



# SUMMARY OF OUR NOTICE OF PRIVACY PRACTICES

Apex Physical Therapy, PLLC

Effective Date: April 1, 2003

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

Please review the full Notice of Privacy Practices (NPP) which is attached. If you have any questions about this notice, please contact Robert M. Paull, Privacy Officer at (509) 465-1749.

### **WHO WILL FOLLOW THIS NOTICE:**

- Apex Physical Therapy, PLLC
- Apex Physical Therapy – North
- Apex Physical Therapy – Cheney
- Apex Physical Therapy – Airway Heights
- Apex Physical Therapy - Fairways Plaza

This notice describes our privacy practices. All these entities, sites, and locations follow the terms of this notice. In addition, these entities, sites and locations may share health information with each other for treatment, payment, or health care operations purposes described in this notice.

### **OUR PLEDGE REGARDING HEALTH INFORMATION:**

We understand that health information about you and your health care is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this health care practice, whether made by your personal physical therapist or others working in this office. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information.

We are required by law to:

- make sure that health information that identifies you is kept private;
- give you this notice of our legal duties and privacy practices with respect to health information about you, and;
- follow the terms of the notice that is currently in effect.

### **HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU.**

The following categories describe different ways that we use and disclose health information. By coming for care, you give us the right to use your information for treatment, to get reimbursed for your care, and to operate our organization.

There are also various other ways in which we may use or disclose your information:

- **Appointment Reminders**
- **Research**
- **To Allow Oversight of the Quality of the Healthcare We Provide**
- **To Allow Workers' Compensation Claims**
- **As Required by Subpoena in Lawsuits and Disputes**
- **Various Uses as Required by Law or to Avert a Serious Threat to Health or Safety**

The full details for all these uses are contained in the full NPP.

## **YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU.**

You have the following rights regarding health information we maintain about you:

- **Right to Inspect and Copy**
- **Right to Amend**
- **Right to an Accounting of Disclosures**
- **Right to Request Restrictions**
- **Right to Request Confidential Communications**
- **Right to a Paper Copy of This Notice**

Information on how to exercise these rights can be seen in the NPP or can be obtained from Robert M. Paull, Privacy Officer at (509) 465-1749

## **CHANGES TO THIS NOTICE**

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in our facility. The notice will contain on the first page, in the top right-hand corner, the effective date. In addition, each time you register for treatment or health care services we will offer you a copy of the current notice in effect.

## **COMPLAINTS**

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, contact Robert M. Paull, Privacy Officer. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

## **OTHER USES OF HEALTH INFORMATION**

Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided you.

# Patient History

Name \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_ Date \_\_\_\_\_

1. Describe the current problem that brought you here? \_\_\_\_\_  
\_\_\_\_\_

2. When did your problem first begin? \_\_\_\_\_

3. Was your first episode of the problem related to a specific incident? Yes/No  
Please describe and specify date \_\_\_\_\_  
\_\_\_\_\_

4. Since that time is it: staying the \_\_\_\_\_ same \_\_\_\_\_ getting worse \_\_\_\_\_ getting better  
Why or how? \_\_\_\_\_

5. If pain is present rate pain on a 0-10 scale 10 being the worst. \_\_\_\_\_ Describe the nature of  
the pain (i.e. constant burning, intermittent ache) \_\_\_\_\_  
\_\_\_\_\_

6. Describe previous treatment/exercises \_\_\_\_\_  
\_\_\_\_\_

7. Activities/events that cause or aggravate your symptoms. Check/circle all that apply

<input type="checkbox"/> Sitting greater than _____ minutes	<input type="checkbox"/> With cough/sneeze/straining
<input type="checkbox"/> Walking greater than _____ minutes	<input type="checkbox"/> With laughing/yelling
<input type="checkbox"/> Standing greater than _____ minutes	<input type="checkbox"/> With lifting/bending
<input type="checkbox"/> Changing positions (ie. - sit to stand)	<input type="checkbox"/> With cold weather
<input type="checkbox"/> Light activity (light housework)	<input type="checkbox"/> With triggers i.e. /key in door
<input type="checkbox"/> Vigorous activity/exercise (run/weight lift/jump)	<input type="checkbox"/> With nervousness/anxiety
<input type="checkbox"/> Sexual activity	<input type="checkbox"/> No activity affects the problem
<input type="checkbox"/> Other, please list _____	

8. What relieves your symptoms? \_\_\_\_\_  
\_\_\_\_\_

9. How has your lifestyle/quality of life been altered/changed because of this problem?  
Social activities (exclude physical activities), specify \_\_\_\_\_  
Diet /Fluid intake, specify \_\_\_\_\_  
Physical activity, specify \_\_\_\_\_  
Work, specify \_\_\_\_\_  
Other \_\_\_\_\_

10. Rate the severity of this problem from 0 -10 with 0 being no problem and 10 being the worst \_\_\_\_\_

11. What are your treatment goals/concerns? \_\_\_\_\_  
\_\_\_\_\_

## Since the onset of your current symptoms have you had:

Y/N	Fever/Chills	Y/N	Malaise (unexplained tiredness)
Y/N	Unexplained weight change	Y/N	Unexplained muscle weakness
Y/N	Dizziness or fainting	Y/N	Night pain/sweats
Y/N	Change in bowel or bladder functions	Y/N	Numbness / Tingling
Y/N	Other /describe _____		

Date of Last Physical Exam \_\_\_\_\_ Tests performed \_\_\_\_\_  
\_\_\_\_\_

Pg 2 History Name \_\_\_\_\_ DOB ID# \_\_\_\_\_ Age \_\_\_\_\_

**General Health:** Excellent Good Average Fair Poor Occupation \_\_\_\_\_  
Hours/week \_\_\_\_\_ On disability or leave? \_\_\_\_\_ Activity Restrictions? \_\_\_\_\_

**Activity/Exercise:** None 1-2 days/week 3-4 days/week 5+ days/week  
Describe \_\_\_\_\_

**Mental Health:** Current level of stress High \_\_\_ Med \_\_\_ Low \_\_\_ Current psych therapy? Y/N

**Have you ever had any of the following conditions or diagnoses? Circle all that apply**

Cancer	Stroke	Emphysema/chronic bronchitis
Heart problems	Epilepsy/seizures	Asthma
High Blood Pressure	Multiple sclerosis	Allergies-list below
Ankle swelling	Head Injury	Latex sensitivity
Anemia	Osteoporosis	Hypothyroid/ Hyperthyroid
Low back pain	Chronic Fatigue Syndrome	Headaches
Sacroiliac/Tailbone pain	Fibromyalgia	Diabetes
Alcoholism/Drug problem	Arthritic conditions	Kidney disease
Childhood bladder problems	Stress fracture	Irritable Bowel Syndrome
Depression	Acid Reflux /Belching	Hepatitis
Anorexia/bulimia	Joint Replacement	Sexually transmitted disease
Smoking history	Bone Fracture	Physical or Sexual abuse
Vision/eye problems	Sports Injuries	Raynaud's (cold hands and feet)
Hearing loss/problems	TMJ/ neck pain	Pelvic pain
Other/Describe _____		

Surgical /Procedure History

Y/N	Surgery for your back/spine	Y/N	Surgery for your bladder/prostate
Y/N	Surgery for your brain	Y/N	Surgery for your bones/joints
Y/N	Surgery for your female organs	Y/N	Surgery for your abdominal organs
Other/describe _____			

Ob/Gyn History (females only)

Y/N	Childbirth vaginal deliveries # _____	Y/N	Vaginal dryness
Y/N	Episiotomy # _____	Y/N	Painful periods
Y/N	C-Section # _____	Y/N	Menopause - when? _____
Y/N	Difficult childbirth # _____	Y/N	Painful vaginal penetration
Y/N	Prolapse or organ falling out	Y/N	Pelvic/genital pain _____
Y/N	Other /describe _____		

Males only

Y/N	Prostate disorders	Y/N	Erectile dysfunction
Y/N	Shy bladder	Y/N	Painful ejaculation
Y/N	Pelvic/genital pain location _____		
Y/N	Other /describe _____		

<u>Medications - pills, injection, patch</u>	<u>Start date</u>	<u>Reason for taking</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

<u>Over the counter -vitamins etc</u>	<u>Start date</u>	<u>Reason for taking</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

## Pelvic Symptom Questionnaire

### Bladder / Bowel Habits / Symptoms

- |   |   |
|---|---|
| Y/N Trouble initiating urine stream       | Y/N Blood in stool/feces                  |
| Y/N Urinary intermittent /slow stream     | Y/N Painful bowel movements (BM)          |
| Y/N Strain or push to empty bladder       | Y/N Trouble feeling bowel urge/fullness   |
| Y/N Difficulty stopping the urine stream  | Y/N Seepage/loss of BM without awareness  |
| Y/N Trouble emptying bladder completely   | Y/N Trouble controlling bowel urge        |
| Y/N Blood in urine                        | Y/N Trouble holding back gas/feces        |
| Y/N Dribbling after urination             | Y/N Trouble emptying bowel completely     |
| Y/N Constant urine leakage                | Y/N Need to support/touch to complete BM  |
| Y/N Trouble feeling bladder urge/fullness | Y/N Staining of underwear after BM        |
| Y/N Recurrent bladder infections          | Y/N Constipation/straining _____% of time |
| Y/N Painful urination                     | Y/N Current laxative use -type _____      |
| Y/N Other/describe _____                  |   |

Describe typical position for emptying: \_\_\_\_\_

1. Frequency of urination: awake hour's \_\_\_\_ times per day, sleep hours \_\_\_\_ times per night
2. When you have a normal urge to urinate, how long can you delay before you have to go to the toilet? \_\_\_\_\_ minutes, \_\_\_\_\_ hours, \_\_\_\_\_ not at all
3. The usual amount of urine passed is: \_\_\_\_small \_\_\_\_ medium\_\_\_\_ large
4. Frequency of bowel movements \_\_\_\_\_ times per day, \_\_\_\_\_ times per week, or \_\_\_\_\_.
5. The bowel movements typically are: watery \_\_\_\_ loose \_\_\_\_ formed\_\_\_\_ pellets \_\_\_\_ other \_\_\_\_\_
6. When you have an urge to have a bowel movement, how long can you delay before you have to go to the toilet? \_\_\_\_\_ minutes, \_\_\_\_\_ hours, \_\_\_\_\_ not at all.
7. If constipation is present describe management techniques \_\_\_\_\_
8. Average fluid intake (one glass is 8 oz or one cup) \_\_\_\_\_ glasses per day.  
Of this total how many glasses are caffeinated? \_\_\_\_\_ glasses per day.
9. Rate a feeling of organ "falling out" / prolapse or pelvic heaviness/pressure:  
 None present  
 Times per month (specify if related to activity or your menstrual period)  
 With standing for \_\_\_\_\_ minutes or \_\_\_\_\_ hours.  
 With exertion or straining  
 Other \_\_\_\_\_

- 10a. Bladder leakage - number of episodes
- No leakage
  - Times per day
  - Times per week
  - Times per month
  - Only with physical exertion/cough

- 10b. Bowel leakage - number of episodes
- No leakage
  - Times per day
  - Times per week
  - Times per month
  - Only with exertion/strong urge

- 11a. On average, how much urine do you leak?
- No leakage
  - Just a few drops
  - Wets underwear
  - Wets outerwear
  - Wets the floor

- 11b. How much stool do you lose?
- No leakage
  - Stool staining
  - Small amount in underwear
  - Complete emptying
  - Other \_\_\_\_\_

12. What form of protection do you wear? (Please complete only one)

- None
- Minimal protection (tissue paper/paper towel/pantishields)
- Moderate protection (absorbent product, maxi pad)
- Maximum protection (specialty product/diaper)
- Other \_\_\_\_\_

On average, how many pad/protection changes are required in 24 hours? \_\_\_\_\_ # of pads