Dear Friend,

Welcome to West Park Rehab. Thank you for choosing us! We look forward to developing a trusting relationship with you.

The vast majority of patients seen at West Park Rehab can be treated easily, however we realize that when you or someone you love is in need of rehabilitation, you are very concerned. We promise to treat you as an important individual, not a number or condition. Our staff will take the time to listen to your concerns and find out about your symptoms. As soon as we have an evaluation of your condition, we will set up a treatment plan that will put you on the road to recovery.

When you come to West Park Rehab for your initial visit, please allow one and one half hours for your Physical Therapist to evaluate you and then begin your treatment. The length of each following visit will depend on your individual treatment plan. We understand the frustration of sitting in a waiting area; here at West Park Rehab our staff will do their best to get you promptly in for your scheduled appointment. It is always a good idea to wear comfortable clothing for your visits.

Here at West Park Rehab, our professional staff keeps up with the latest developments in Physical Therapy. Our Physical Therapists and Physical Therapists Assistants enjoy attending annual continuing education classes and are active in various professional organizations.

Our support staff also has extensive training and we take the team approach in our patient care. From our professionals to our receptionist to our office staff and aides, we provide a warm atmosphere where you receive the best quality of care. It is our goal at West Park Rehab when you come in for treatment, you are satisfied with your experience and are happy that you chose West Park Rehab.

Sincerely,

Edward A. St. Clair, DPT

NOTICE OF PATIENT INFORMATION PRACTICES

This notice describes how medical information about you may be used or disclosed and how you can get access to information. Please review it carefully.

WEST PARK REHAB PHYSICAL THERAPY'S LEGAL DUTY

West Park Rehab is required by law to protect the privacy of your personal health information, provide this notice about our use and disclosure of information practices and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

West Park Rehab uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, West Park Rehab may use your personal health information to contact you to provide appointment reminders, or information about treatment. West Park Rehab may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law.

In any other situation, our policy is to obtain your written authorization before disclosing your personal health information. If you provide us with written authorization to release your information for any reason, you may revoke that authorization to stop future disclosure at any time. West Park Rehab may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and patient exam area and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

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 any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. West Park Rehab will consider all such requests on a case-by-case basis, but the practice is not legally required to accept them.

CONCERNS AND COMPLAINT

If you are concerned that West Park Rehab may have violated your rights or if you disagree with decisions that have been made regarding access or disclosure of your personal health information, please contact our practice manager at the address listed below.

You may also send a written complaint to the US Department of Health and Human Services. For further information on West Park Rehab's health information practices or if you have a complaint, please contact the following person:

WEST PARK REHAB – FRANKLIN
571 PONE LANE
FRANKLIN, PA 16323
Phone: (814) 437-6191

WEST PARK REHAB - SENECA
3233 STATE ROUTE 257
SENECA, PA 16346
Phone: (814) 493-8631

West Park Rehab – Franklin
571 Pone Lane
Franklin, PA 16323
Ph: (814) 437-6191
Fax: (814) 437-6197

West Park Rehab – Seneca
3233 St. Route 257 Suite 3
Seneca, PA 16346
Ph: (814) 493-8631
Fax: (814) 493-8629

BP: _____ HR: _____

Please Print

Patient Name: _____Social Security #:_____

Address: _____

Home: _____ Cell Phone: _____ *Email address:_____

Your email address will allow us to provide you with information about your treatment

Height: _____ Weight: _____Date of Birth: _____/_____/_____Age: _____ Sex: _____

Employer: _____ Occupation: _____

Work/School Address: _____ Phone: _____

Referring Physician: _____ Primary Care Physician: _____

Please list two emergency contacts

Name: _____Phone: _____ Relationship: _____

Name: _____Phone: _____ Relationship: _____

Is this a worker's compensation injury? Yes/No Is this a result of an auto accident? Yes/No

Primary Insurance: _____ Subscriber: _____

Relationship to patient: _____ Subscriber's Date of Birth: _____

Secondary Insurance: _____ Subscriber: _____

Relationship to patient: _____ Subscriber's Date of Birth: _____

West Park Rehab
PHYSICAL THERAPY

West Park Rehab – Franklin
571 Pone Lane
Franklin, PA 16323
(814) 437-6191

West Park Rehab – Seneca
3233 St. Route 257 Suite 3
Seneca, PA 16346
(814) 493-8631

I, _____, understand that I am ultimately responsible for payment of all services rendered, unless otherwise provided by law. This may include, but not limited to, deductibles and all copays. Payment is expected when services are rendered unless prior arrangements have been made.

Signature: _____ Date: _____/_____/_____

West Park Rehab
Notice of Patient Information Practices

I have read and fully understand West Park Rehab's Notice of Information Practices. I understand that West Park Rehab may use or disclose my personal health information for the purpose of carrying out treatment, obtaining payment, evaluation the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclose for treatment, payment and administrative operations if I notify the practices. I also understand that West Park Rehab will consider requests for restriction on a case by case basis, but does not have to agree to request for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in West Park Rehab's Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

Patient Name: _____

Signature: _____

Date: _____/_____/_____

Medical History Questionnaire

Name: _____ Date of birth____/____/_____ Age:_____ Sex M/F

Treatment side of our body ____ n/a _____ right ____left _____both

Injury/Onset Date/Change of Status Date: _____/_____/_____

Is your condition (choose one)

_____Chronic (> 3 months), _____Insidious (came on slowly over past couple of months), _____New Injury (< 1 month ago),_____ No New Aggravation/Injury (unknown)

Did you have surgery for this condition? Yes/No If yes, what kind of surgery did you have? _____

Date of surgery: ____/____/_____

History of Present Condition/Mechanism of Injury: (What happened?)

_____

Is your problem a result of: ____ accident, _____ work injury, _____ auto accident, _____ medical condition, _____ other, _____ unknown

Primary Concern/Chief Complaint: (Describe your problem) _____

_____

Choose all the areas that you are having problems with: (Baseline Function Level)

_____ **Taking care of yourself (including activities of daily living):**

____hygiene (washing yourself) ____sleeping ____shopping/cooking

____household chores ____driving ____volunteering ____caregiving (for family or friends)

_____ **Mobility:**

____need a device to get around (wheel chair, cane, etc.) ____walking ____negotiating obstacles

_____ **Changing and maintain body positions:**

____change/maintain body position (balance, getting out of bed/chair) ____transfers (out of bed/chair/car)

_____ **Carrying and handling objects:**

____using hand/arms ____fine hand use ____moving objects ____getting around in the community

____work/occupation ____recreational activities

_____ **Othe**r: _____

Pain location: ___shoulder ___ elbow ___wrist ___ hand ___hip ___ knee ___ ankle/foot ___ low back ___ mid back ___ neck **Or is your problem** ___ dizziness ___ balance ___ weakness

Pain Scale No pain at all 0 1 2 3 4 5 6 7 8 9 10 the worst pain possible

Please rate each of the following: Worst _____ Current _____ Best _____

Pain Description: ____burning ____dull ____achy____throbbing____ shooting____ numbness/tingling

Have Previous History of Similar Symptoms: ____ yes ____no (if yes, when?) _____

Rate your General Health: _____good ____fair ____poor

Are you currently receiving Home Health Care: ____yes ____no

History of Falls: ____ yes ____no
If yes, how many times in the last year? _____ Were you injured? ____ yes ____ no

Do you have a pacemaker or defibrillator? ____ yes ____ no

If you are a female, are you or could you be pregnant? _____yes ____no

Medical History: YOU

X		X	
	Alzheimer's		History Of Cancer
	Cardiovascular Disease		Huntington's
	Cauda Equina Syndrome		Lupus
	Cerebral Vascular Accident (stroke)		Muscular Dystrophy
	Current Infection		Obesity
	Diabetes Mellitus Type 1 _____A1C		Osteoarthritis
	Diabetes Mellitus Type 2 _____A1C		Parkinson's
	Fibromyalgia		Rheumatoid Arthritis
	Fracture Or Suspected Fracture		Traumatic Brain Injury
	Blurred/double vision		Allergies
	Osteoporosis		Headaches / Migraines
	Tuberculosis		Hepatitis
	Ulcers		Thyroid
	Kidney Disease		MS
	COPD/Lungs		High Blood Pressure
	Change in bowel and bladder		Anxiety
	Depression		Memory
	Fever/Chills/Sweats		Nausea/Vomiting
	Neuropathy (numbness/burning)		Unexplained change in weight
	Difficulty swallowing		Dizziness / Vertigo
	Asthma/ Bronchitis		

Other (explain):_____

Recent Diagnostic Testing/Imaging: _____ X ray, _____ MRI, _____ CT Scan, ____ ultrasound
_____EMG/nerve testing, _____ bone scan, _____ Blood work
Where were these tests done? _____UPMC _____ other (where) _____

Surgical history

	Orthopedic		**Medical**		**Heart**
	Shoulder		Prostate/Uterus		Stent
	Elbow		Bladder/Kidney		Angioplasty
	Wrist/Hand		Lungs		Bi Pass
	Hip		Skin		Valve
	Knee		Eyes/ Ears		Aorta
	Ankle		Stomach		Pacemaker
	Neck		Hernia		Defibrillator
	Mid Back		Colon		
	Low Back		Brain		

Other: _____

Have you had any previous therapy for this condition this year? ____ yes, ____no
____Physical Therapy ____ Chiropractic ____ Injections ____ heat/cold ____ Massage ____ Acupuncture
If yes, for how long and where? _____

Have you had any unexplained weight loss? ____yes ____no

Can you provide a list of your current medications with dosages: _____ yes, _____ no
*****this is required by Medicare to include
Prescriptions_____
Over the counter_____
Herbals, vitamins/Supplements _____
Other _____

What are your goals for therapy?:
DECREASE: _____ pain, _____ dizziness, _____falls, _____ avoid surgery

INCREASE: _____ movement, ____ strength, _____ balance, _____endurance
_____ return to work, ____ return to pre injury activities (home/recreation)

THE ABOVE STATEMENTS ARE TRUE TO THE BEST OF MY KNOWLEDGE

Printed name: _____ Date: _____

Signature: _____

Have you received any physical therapy, speech or occupational therapy services this year?

☐ YES: How many visits? _____
☐ NO

Have you or are you currently receiving services from the VNA in your home?

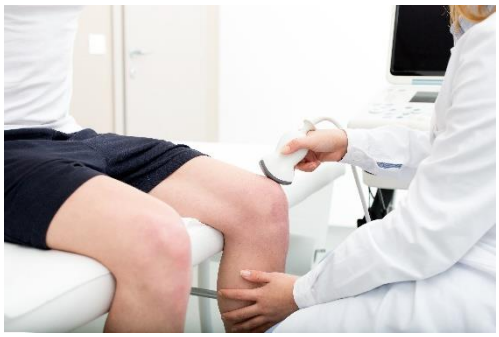
☐ YES: What services? _____
☐ NO

Is your insurance policy slated to change any time soon?

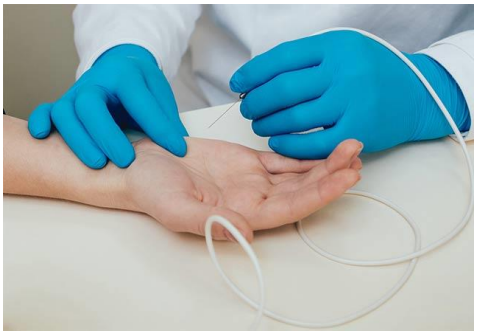
☐ YES: How will it change? _____
☐ NO

West Park Rehab Provides Advanced Testing

Musculoskeletal Ultrasound



EMG/NCV Nerve Testing



A more accurate diagnosis of your problem can be possible with diagnostic testing.

Please check all that apply:

____ Numbness, tingling, altered sensation or burning in arms or hands

____ Weakness in legs or arms

____ You have diabetes or neuropathy

____ Thyroid Dysfunction Muscle Disease / Muscle cramping

____ Tendinitis / Bursitis / Arthritis shoulder pain or instability

____ Elbow pain or instability / Wrist-hand pain or instability

____ Hip or knee pain or instability / ankle or foot pain or instability

____ **I would like my Therapist to talk with me about diagnostic testing**

HANDS-ON DIAGNOSTIC CENTER