



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

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.



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Dear Patient,

Welcome to Apex Physical Therapy. We look forward to working with you to overcome your dizziness, vertigo, and/or imbalance. There are a few things that we would like you to consider prior to your first physical therapy visit:

1. It is best to come to your initial appointment at the time of day that your symptoms are most present, or at their worst.
2. From that point on, schedule your appointments at times that are convenient for you, at a consistent time of day if possible.
3. Have your doctor's office send over the results of any special tests you have had. For example: ENG, rotary test, posturography, caloric test, MRI, etc...
4. Bring a list of the current medications you are taking.
5. Complete the enclosed paperwork **prior** to your first physical therapy visit and bring it with you to the appointment.

Thank you. Please feel free to contact us if you have any questions.

Sincerely,

Apex Physical Therapy

MEDICAL HX SCREEN (VESTIBULAR)

- 1) Name: _____
LAST FIRST M.I.
- 2) Birth date: _____
- 3) Primary Care Provider: _____
Referring Doctor (if other): _____
- 4) Employment:
 Full Time Student
 Part Time Homemaker
 Retired Unemployed
- Occupation: _____
- 5) Do you live alone? Yes No
- 6) Where do you live?
 One level home Apartment (2 stairs)
 Split entry Apartment (3 stairs)
 Two Story home Assisted Living
 Other (specify): _____
- 7) What assistive devices do you use/have available?
 Walker Raised Toilet seat Crutches
 Contacts/Glasses Wheelchair Cane
 Hearing device Motorized Wheelchair
 Ramps
 Other (braces, AFO): _____

CURRENT/GENERAL HEALTH

- 1) Overall Perceived Health
 Excellent Good Fair Poor
- 2) How often do you exercise?
 >5x/week 3-4x/week <3x/week Rarely
- 3) Do you smoke? Yes No
Estimated packs/day: _____
If not currently, quit date: _____
- 4) Alcohol?
Days/week you drink _____.
How many drinks/day _____.

FAMILY HISTORY

Indicate medical history of relative (mother, father, brother, sister, etc.) if applicable or known.

- 1) Cancer _____
2) Hypertension _____
3) Diabetes _____
4) Stroke _____
5) Heart Disease _____
6) Inherited disorder (name if able): _____
7) Other _____

YOUR MEDICAL HISTORY (check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Broken bones/Fractures |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Diabetes Type I__ II__ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart/Lung Disorders |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Muscular dystrophy |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy/Seizures |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Kidney difficulties |
| <input type="checkbox"/> Vascular Issues | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Thyroid | <input type="checkbox"/> Low blood sugar |
| <input type="checkbox"/> Skin diseases | <input type="checkbox"/> Infectious diseases |
| <input type="checkbox"/> Blood disorders | <input type="checkbox"/> Parkinson's Disease |
| <input type="checkbox"/> Multiple Sclerosis | |
| <input type="checkbox"/> Other (please specify) _____ | |

SURGICAL HISTORY

- 1) Have you ever had surgery? Yes No
Applicable dates/procedures
a) _____
b) _____
c) _____
d) _____
e) _____

Over the past year, have you experienced or are currently experiencing any of the following symptoms?

- | | |
|---|---|
| <input type="checkbox"/> Excessive weight loss/gain | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Difficulty Sleeping | <input type="checkbox"/> Night Pain |
| <input type="checkbox"/> Balance/Coordination Problems | <input type="checkbox"/> Blackouts |
| <input type="checkbox"/> Dizziness/Fainting | <input type="checkbox"/> Frequent Falls |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Fever/Sweats |
| <input type="checkbox"/> Bowel/Bladder problems | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Hearing/Vision difficulties | <input type="checkbox"/> Joint Pain |
| <input type="checkbox"/> Ringing in the ears | <input type="checkbox"/> Loss of appetite |
| <input type="checkbox"/> Nausea/Vomiting | <input type="checkbox"/> Weakness |
| <input type="checkbox"/> Heart Palpitations | |
| <input type="checkbox"/> Difficulty swallowing | |
| <input type="checkbox"/> Other _____ | |
| <input type="checkbox"/> Does your PCP know about these complaints? | |

MEDICATIONS

- 1) Please list all current medications you are taking:

- 2) Are you taking any non-prescription meds or over the counter medications? Yes No

Please check all known clinical tests you have undergone in the past year.

- Bone Scan
- MRI
- X-rays
- Ultrasound
- Stress Tests
- EMG
- EKG
- EEG
- ENG
- CT Scan
- Myelogram
- Caloric Test
- Other (please specify): _____
- Nerve Conduction Velocity
- Pulmonary Function Test
- Angiogram/Arterial Scan
- Arthroscopy
- Biopsy
- Blood Tests
- Bronchoscopy
- Rotary Test
- Echocardiogram
- Mammogram
- Urine Tests
- Posturography

Any difficulty/abnormal finding that you have experienced over the past year, that you may or may not associate with your current symptom that you are concerned about? Yes No
Specify: _____

SPECIAL QUESTIONS

- 1) Are you or could you be pregnant?
 Yes No N/A
- 2) Complicated pregnancies in the past? Yes No
- 3) Any gynecological/obstetrical difficulties?
 Yes No

CURRENT/CHIEF COMPLAINT

1) Why are you seeking Physical Therapy Intervention? _____

2) Date when pain/injury began:
MONTH DAY YEAR
____ _

3) CAUSES OF SYMPTOMS (IF KNOWN): _____

Vestibular Disorders (check diagnosis):

- BPPV / BPPN
- Hydrops
- Labyrinthitis
- Ototoxicity
- Acoustic neuroma
- Age related degeneration
- Meniere's Disease
- Neuritis
- Fistula
- Vertigo

1) Have you had a similar problem in the past?

- Yes No

If so, what? _____

How long did it last? _____

Did you seek treatment? _____

2) Activities you are unable to do due to symptoms

3) Next scheduled doctor recheck appointment

4) Treatment for current condition?

5) Pertinent accidents or injuries and dates

6) Have you or are you going to see any other healthcare providers for you current condition?

Check all that apply.

- Another physical therapist
- Acupuncturist
- Chiropractor
- Dentist
- ENT
- Family Practitioner
- Massage Therapist
- Audiologist
- Rheumatologist
- Occupational therapist
- Orthopedist
- Osteopath
- Optometrist
- Pediatrician
- Podiatrist
- Neurologist
- Other: _____

15) Any special needs you require?

Please be specific: _____

Signature: _____

Date: _____

Patient Name: _____ **Date:** _____

Dizziness Handicap Inventory

Instructions: The purpose of this scale is to identify difficulties that you may be experiencing because of your dizziness or unsteadiness. Please answer “yes”, “no”, or “sometimes” to each question. Answer each as it pertains to your dizziness or unsteadiness problem only.

<u>Item</u>	<u>Response</u>
P1. Does looking up increase your problem?	_____
E2. Because of your problem, do you feel frustrated?	_____
F3. Because of your problem, do you restrict your travel for business or recreation?	_____
P4. Does walking down the aisle of a supermarket increase your problem?	_____
F5. Because of your problem, do you have difficulty getting into or out of bed?	_____
F6. Does your problem significantly restrict your participation in social activities such as going out to dinner, going to the movies, dancing, or going to parties?	_____
F7. Because of your problem, do you have difficulty reading?	_____
P8. Does performing more ambitious activities, like sports, dancing, household chores (sweeping or putting dishes away) increase your problem?	_____
E9. Because of your problem, are you afraid to leave your home without having someone accompany you?	_____
E10. Because of your problem, have you been embarrassed in front of others?	_____
P11. Do quick movements of your head increase your problem?	_____
F12. Because of your problem, do you avoid heights?	_____
P13. Does turning over in bed increase your problem?	_____

Patient Name: _____ **Date:** _____

F14. Because of your problem, is it difficult for you to do strenuous homework or yard work? _____

E15. Because of your problem, are you afraid that people may think you are intoxicated? _____

F16. Because of your problem, is it difficult for you to go for a walk by yourself? _____

P17. Does walking down a sloped sidewalk or ramp increase problem? _____

E18. Because of your problem, is it difficult for you to concentrate? _____

F19. Because of your problem, is it difficult for you to walk around you house in the dark? _____

E20. Because of your problem, are you afraid to stay at home alone? _____

E21. Because of your problem, do you feel handicapped? _____

E22. Has your problem placed stress on your relationships with members of your family or friends? _____

E23. Because of your problem, are you depressed? _____

F24. Does your problem interfere with your job or household responsibilities? _____

P25. Does bending over increase your problem? _____

DIZZINESS AND BALANCE QUESTIONNAIRE

NAME _____ AGE _____ DATE _____

Please circle the word(s) that best describe your symptoms:

Spinning	disoriented	swimmy	fullness in ears	off balance
Rocking	lightheaded	woozy	ringing in ears	blurred vision
Nausea	blacking out	leaning	falling	drunk

When did your symptoms start? _____

Are they getting: better? worse? not changing?

DIZZINES

Is your dizziness constant or does it come and go? _____

How often does your dizziness occur? _____

How long does your dizziness last? seconds minutes hours days

Does anything make your dizziness better? _____

Does anything make your dizziness worse? _____

List any medications you take for your dizziness: _____

BALANCE

Please circle the activities that you have difficulty with:

Walking a straight path	making quick turns	looking around when you walk
Bending over	looking up	walking on uneven ground
Walking at night	standing unsupported	

How frequently do you lose your balance? 1-3x/day 1-3x/week 1-3x/month

How frequently do you fall? None 1-3x/day 1-3x/week 1-3x/month

GENERAL

Do you have any pain, related or not to your current problem? Yes No

How severe? None 0 1 2 3 4 5 6 7 8 9 10 Severe

Where? _____ Describe: _____

What aggravates it? _____ what relieves it? _____

DESIRED OUTCOME:

What is your goal in coming to physical therapy? _____