HEALTH HISTORY FORM

Name: | Date:

Current Problem: Please describe the problem(s) that brings you into our clinic today:

❑ Neck pain ❑ Headache ❑ Mid back pain ❑ Low back pain ❑ Other:
❑ Marked Morning Pain or Stiffness ❑ Pain at night ❑ Pain wakes you up at night ❑ Abnormal Weight: ❑ Gain ❑ Loss

Date Problem Began: | Is This? ❑ Work-related ❑ Auto-related

How Problem Began:

How often are your symptoms present? ❑ 0-25% ❑ 26-50% ❑ 51-75% ❑ 76-100%

Circle two numbers below to indicate your pain at its best and at its worst:

Current complaint (how you feel today): 0 1 2 3 4 5 6 7 8 9 10
(No Pain) (Unbearable Pain)

What treatment have you already received for this problem/condition? ❑ Acupuncture ❑ Chiropractic ❑ Massage ❑ Naturopathy ❑ Osteopathy
❑ Physical Therapy ❑ Psychology ❑ Vocational Rehab Counselor ❑ Other Specialist : *(Please list, e.g. Neurologist, Orthopedist):*____________________

Name of your current Primary Medical Physician: ______________________________

Name of other doctor(s) who have treated you for your condition: ______________________________

Place a check mark in the appropriate "Yes" or "No" box to indicate if you have EVER been diagnosed or received treatment with following:

AIDS/HIV ❑ Yes ❑ No
Ankylosing Spondylitis ❑ Yes ❑ No
Aortic Aneurysm ❑ Yes ❑ No
Arterial Blockage ❑ Yes ❑ No
Arthritis ❑ Yes ❑ No
Bleeding Disorders ❑ Yes ❑ No
Breast Lump ❑ Yes ❑ No
Cancer ❑ Yes ❑ No (If yes, please ✓ below)
❑ Bone ❑ Breast ❑ Colon ❑ Leukemia ❑ Lung ❑ Lymphoma
❑ Ovarian ❑ Prostate ❑ Skin ❑ Uterine
❑ Other: ______________________________
Deep Venous Thrombosis (Blood Clots in Legs) ❑ Yes ❑ No
Degenerative Osteoarthritis ❑ Yes ❑ No
Depression ❑ Yes ❑ No
Diabetes ❑ Yes ❑ No
Dizziness/Fainting ❑ Yes ❑ No
Emphysema ❑ Yes ❑ No
Epilepsy/Seizures ❑ Yes ❑ No
Gout ❑ Yes ❑ No
Heart Attack ❑ Yes ❑ No
Heart Disease ❑ Yes ❑ No
Heart Valve Condition ❑ Yes ❑ No

Hepatitis ❑ Yes ❑ No
High Blood Pressure ❑ Yes ❑ No
High Cholesterol ❑ Yes ❑ No
Hyper or Hypo Thyroid ❑ Yes ❑ No
Kidney Disease ❑ Yes ❑ No
Liver Disease ❑ Yes ❑ No
Migraine Headaches ❑ Yes ❑ No
Mononucleosis ❑ Yes ❑ No
Multiple Sclerosis ❑ Yes ❑ No
Parkinson's Disease ❑ Yes ❑ No
Polio ❑ Yes ❑ No
Pregnancy ❑ Yes ❑ No (No. of births__________)
Prostate Problems ❑ Yes ❑ No
Prosthesis ❑ Yes ❑ No
Rheumatoid Arthritis ❑ Yes ❑ No
Stroke ❑ Yes ❑ No
Tuberculosis ❑ Yes ❑ No
Tumors/Growths ❑ Yes ❑ No
Ulcers ❑ Yes ❑ No
Urinary Incontinence ❑ Yes ❑ No
Visual Disturbances ❑ Yes ❑ No
Other:
____

Are you pregnant? ❑ Yes ❑ No Due Date: ______________________

Family History: ❑ Cancer ❑ Diabetes ❑ High Blood Pressure ❑ Cardiovascular Problems ❑ Stroke

EXERCISE:	WORK ACTIVITY:	HABITS:
❑ None ❑ Daily ❑ Moderate ❑ Heavy	❑ Sitting ❑ Light Labor ❑ Standing ❑ Heavy Labor	❑ Alcohol Drinks/Week______________________ ❑ Coffee/Caffeine Drinks Cups/Day ______________________ ❑ High Stress Level Reason ______________________

Have you had any surgeries? (Please List):	**Within the last 12 months**	**More than 12 months ago**
______________________________	❑ Yes	❑ Yes, date: ________________
______________________________	❑ Yes	❑ Yes, date: ________________
______________________________	❑ Yes	❑ Yes, date: ________________

Injuries you have had:			**Description: Injuries**	**Date(s):**
Motor Vehicle Accident:	❑ Yes	❑ No	______________________	____________
Work-related Injuries:	❑ Yes	❑ No	______________________	____________
Sports Injuries:	❑ Yes	❑ No	______________________	____________
Other :______________________			______________________	____________

HAWAII PHYSICAL THERAPY & CHIROPRACTIC CLINIC, INC.
Harvelee H. Leite-Ah Yo, D.C., R.P.T. @ 261 Waianuenue Avenue

PT Department @ 1059 Kilauea Avenue, Hilo, Hawai'i 96720 ◆ (808)961-5663 ◆ Fax (877)227-3133

WELCOME LETTER

Dear Valued Patient:

Welcome to Hawaii Physical Therapy & Chiropractic Clinic, Inc. We are pleased and delighted to have you as a new patient and we look forward to providing you with the highest quality care. Your physician has referred you to our clinic to assist in your healing and recovery. In order for us to most effectively assist you on the road to recovery, we kindly request that you observe the following guidelines and policies:

ATTENDANCE:
To assist you in your care, consistent and timely attendance is extremely important. If you must cancel, please call immediately prior to your appointment. **To avoid a $25.00** cancellation/no show fee, please call 24 hours in advance. In fairness to other patients, we would like to have the opportunity to fill these time slots. Please be aware that our answering machine is always on when our office is closed and the date and time of your call is automatically recorded. Be sure to reschedule a cancelled appointment within the same week. If you are more than 15 minutes late for your appointment, it may be necessary to be rescheduled.

CHILDREN IN THE GYM AREA:
For your child's safety, children who are not being seen as patients, will not be allowed in the gym area. We do realize that occasional situations may arise in which you must bring your children, but it should not be a common occurrence.

DRESS:
It is important that you dress appropriately for your treatment sessions. We recommend shorts/sweats/yoga pants, t-shirt and athletic shoes. For treatment of shoulder, upper and mid back symptoms, tank tops and spaghetti strap tops are appropriate.

PERSONAL HYGIENE:
We are a manually-based clinic and your treatment may consist of soft tissue mobilization, joint mobilization and massage. We would greatly appreciate clean personal hygiene (i.e. clean feet, use of deodorant or organic alternatives).

FEES AND INSURANCE BILLING:
As a courtesy to you, we bill your insurance company for the services you receive. However, any co-payment and or deductibles are due at the time of service. We will also verify your benefits for our services, however, please remember that eligibility is advisory only and **does not**, guarantee benefits. We do not accept third party billing.

CELL PHONES:
Except in emergency situations, please keep cell phones off or on vibrate mode as your therapist will require your full attention.

Our staff is committed to providing you with the best care possible and we hope that you will be satisfied with our services. We appreciate your honest feedback regarding your experience with us. We will do everything possible to speed your recovery and facilitate a positive experience. We thank you for the opportunity to serve you.

Sincerely,

Dr. Harvelee Leite-Ah Yo & Staff

____________________________ Patient's Signature

____________________________ Date Signed

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have access to your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment of health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: ______________________________________

Relationship to Patient: ❑ Self ❑ Child ❑ Other:____________

Signature: ______________________________________

Date: ______________________________________

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment on this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Date: ____________________________ Initials: ______________________

Reason:

____

____

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INFORMED CONSENT DOCUMENT

Patient Name: ______________________________ Date: ______________________

To the Patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign, if anything is unclear.

❑ **THE NATURE OF CHIROPRACTIC ADJUSTMENT:** The primary treatment used by Doctors of Chiropractic is spinal manipulative therapy. The Doctor will use that procedure to treat you. The Doctor may use her hands or a mechanical instrument upon your body in such a way as to move your joint. That may cause an audible “pop” or “click”, much as you have experienced when you “crack” your knuckles. You may feel a sense of movement.

❑ **THE NATURE OF PHYSICAL THERAPY:** Physical therapy is a dynamic and conservative treatment practice that incorporates exercise, manual mobilizations, modalities and many other health, wellness & fitness principles in the restoration, maintenance and promotion of optimal physical function.

Analysis ◆ Examination ◆ Treatment: As part of the analysis, examination and treatment, you are consenting to the following procedures: (***Please initial each procedure you are consenting to).***

________	Spinal Manipulative Therapy	________	Mobilization (soft tissue/joint)
________	Vital Signs	________	Range of Motion Testing
________	Orthopedic Testing	________	Basic Neurological Testing
________	Muscle Strength Testing	________	Postural Analysis
________	Therapeutic Exercises	________	Manual/Mechanical Traction
________	Ultrasound	________	Laser Therapy
________	Electrical Stimulation	________	Hot/Cold Therapy
________	Palpation	________	Facilitative Taping
________	***Other: (Please explain):*** ______________________________		

In this office, if your Doctor or physical therapist is unavailable, another clinic doctor or physical therapist may be assigned to treat you on that day.

THE MATERIAL RISKS INHERENT IN CHIROPRACTIC ADJUSTMENT: As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. The Doctor will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to the Doctor’s attention, it is your responsibility to inform the Doctor.

THE PROBABILITY OF THOSE RISKS OCCURRING: Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination and x-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare. These problems occur so rarely that there are no available statistics to quantify their probability.

THE MATERIAL RISKS INHERENT IN PHYSICAL THERAPY: Physical therapy involves the use of many different types of physical evaluations and treatments. Therapeutic exercises are an integral part of most physical therapy treatment plans. Exercise has inherent associated physical risks. If you have any questions regarding the type of exercise you are performing and any specific risks associated with your exercises, your physical therapist will be glad to answer them. The physical therapist may use a variety of procedures and modalities to help obtain optimal function. I, the patient, acknowledge that participation in physical exercise involving flexibility, strength, balance, agility, and aerobic exercise, including the use of equipment and devices, may be a potentially hazardous activity. If you have a condition that would otherwise not come to the physical therapist’s attention, it is your responsibility to inform the physical therapist.

TREATMENT BURNS: Some of the machines we use generate heat. We also use both heat and ice, and occasionally recommend them for home use. Everyone's skin has a different sensitivity to these modalities, and rarely, either heat or ice can burn or irritate the skin. The result is temporary increase in skin pain, and there may even be some blistering of the skin. These problems occur so rarely that there are no available statistics to quantify their probability.

SORENESS: It is common for chiropractic adjustments, soft tissue/joint mobilization, manual/mechanical traction, massage therapy, therapeutic exercise, treatment modalities and procedures, etc. to result in a temporary increase in soreness in the region being treated. This is nearly always a temporary symptom that occurs while your body is undergoing therapeutic change. It is not dangerous, but please do tell your Doctor or physical therapist about it.

OTHER PROBLEMS: There may be other problems or complications that might arise from chiropractic and/or physical therapy treatment other than those noted above. These other problems or complications occur so rarely that it is not possible to anticipate and/or explain them all in advance of treatment.

Chiropractic and/or physical therapy is a system of health care delivery, and therefore, as with any health care delivery system, we cannot promise a cure of any symptoms, disease or condition as a result of treatment in this clinic. We will always give you our best care, and if results are not acceptable, we will refer you to another provider who we feel will assist your situation.

THE AVAILABILITY OF NATURE OF OTHER TREATMENT OPTIONS: Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs, such as, anti-inflammatory, muscle relaxants and pain-medication
- Hospitalization
- Surgery

If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

THE RISKS AND DANGERS ATTENDANT TO REMAINING UNTREATED: Remaining untreated may allow the formation of adhesions and reduce mobility, which may set up a pain reaction further reducing mobility. Over time, this process may complicate treatment making it more difficult and less effective, the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.
PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW.

❑ I have read, or ❑ have had read to me, the above explanation of:
❑ chiropractic adjustment and related treatment;
❑ physical therapy and related treatment.

I have discussed it with: ❑ Dr. Harvelee Leite-Ah Yo, D.C., R.P.T., or ❑ Kanani Leite-Ah Yo, P.T., D.P.T. or ❑ Linda Loewenherz, R.P.T. and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Print Patient's Name:	
Today's Date:	
Patient's Signature: **Parent or Guardian Signature:** (if a minor)	

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ELECTRONIC HEALTH RECORDS INTAKE FORM

In compliance with requirements for the government EHR incentive program

Name:	Birth Date:	SSN:
Primary or Cellular No.:	Home No.:	Work No.:

Mailing Address:	City:	State:	Zip:
Email:	Marital Status: M, S, D, W (Circle One):	Gender: ❑ Male ❑ Female	Student: ❑ FT ❑ PT

Occupation:	Employer: Employer's Address:

Emergency Contact:	Relationship:	Phone:

Preferred method of communication for patient reminders (Check One): ❑ Email ❑ Phone ❑ No Reminders Preferred

Insurance Carrier:	**Present *ALL* Insurance Cards to Front Office Reception!**

Smoking Status: ❑ Every Day Smoker ❑ Occasional Smoker ❑ Former Smoker ❑ Never Smoked Smoking Start Date (optional):

CMS Requires Providers to Report Both Race and Ethnicity:

Patient's Race: (Check One): ❑ American Indian or Alaskan Native ❑ Asian ❑ Black or African American ❑ Native Hawaiian or Pacific Islander ❑ White (Caucasian) ❑ I Decline to Answer

Ethnicity (Check One): ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ I Decline to Answer

Preferred Language: ❑ English ❑ Other: ______________________________

Medication Name:	Dosage and Frequency (i.e. 5mg. once a day, etc.)

Do you have any medication allergies? ❑ **Yes** ❑ **No**

Medication Name	Reaction	Onset Date	Additional Comments:

Do you have any environmental allergies? ❑ **Yes** ❑ **No** If yes, please list:

AGREEMENT:	I understand that I am financially responsible for all charges whether or not paid by said insurance, including deductible, co-payment, and/or non-covered services. I understand that payment is due at the time of service.
AUTHORIZATION:	I authorize the release of any medical information necessary to process my claims, I further authorize payment of insurance benefits directly to Hawaii Physical Therapy & Chiropractic Clinic, Inc. for all services rendered.

Signature: ______________________________ Date: ______________________________

(Patient or Responsible Person, Parent/Guardian)

OFFICE USE ONLY			
Height:	Weight:	Blood Pressure:	Pulse:
Date Scanned into EHR:		Scanned By:	Acct No.: