YONEMOTO
PHYSICAL THERAPY SERVICES, INC.
55 S. Raymond Ave. • Suite 100 • Alhambra • CA 91801 • (626) 576-0591 • Fax (626) 576-5890 • http://www.yonemoto.com

For Office Use Only
P.T.: _____ Acct.#: _____
Eval Date: _____ Time: _____

**Date:** _____

**Patient Information:**

Name: _____ Sex (circle): M / F Birth date: _____ Age: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Driver's License Number: _____
Cell Phone: _____ E-mail address: _____
Social Security/Medicare Number: _____ Marital Status: _____

**Employer:**

Name of Company: _____ Phone: _____
Address: _____ City: _____ State: _____ Zip: _____
Your Occupation: _____

**Spouse/Parent Information:**

Spouse/Parent Name: _____ Spouse/Parent Work Phone Number: _____
Spouse/Parent Employer: _____

**Nearest Relative (not living with you) – In Case of *Emergency*:**

Name: _____ Relationship: _____ Phone Number: _____
Address: _____ City: _____ State: _____ Zip: _____

**Referring Doctor:**

Name: _____ Phone Number: _____
Address: _____ City: _____ State: _____ Zip: _____
Family Physician Name: _____ Dr's Phone Number: _____
Problem you are handling: _____
Diagnosis: _____ ICD9 DX Code: _____

Are you involved in litigation at this time? (Circle one) Yes / No
Is this injury accident related? (Circle one) Yes / No
If yes, please briefly describe the accident for insurance purposes: _____
_____

I, _____,
CERTIFY THAT ALL INFORMATION PROVIDED IS TRUE AND COMPLETE.
Signed: _____ Date: _____

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# NON-COMPLIANCE NOTIFICATION

It is the experience of our office that employees presenting legitimate work related injuries arrive on time for all appointments and do not miss scheduled physician appointments, physical therapy and specialist consultations. Their focus is on getting well, complying with prescribed treatment and returning safely to the workplace as soon as possible. Any patient that is noncompliant with their treatment in our office will be brought to your immediate attention.

This letter is to notify you that:

Name: _____

Employer: _____

Date of injury: _____ S.S. #: _____

Insurance carrier: _____

Has missed appointments for the following:

Physical Therapy Dates: _____

For nearly three decades, our office has been committed to excellence in patient care and dedicated to the rehabilitation of our Workers' Compensation patients. If you have any question or concerns regarding a patient, please do not hesitate to contact our office.

You have been informed that this letter will go to your insurance carrier on all consistent late and/or cancelled and broken appointments unless 24 hour notice is given.

_____ _____

Patient Initials Date

# Yonemoto Physical Therapy Services, Inc.

## Medical Insurance HIPAA Notice

**HIPAA Notice of Privacy Practices for Personal Health Information**

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**

**PLEASE REVIEW IT CAREFULLY.**

Dear Patient:

This is your Health Information Privacy Notice from Yonemoto Physical Therapy Service. **Please read it carefully.** You have received this notice because of your physical therapy services with our office. This notice refers to Yonemoto Physical Therapy Service by using the terms "us", "we", or "our".

This notice describes how we protect the personal health information we have about your which relates to your physical therapy treatments, and how we may use and disclose this information. Personal Health Information includes individually identifiable information which relates to your present or future health, treatment, or payment for health care services. This notice also describes your rights with respect to the Personal Health Information and how you can exercise those rights.

We are required to provide this Notice to you by the Health Insurance Portability and Accountability Act ("HIPAA"). For Additional information regarding your HIPAA Medical Information Privacy Policy or our general privacy practice please contact a representative in our office. You may submit questions to us or you may write to us directly at Yonemoto Physical Therapy Services, Inc. 55 S Raymond Avenue, Suite 100, Alhambra, CA 91801.

We are required by law to:

- Maintain the privacy of your Personal Health Information;
- Provide you this notice of our legal duties and privacy practices with respect to your Personal Health Information;
- Follow the terms of this notice.

We **protect** your Personal Health Information from inappropriate use or disclosure. Our employees, and those of companies that help us service you are required to comply with our requirements that protect the confidentiality of Personal Health Information. They may look at your Personal Health Information only when there is an appropriate reason to do so, such as to administer our products or services. The main reasons for which we may **use** and may **disclose** your Personal Health Information are to evaluate and process any requests for services that may be of interest to you.

We will **not disclose** your Personal Health Information to any other company for their use in marketing their products to you. However, as described below, we will use and disclose Personal Health Information about you for business purposes relating to your Health Insurance Coverage and treatments.

**ADDITIONAL INFORMATION**

**Changes to This Notice:** We reserve the right to change the terms of this notice at any time. We reserve the right to make the revised or changed notice effective for Personal Health Information we already have about you as well as any Personal Health Information we receive in the future. The effective date of this notice and any revised or changed notice may be found on the last page, on the bottom right hand corner of the notice.

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## Acknowledgement of Receipt of Notice of Privacy Practices

Yonemoto Physical Therapy Service reserves the right to modify the privacy practices outlined in the notice.

I have received a copy of the Notice of Privacy Practices for Yonemoto Physical Therapy Service.

_____

Name of Patient (Print or Type)

_____

Signature of Patient

_____

Date

_____

Signature of Patient Representative
(Required if the patient is a minor or an adult who is unable to sign this form)

_____

Relationship of Patient Representative to Patient

# Yonemoto Physical Therapy Services

Patient: _____

Consent Form for Physical Therapy

Informed Consent to Treatment I hereby consent, by my own free will, to voluntarily engage in an in-person visit by a licensed physical therapist. The physical therapist will explain the purposes of the evaluation and provide a treatment plan that may include therapeutic exercises, therapeutic activities. soft tissue/hands on physical therapy and modalities. These recommendations will be made by my therapist to improve my condition and overall wellness.

My therapist will make every effort to address my symptoms, functional deficits (if any), and concerns for relief of symptoms and/ or improvement of function. I recognize that these sessions will allow me to learn ways to move better, feel better, and teach me techniques and skills that I can utilize independently on a daily basis. I am aware that addressing my symptoms or diagnosis may take a few sessions and I am required to closely follow all provided instruction to ensure improvements. The number of sessions will vary based on the primary complaints and symptoms.

I may not get immediate relief of symptoms and may even have an aggravation of symptoms. I will honestly report my symptoms to my physical therapist so that he/she can best guide my treatment. I can decline any suggested treatment and also stop any treatment at any time.

I consent that I have read, agree with, and understand the above statements and consent to physical therapy.

Signature: _____ Date: _____

# PATIENT QUESTIONNAIRE

Name: _____
Referring Physician: _____
Date: _____

**Pain Rating**

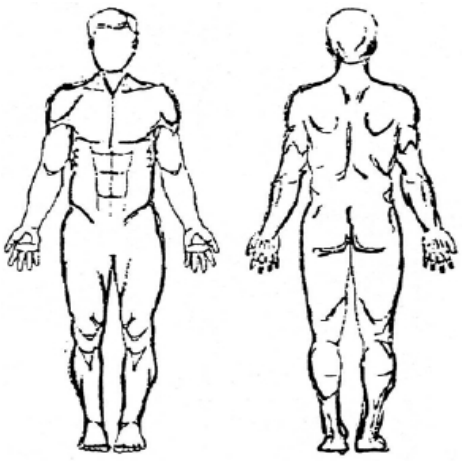
Use this chart as a reference for the question below.

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| No Pain | | | Moderate | | Strong | | Very Strong | | Emergency | |

Choose the number from the rating chart above that best describes the severity of your pain:
On Average: _____ At its best: _____ At its worst: _____
What percentage of the day do you have pain or discomfort? 0% 10% 15% 25% 50% 75% 90% 100%
Explain: _____
_____

Is your pain the worst in the… Morning: _____ Evening: _____ Both: _____ Evening:_____

*Describe or illustrate your symptoms on the diagram using these symbols:*
/// Stabbing XXX Burning OOO Pins & Needles = = = Numbness > > > Shooting



Other descriptions of your symptoms: _____
_____
_____
_____
_____

**Social History**

Age: _____ Number of children: _____

| | YES | NO |
|---|---|---|
| Do you exercise regularly? | ____ | ____ |
| What type of exercise? _____ | | |
| Do you take vitamins/ minerals? | ____ | ____ |
| Do you drink alcohol? | ____ | ____ |
| How much? _____ | | |
| Do you drink coffee/tea/colas? | ____ | ____ |
| How much? _____ | | |
| Do you smoke cigarettes or cigars? | ____ | ____ |
| How much? _____ | | |

**Work History**

| | | |
|---|---|---|
| Do you work or did you work at the time of your injury / illness? | ____ | ____ |
| If yes, please answer the following: | | |
| What is / was your job title? _____ | | |
| Which work tasks affect your pain? _____ | | |
| _____ | | |
| _____ | | |
| Are you currently on disability? | ____ | ____ |

**Other Symptoms**

| | YES | NO |
|---|---|---|
| Do you have difficulty staying asleep due to your pain? | ____ | ____ |
| Do you have weakness in your arms or legs? | ____ | ____ |
| Do you have weakness in your neck or back? | ____ | ____ |
| Do you have problems with dizziness? | ____ | ____ |
| Do you have problems with blurred vision? | ____ | ____ |
| Do you have problems with swelling? | ____ | ____ |
| Do you have problems with joints popping or cracking? | ____ | ____ |
| Do you have to lie down or recline during the day due to your pain? | ____ | ____ |
| Does stress affect your pain? | ____ | ____ |
| Do you have problems with nausea or vomiting? | ____ | ____ |
| Do you have abdominal pain? | ____ | ____ |
| Do you have difficulties with bowel or bladder control? | ____ | ____ |

Please describe the activities that cause you the most trouble:

_____

| | | |
|---|---|---|
| Have you fallen within the past year? | ____ | ____ |
| If so, how many times? _____ | | |
| Did any of the falls result in any kind of injury? | ____ | ____ |
| If so, please explain: | | |

_____

**Medical History**

| | | |
|---|---|---|
| Are you receiving therapy due to an injury? | ____ | ____ |
| If so, what was the date of the injury or accident? _____ | | |

Please describe what happened at the time of the injury_____

If this problem is not injury-related, how long have you had your current symptoms?_____

Have you had previous physical or occupational therapy for your present condition? (circle one) Yes / No

List any diagnostic testing you have had (X-ray, MRI, CT scan, etc.):_____

_____

Do you have a history of the following?

| | Yes | No | If Yes, give date: | | Yes | No | If Yes, give date: |
|---|---|---|---|---|---|---|---|
| Diabetes | ____ | ____ | _____ | Allergies to Heat/Ice | ____ | ____ | _____ |
| High Blood Pressure | ____ | ____ | _____ | Other Allergies | ____ | ____ | _____ |
| Heart Disease | ____ | ____ | _____ | Previous Surgery | ____ | ____ | _____ |
| Heart Attack | ____ | ____ | _____ | Hernia | ____ | ____ | _____ |
| Pacemaker | ____ | ____ | _____ | Seizures | ____ | ____ | _____ |
| Headaches | ____ | ____ | _____ | Dental Implants | ____ | ____ | _____ |
| Kidney Problems | ____ | ____ | _____ | Tuberculosis | ____ | ____ | _____ |
| Nervous Disorders | ____ | ____ | _____ | Hepatitis | ____ | ____ | _____ |
| AIDS | ____ | ____ | _____ | Cancer | ____ | ____ | _____ |
| Pregnancies | ____ | ____ | _____ | | ____ | ____ | _____ |

Please explain what medications you are currently taking and for what condition(s):

| **Medication** | **Condition** |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Signature _____ Date _____

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Dear New Patient,

Welcome to Yonemoto Physical Therapy!

The Yonemoto Physical Therapy team is here to help you improve movement and function, relieve pain, and expand your movement potential. Through evaluation and individualized treatment programs, physical therapists can treat existing problems and provide preventive health care for people with a variety of needs.

Treatment may include mobilizing stiff joints and tissue, exercise stretching, and education. The goals of physical therapy are to restore or achieve optimal movement/function and to relieve pain.

You should notice changes in how your body is functioning or feeling during or after therapy. It is always good to tell your therapist anything you're noticing so they can modify your treatments appropriately, if needed.

Proper attire for therapy would be comfortable clothing, such as shorts, sweats, T-shirts and tennis shoes. We kindly request that you not bring small children into the gm are for safety reasons. The gym equipment is for patient use only.

Our office hours are: M-F 7:30am - 6:30pm

**If for any reason you cannot make a scheduled appointment, please call our office at (626) 576-0591. Our answering machine is on after hours and 24 hours on Saturday and Sunday. We do charge a fee of $45.00 for not showing up for an appointment without giving our office at least 24 hours notice. This charge is to cover our therapists downtime, if we are unable to schedule someone else in that slot. (PLEASE NOTE: You are responsible for this $45.00 payment before or at your next visit. It is not covered by your insurance.)**

Insurance deductibles and any co-payment due will be collected at each visit. Our financial representatives will meet with you and answer any questions you may have. You have several payment options: cash, check, Mastercard or Visa.

While receiving therapy at Yonemoto Physical Therapy, we want to know that we are servicing you the best we can. For that reason we have placed a "Suggestion Box" in the reception area and gym. Please use it if there is anything we can improve in our service.

If you have any questions, please do not hesitate to ask. Again, welcome to Yonemoto Physical Therapy!

Sincerely,
Sheila Yonemoto, PT