

**BRADY PHYSICAL THERAPY  
PATIENT INFORMATION AND BRIEF HISTORY**

Name \_\_\_\_\_ Home PH# \_\_\_\_\_ Cell #/Pager \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

SSN or Drivers license \_\_\_\_\_ DOB \_\_\_\_\_ M \_\_\_ F \_\_\_ Married \_\_\_ Single \_\_\_ Other \_\_\_

Employer \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_ PH# \_\_\_\_\_

Spouse (Parent, if minor) \_\_\_\_\_ DOB \_\_\_\_\_ Day PH# \_\_\_\_\_

Primary Physician \_\_\_\_\_ Referring Physician \_\_\_\_\_

Problem Area \_\_\_\_\_ Does this relate to an accident? Yes / No - At Work \_\_\_ Other \_\_\_

Date of injury/onset/surgery? \_\_\_\_\_ Are you currently working? Yes / No

Time of injury, address where it took place, how it happened: \_\_\_\_\_

Do you have an attorney for this injury? Yes / No Name \_\_\_\_\_

Address \_\_\_\_\_ PH# \_\_\_\_\_ FAX# \_\_\_\_\_

Brief History - Do you have or have you had any of the following:

Diabetes _____	Kidney Problems _____	Previous Surgery _____
High blood pressure _____	Nervous disorders _____	Hernia (Ventral, _____
Heart Disease _____	Pregnancy _____	Inguinal, etc.) _____
Pacemaker _____	Allergies heat/ice _____	Seizures _____
Heart Attack _____	Other Allergies _____	Metal or other _____
Headaches _____	Dermatitis _____	Implant _____

If yes, please give dates, details, and family history: \_\_\_\_\_

Are you presently taking medications? \_\_\_\_\_ If yes, please list what medications and for what condition: \_\_\_\_\_

How did you hear about Brady Physical Therapy? \_\_\_\_\_

The above information is correct to the best of my knowledge. I agree that Brady Physical Therapy may furnish the insurance company, the financially responsible entity or the referral doctor, or any other person I authorize in writing, information concerning said physical therapy services. I hereby assign payment to Brady Physical Therapy of medical benefits, if any, otherwise payable to me, for physical therapy services. I understand I am financially responsible for changes not covered by this assignment.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of insured person (or parent if minor)



# BRADY PHYSICAL THERAPY

## 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.

### **BRADY PHYSICAL THERAPY'S LEGAL DUTY**

BRADY PHYSICAL THERAPY is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

### **USES AND DISCLOSURES OF HEALTH INFORMATION**

BRADY PHYSICAL THERAPY 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, BRADY PHYSICAL THERAPY may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

BRADY PHYSICAL THERAPY 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, BRADY PHYSICAL THERAPY's policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

BRADY PHYSICAL THERAPY 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 areas 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. BRADY PHYSICAL THERAPY will consider all such requests on a case by case basis, but the practice is not legally required to accept them.

**PATIENT INFORMATION CONSENT FORM**

I have read and fully understand BRADY PHYSICAL THERAPY's Notice of Information Practice. I understand that BRADY PHYSICAL THERAPY may use or disclose my personal health information for the purpose of carrying out treatment, obtaining payment, evaluating 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 disclosed for treatment, payment, and administrative operations if I notify the practice. I also understand the BRADY PHYSICAL THERAPY will consider requests for restriction in a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for the purposes as noted on BRADY PHYSICAL THERAPY'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

**DESIGNATED INDIVIDUALS AUTHORIZATION**

I hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. Examples: Doctors, insurance, attorney, and/or family members.

Authorized Designees:

Name: \_\_\_\_\_

Relationship \_\_\_\_\_

Name: \_\_\_\_\_

Relationship \_\_\_\_\_

Name: \_\_\_\_\_

Relationship \_\_\_\_\_

Name: \_\_\_\_\_

Relationship \_\_\_\_\_

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Daniel T. Brady, M.A.  
Registered Physical Therapist  
Certified Athletic Trainer

# BRADY

PHYSICAL THERAPY

Brady Physical Therapy  
2001 Winward Way, #101  
San Mateo, Ca 94404

## PATIENT QUESTIONNAIRE

DATE: \_\_\_\_\_

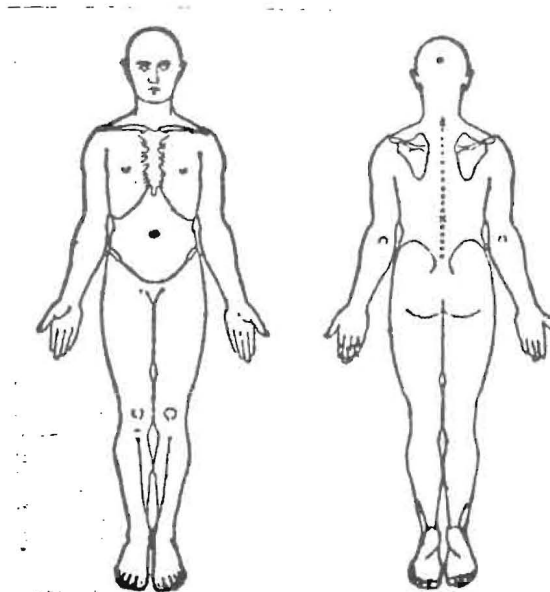
NAME: \_\_\_\_\_

DIAGNOSIS: \_\_\_\_\_

PLEASE DESCRIBE HOW THIS PROBLEM FIRST BEGAN: \_\_\_\_\_

\_\_\_\_\_

PLEASE MARK AREA OF PAIN  
OR PROBLEM ON CHART



DESCRIBE PAIN OR PROBLEM: \_\_\_\_\_

\_\_\_\_\_

ON A SCALE OF 1-10, 1 BEING NO PAIN, 10 BEING THE WORST PAIN YOU  
HAVE FELT FROM THIS PROBLEM, HOW IS YOUR PAIN? RATE EACH AREA  
SEPARATELY? \_\_\_\_\_

\_\_\_\_\_

DO YOU HAVE ANY QUESTIONS FOR THE THERAPISTS? \_\_\_\_\_

\_\_\_\_\_