

PATIENT QUESTIONNAIRE/ PROTECTED HEALTH INFORMATION

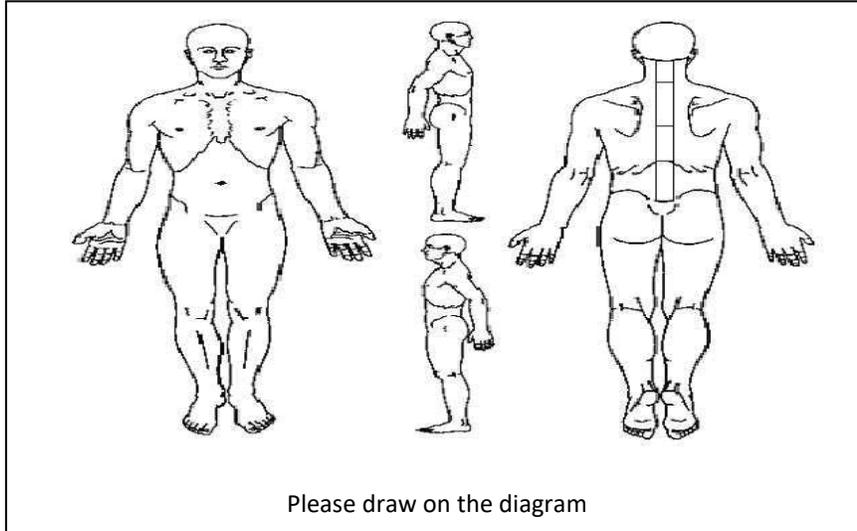
Patient Name _____

Date _____

What are your symptoms? _____

When did your symptoms start? (How long ago or a specific date) _____

Cause: (Circle) Accident/ Fall/ Sports/ Work accident/ Unknown/ Other _____



Pain Scale today (for each complaint): None 0 1 2 3 4 5 6 7 8 9 10 (Worst pain EVER)

Do your symptoms radiate? N / Y (location/s) _____

What makes it better (circle all that apply): Rest / Movement / Stretching / Heat / Ice / OTC medications / Other: _____

What make it worse (circle all that apply): Rest / Movement / Walking / Lifting / Other: _____

How often (circle one): Constant / Frequent / Intermittent / Occasional

What is the quality (circle all that apply): Sharp / Dull-Ache / Burning / Shooting / Numb / Tingling / Other _____

Progression (circle one): Improving / No change / Getting worse

Have you had these symptoms in the past? No / Yes (how long ago) _____;

Self treatment (circle all that apply): Rest / Ice / Heat / OTC medications / Stretching / Other _____

Have you seen someone else/ or been treated by someone else?

No one / Another doctor/ facility: _____ / Other: _____

Were any tests prescribed/ performed for the condition/s (ever)?

None / Yes: X-rays MRI CT Scan/ Other (areas and dates) _____

HIPAA

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (NPP) DYNAMIC CARE, INC.

I acknowledge that I was provided with a copy of the NPP and that I have read them (or declined the opportunity to read them) and understand the NPP. I understand that this form will be placed in my patient chart and maintained for six years.

Patient name (print): _____ (signature of patient if adult) _____

If patient is a minor: Parent/ Legal Guardian/ name (print) _____; (sign) _____

COMMUNICATIONS/ REMINDERS/ ANNOUNCEMENTS: I give permission to use (all that apply): PHONE TEXT EMAIL MAIL _____

(I do not want to receive communications with): _____

List names/ relationships of those you authorize Dynamic Care, Inc. to release PHI.

_____/_____/_____/_____/_____