T. can use your protected health information for treatments, payment and health care operations. A) Treatment – We may use or disclose your health information to a physician or other health care provider providing treatment to you. B) Payment – We may use and disclose your health information to obtain payment for the services we provide you. C) Health care operations – We may use and disclose your health information in connection with our health care operations. Health care operations include quality assessment and improvement activities, reviewing the competency or qualifications of health care professionals, evaluating provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization – Most uses and disclosures that do not fall under treatment, payment, and health care operations will require written authorization. Upon signing, you may revoke your authorization (in writing) through our practice at any time.

Emergency Situations – In the event of your incapacity or an emergency situation, we will disclose health information to a family member, or another person responsible for your care, using our professional judgment. We will only disclose health information that is directly relevant to the person's involvement in your health care.

Marketing – We will not use your health information for marketing communications without your written authorization.

Required by Law – We may also use or disclose your health information when we are required to do so by law.

Abuse or Neglect – We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety, or someone else's.

National Security – We may disclose the health information of Armed Forces personnel to military authorities under certain circumstances. We may disclose health information to authorized federal officials required for lawful intelligence, counterintelligence, and other national security activities. We may disclose health information on inmates or patients to the appropriate authorities under certain circumstances.

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National Security – We may disclose the health information of Armed Forces personnel to military authorities under certain circumstances. We may disclose health information to authorized federal officials required for lawful intelligence, counterintelligence, and other national security activities. We may disclose health information on inmates or patients to the appropriate authorities under certain circumstances.

Appointment Reminders – We may use or disclose your health information to provide you with appointment reminders via phone, e-mail, or letter.

Your Rights as a Patient – You have the right to restrict the disclosure of your protected health information (in writing). The request may be denied if the information is required for treatment, payment, or health care operations. You have the right to receive confidential communications regarding your protected health information. You have the right to request that we change your protected health information. You have the right to request that we change your protected health information. You have the right to receive an account of disclosures of your protected health information for purposes other than treatment, payment, and health care operations and other specified exceptions. You have the right to a paper copy of this notice of privacy practices.

Legal Requirements – Therapist Richard Farnham is required by law to maintain the privacy of your protected health information. He is required to abide by the terms of this notice as it is currently stated, and reserves the right to change this notice. The policies in any new notice will not be in effect until the new notice is available in the office.

Complaints – If you have complaints regarding the way your protected health information is handled, you may submit a complaint in writing to our office. You will not be retaliated against in any manner for a complaint.

Contact Information – For further information about Richard Farnham’s privacy policies, please contact him and the above address, telephone or fax number.

Acknowledgement – I have received the Notice of Privacy Practices and I have been provided an opportunity to review it. There are no privacy issues that I wish to make to Richard Farnham aware of at this time.

Print Name _____ Date _____

Signature of Patient or Legal Guardian _____