Golob Physical Therapy
7741 Market Street, Suite C
Wilmington, NC 28411
Phone: 910-617-6499

CLIENT INFORMATION SHEET

Date: _____

Client's Name:_____

Address: _____
Street City State Zip

Date of Birth: _____/____/____ Sex: _____ Marital Status: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

If client is a minor, name of responsible party: _____

Address (responsible party): _____
Street City State Zip

Telephone (responsible party): _____

Primary Insurance Subscriber's Name (if different than client):_____

Primary Insurance Subscriber's Date of Birth: _____

Contact Person In Case of Emergency: _____

Relationship of Contact Person: _____ Contact Person's Phone: _____

Purpose of today's visit: _____

Type of injury: _____

Date of injury: _____ Auto Accident? _____ Work Related?_____

If work related, name of supervisor: _____Telephone: _____

Who referred you to this office? _____ Telephone: _____

My signature authorizes this practice to release my medical records to insurance carriers in order to secure payment of benefits, to my referring physician and to any physician this practice may refer me. I herby assign to this practice all payments for medical services rendered for myself or my dependent(s). I understand that I am responsible for all noncovered services.

_____ _____

Signature of Patient, Parent, Guardian or Power of Attorney Date

Golob Physical Therapy
Medical History Questionnaire

If you do not understand a question leave it blank and your therapist will assist you.

NAME:_____ OCCUPATION:_____

LEISURE ACTIVITIES:_____

ALLERGIES: List any medication(s) allergies: _____

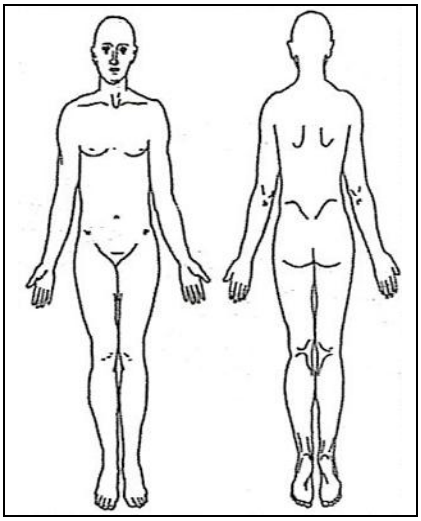
Are you latex sensitive ? Yes No

List any other allergies we should know about_____

Please check ( ) any of the following whose care you're under

___ Medical doctor (MD) ___Psychiatrist/Psychologist Other_____
___ Osteopath ___Physical Therapist _____
___ Dentist ___Chiropractor

On the diagram below, please indicate the location of your symptoms



Have you EVER been diagnosed as having any of the following conditions?

YES NO Cancer. If YES, describe what kind:_____
YES NO Heart Problems
YES NO High blood pressure
YES NO Circulation problems
YES NO Asthma
YES NO Emphysema/Bronchitis
YES NO Chemical dependency (i.e., alcoholism)
YES NO Thyroid problems
YES NO Diabetes
YES NO Multiple sclerosis
YES NO Rheumatoid arthritis
YES NO Other arthritic conditions
YES NO Depression
YES NO Hepatitis
YES NO Tuberculosis
YES NO Stroke
YES NO Kidney disease
YES NO Anemia
YES NO Epilepsy
YES NO Head injury
YES NO Amputation
YES NO Spinal cord injury
YES NO Other

Have you recently noted:

YES NO weight loss/gain
YES NO nausea/vomiting
YES NO dizziness/lightheadedness
YES NO fatigue
YES NO weakness
YES NO fever/chills/sweats
YES NO numbness or tingling
YES NO tremors
YES NO seizures
YES NO double vision
YES NO loss of vision
YES NO eye redness
YES NO skin rash
YES NO problems sleeping

YES NO joint/muscle swelling
YES NO easy bruising
YES NO excessive bleeding
YES NO difficulty breathing
YES NO persistent cough
YES NO arm/leg swelling
YES NO heart racing in you chest
YES NO difficulty swallowing
YES NO heartburn/indigestion
YES NO constipation/diarrhea
YES NO blood in stools
YES NO pregnant or think you might be pregnant
YES NO problems urinating (difficulty starting, painful, etc.)
YES NO urinary incontinence

YES NO blood in the urine
YES NO night sweats
YES NO hearing problems
YES NO stress at home or work
YES NO post menopause
YES NO sexual difficulties

Medical History Questionnaire Continued

Please list any surgeries or other conditions for which you have been hospitalized, including the approximate date and reason for the surgery or hospitalization:

DATE	REASON FOR SURGERY/HOSPITALIZATION	DATE	REASON FOR SURGERY/HOSPITALIZATION
1._____	_____	2._____	_____
3._____	_____	4._____	_____
5._____	_____	6._____	_____

Please describe any significant injuries (including fractures, dislocations, sprains) and the approximate date of injury:

DATE	INJURY	DATE	INJURY
_____	_____	_____	_____
_____	_____	_____	_____

Please list OVER-THE-COUNTER medications you have taken in the last week:

_____

_____

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

1._____2._____3._____

4._____5._____6._____

How many caffeinated coffee or caffeine containing beverages do you drink per day?_____

How many packs of cigarettes do you smoke per day? _____

How many alcoholic drinks do you consume per week?_____

How many days per week do you exercise?_____

_____ _____

Patient signature Date

_____ _____

Parent/Guardian Date

GOLOB PHYSICAL THERAPY NOTICE OF PRIVACY 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.

GOLOB PHYSICAL THERAPY'S LEGAL DUTY

By law Golob Physical Therapy is required 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

Golob Physical Therapy uses your personal health information primarily for treatment; evaluating the quality of care we provide; maintaining communication with your referring physician if you have a referral; conducting internal administrative activities and obtaining payment for treatment. For example: Golob Physical Therapy, may use your personal health information to provide you with appointment reminders, or information about other treatment alternatives or health related benefits that could be of interest to you.

CLIENTS 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 under emergency circumstances. Golob Physical Therapy will consider all such request on a case-by-case basis.

CONCERNS AND COMPLAINTS

If you are concerned that Golob Physical Therapy may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, you may send a written complaint to the Director, Office of Civil Rights, US Department of Health and Human Services.

Golob Physical Therapy may from time to time update this Notice of Privacy Practices. If changes are made, a new Notice of Privacy Practices will be posted in the waiting room. You may request an updated copy of our Notice of Privacy Practices at any time.

By my signature below I, _____, acknowledge that I received a copy of Golob Physical Therapy's Notice of Privacy Practices.

_____ _____

Signature of client (or personal representative) Date

If person representative:_____ _____

Name Relationship to client

Golob Physical Therapy Cancellation Policy

Thank you for choosing Golob Physical Therapy for your rehabilitation needs. It is our pleasure to serve you. Please inform us at any time if you have any concerns.

You are scheduled for one hour one-on-one therapy sessions. In the event you must cancel an appointment, please call our office no later than the day before that scheduled appointment. Cancellations on the day of service or "No Shows" are subject to a $50.00 fee which can not be billed to insurance providers. The fee will be waived in case of an emergency or in case of inclement weather such as an impending hurricane or snowstorm.

Your signature below indicates you have read this policy and agree to its terms. Thank you.

Signature_____

Date_____