


HEALTH INTAKE FORMS

FITNESS FOR HER Synergy

STEPS TO COMPLETING THESE FORMS

1. Download the Multi-Page PDF
2. Open and complete the fillable documents

   There is NO need to digitally sign these forms. You will have an opportunity to sign them when we see you at your first appointment.
3. Save the completed document
4. Email the saved document to pt@synergyfitnessforher.com

FITNESS FOR HER Synergy

Synergy Fitness for Her- Fitness Prescription LLC

Patient Information

Last Name: _____ First: _____ M.I:_____

Address: _____ Apt#: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Cell #: _____ EMAIL: _____

Date of Birth: _____ Age: _____ Sex: ☐ M ☐ F Marital Status ☐ M ☐ S ☐ D

Occupation: _____

Emergency Contact

Name: _____ Relationship: _____ Phone #: _____

Primary Care Physician

Name: _____ Phone #: _____ Date of next visit: _____

Injury Type

☐ Work ☐ Auto ☐ Home ☐ Surgery ☐ Other

Who may we thank for your referral? _____

Informed Consent

I understand that Synergy Fitness for Her will maintain my privacy to the highest standards and may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided, and any administrative operations related to treatment or payment.

I understand I am financially responsible for payment of all co-pays, deductibles, and balances not covered by Medicare, or my insurance carrier.

I do hereby agree and give consent for Synergy Fitness for Her to provide care and treatment that is considered necessary and proper in the diagnosing or treating of my physical condition.

I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

I acknowledge that I have received a copy of the Notice of Privacy Practices of Synergy Fitness for Her and agree to the liability limita-tions explained therein.

Signature of Patient or Legal Representative: _____

Relationship to Patient: _____

Printed Name of Patient: _____ **Date:** _____

FITNESS FOR HER Synergy

To help us serve you better and give you a complete and thorough examination, please complete the health background information form below. Thank you!

NAME: _____ **DATE OF BIRTH:** _____

Please check any of the following healthcare providers whose care you are under

- ☐ Physician (MD, OD)
- ☐ Surgeon
- ☐ Dentist
- ☐ Other_____
- ☐ Psychiatrist/Psychologist
- ☐ Physical Therapist

Have ever been diagnosed with any of the following conditions?

- ☐ **YES** ☐ **NO** Cancer. If yes, what kind: _____
- ☐ **YES** ☐ **NO** High blood pressure
- ☐ **YES** ☐ **NO** Heart Problems. If yes, what kind: _____
- ☐ **YES** ☐ **NO** Circulation Problems
- ☐ **YES** ☐ **NO** Stroke
- ☐ **YES** ☐ **NO** Diabetes
- ☐ **YES** ☐ **NO** Thyroid problems
- ☐ **YES** ☐ **NO** Asthma
- ☐ **YES** ☐ **NO** Emphysema/Bronchitis
- ☐ **YES** ☐ **NO** Chemical dependency (eg alcoholism)
- ☐ **YES** ☐ **NO** Depression
- ☐ **YES** ☐ **NO** Rheumatoid arthritis
- ☐ **YES** ☐ **NO** Other arthritis conditions
- ☐ **YES** ☐ **NO** Blood clots
- ☐ **YES** ☐ **NO** Osteoporosis/osteopenia
- ☐ **YES** ☐ **NO** Kidney disease
- ☐ **YES** ☐ **NO** Allergies. If yes, list_____
- ☐ **YES** ☐ **NO** Hepatitis
- ☐ **YES** ☐ **NO** Tuberculosis
- ☐ **YES** ☐ **NO** Neurological problems (eg MS, Parkinson's)
- ☐ **YES** ☐ **NO** Other_____

Please list any surgeries and hospitalizations for other conditions

1. Date:_____ Reason:_____
2. Date:_____ Reason:_____
3. Date:_____ Reason:_____

Have you been treated for any fractures, dislocations, sprains or other significant injuries? If yes, please indicate date and injury below:

1. Date:_____ Injury:_____
2. Date:_____ Injury:_____
3. Date:_____ Injury:_____

During the past month have you been feeling down, depressed or hopeless? ☐ **YES** ☐ **NO**
During the past month have you felt little interest or pleasure in doing things? ☐ **YES** ☐ **NO**

Do you ever feel threatened at home or has anyone hit or tried to injure you in any way? ☐ **YES** ☐ **NO**

For Women: Are you currently pregnant, or think you might be? ☐ **YES** ☐ **NO**

Please mark any of the following that are NEW or UNUSUAL for you:

- ☐ **YES** ☐ **NO** Weight loss/gain
- ☐ **YES** ☐ **NO** Fatigue
- ☐ **YES** ☐ **NO** Weakness
- ☐ **YES** ☐ **NO** Joint/muscle swelling
- ☐ **YES** ☐ **NO** Leg/arm swelling
- ☐ **YES** ☐ **NO** Numbness/tingling
- ☐ **YES** ☐ **NO** Dizziness/lightheadedness
- ☐ **YES** ☐ **NO** Nausea/vomiting
- ☐ **YES** ☐ **NO** Fever/chills/sweats
- ☐ **YES** ☐ **NO** Excessive bleeding /bruising
- ☐ **YES** ☐ **NO** Constipation/diarrhea
- ☐ **YES** ☐ **NO** Change in urination
- ☐ **YES** ☐ **NO** Change in vision
- ☐ **YES** ☐ **NO** Difficulty breathing

Which of the following over–the-counter medications have you taken in the past week?

- ☐ **YES** ☐ **NO** Aspirin
- ☐ **YES** ☐ **NO** Anti-inflammatories (Advil, Motrin)
- ☐ **YES** ☐ **NO** Tylenol
- ☐ **YES** ☐ **NO** Heartburn/ulcer medication
- ☐ **YES** ☐ **NO** Vitamin/Mineral Supplements
- ☐ **YES** ☐ **NO** Other medications/supplements

Please list all prescription medications below:

_____ _____

_____ _____

_____ _____

How many days a week do you exercise? _____

How many cups of coffee or other caffeinated beverages do you drink per day? ___

How many cigarettes do you smoke per day? _____ For how many years? _____ If you quit, when? _____

How many days per week do you drink alcohol? _____

If one drink equals one beer, one glass of wine, or one ounce of hard liquor, how many do you drink per average sitting? ____

Have any of your immediate family members (parents, brothers, sisters) been treated for any of the conditions below?

- ☐ **YES** ☐ **NO** Diabetes
- ☐ **YES** ☐ **NO** Cancer
- ☐ **YES** ☐ **NO** Arthritis
- ☐ **YES** ☐ **NO** Heart problems
- ☐ **YES** ☐ **NO** Kidney disease
- ☐ **YES** ☐ **NO** Stroke
- ☐ **YES** ☐ **NO** High blood pressure
- ☐ **YES** ☐ **NO** Depression
- ☐ **YES** ☐ **NO** Chemical dependence

Patient Signature_____

Therapist Signature_____ **Date**_____

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Synergy Fitness for Her- Fitness Prescription LLC

Name: _____ **Date:** _____

What is the primary problem that brings you in today?

_____

_____

Onset? _____

Have you had this problem before? ☐ **YES** ☐ **NO**

If so, how long did it take to resolve? _____

Secondary concern/problem? _____

Type of Pain

☐ Sharp ☐ Burning ☐ Aching ☐ Pins&Needles ☐ Throbbing ☐ Numbness ☐ Other

Rate your average pain on a 0 to 10 scale (0=no pain, 10= worst imaginable pain)

Current_____ Best in 24 hours ____ Worst in 24 hours _____

Symptoms: Come and go ____ Are constant ____ Are constant but change with activity____

When are your symptoms worst? _____

Best? _____

My symptoms are currently

☐ getting better ☐ getting worse ☐ staying about the same

What aggravates your symptoms? _____

What relieves your symptoms? _____

How are you currently able to sleep at night due to your symptoms?

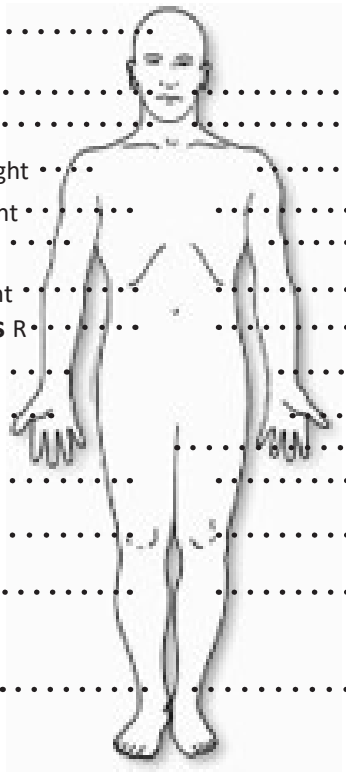
☐ No problem ☐ Difficulty falling asleep ☐ Awakened by pain
☐ Sleep only with medication

Any treatment received so far for these symptoms?

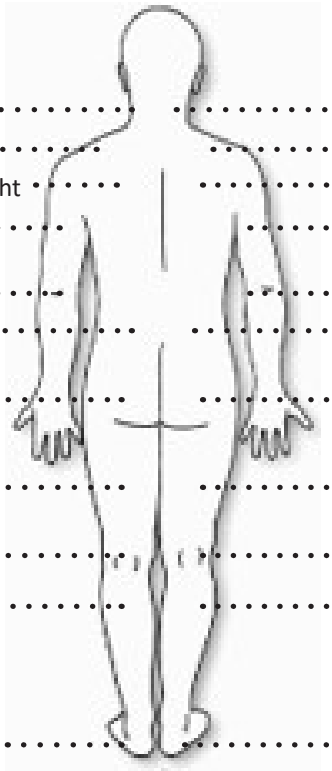
_____

Any special tests? _____

Please mark on the body where your symptoms are located



- ☐ **Head**
- ☐ **Jaw** Right
- ☐ **Neck** Right
- ☐ **Shoulder** Right
- ☐ **Pectoral** Right
- ☐ **Bicep** Right
- ☐ **Ribcage** Right
- ☐ **Abdominals** R
- ☐ **Wrist** Right
- ☐ **Hand** Right
- ☐ **Thigh** Right
- ☐ **Knee** Right
- ☐ **Calf** Right
- ☐ **Ankle** Right
- ☐ **Jaw** Left
- ☐ **Neck** Left
- ☐ **Shoulder** Left
- ☐ **Pectoral** Left
- ☐ **Bicep** Left
- ☐ **Ribcage** Left
- ☐ **Abdominals** L
- ☐ **Wrist** Left
- ☐ **Hand** Left
- ☐ **Groin**
- ☐ **Thigh** Left
- ☐ **Knee** Left
- ☐ **Calf** Left
- ☐ **Ankle** Left



- ☐ **Neck** Left
- ☐ **Shoulder** Left
- ☐ **Upper Back** Right
- ☐ **Tricep** Left
- ☐ **Elbow** Left
- ☐ **Low Back** Left
- ☐ **Glute** Left
- ☐ **Thigh** Left
- ☐ **Knee** Left
- ☐ **Calf** Left
- ☐ **Foot/Heel** Left
- ☐ **Neck** Right
- ☐ **Shoulder** Right
- ☐ **Upper Back** Left
- ☐ **Tricep** Right
- ☐ **Elbow** Right
- ☐ **Low Back** Right
- ☐ **Glute** Right
- ☐ **Thigh** Right
- ☐ **Knee** Right
- ☐ **Calf** Right
- ☐ **Foot/Heel** Right

Identify important activities that you are unable to do or are having difficulty with as a result of your problem/symptoms. Rate your difficulty based on a 0 to 10 scale with 0= "unable to perform" and 10= "no difficulty"

1. _____ 10
2. _____ 10
3. _____ 10

FITNESS FOR HER Synergy

4810 HOPE VALLEY RD, STE 107
DURHAM NC 27707

SYNERGY FITNESS FOR HER
PHYSICAL THERAPY CANCELLATION POLICY

While some physical therapy offices squeeze as many patients as possible onto their schedule, at Synergy Fitness for Her, when you make an appointment that time is allotted only for you. When you are unable to make it to your appointment and unable to give us 12 hours notice, then many times we have dead time in our schedule that could have been used by other patients eager to get into the practice. We completely understand that unexpected emergencies and illnesses happen; we only ask that you let us know AS SOON AS POSSIBLE. For all cancellations or changes of appointments we ask for 12-hour notification. Any cancellations made less than 12 hours are subject to a $50 cancellation fee at our discretion. Multiple violations of our cancellation policy will increase this fee up to $100, required pre-payment for future booking, or discharge from our practice. We strive to provide the highest quality of personalized care for our patients and simply ask that as a patient you respect our time as we respect yours.

Sincerely,
Your Synergy Fitness for Her Family

I certify that I have read and understand the cancellation policy and that if I cancel with less than 12-hour notice that penalties may apply.

Please Sign: _____

Date: _____

NOTICE OF PRIVACY PRACTICES

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.

Uses and Disclosures

There are a number of situations where we may use or disclose to other persons or entities your confidential medical information. Your confidential medical information is defined under federal law as "protected health information" ("PHI"). When we retain your confidential medical information on its computer system, it is called "electronic protected health information" ("ePHI"). This Notice applies to all PHI and ePHI related to your care that we have created or received. It also applies to any personal or general information we receive from patients, including information contained on driver's licenses. Certain uses and disclosures will require you to sign an Acknowledgement that you received our Notice of Privacy Practices, including treatment, payment and health care operations. Any use or disclosure of your protected health information required for anything other than treatment, payment or health care operations requires you to sign an Authorization. Certain disclosures required by law or under emergency circumstances, may be made without your Acknowledgement or Authorization. Under any circumstance, we will use or disclose only the minimum amount of information necessary from your medical records to accomplish the intended purpose of the disclosure.

Use and Disclosure without Patient Acknowledgement of this Notice

We will attempt in good faith to obtain your signed Acknowledgement that you received this Notice to use and disclose your confidential medical information for the following purposes:

Treatment: We will use your medical information to make decisions about the provision, coordination or management of your health care, including diagnosing your condition and determining the appropriate treatment for that condition. It may also be necessary to share your medical information with another health care provider whom we need to consult with respect to your care.

Payment: We may need to use or disclose information in your medical record to obtain reimbursement from you or your health insurance plan, or another insurer for our services rendered to you. This may also include determinations of eligibility or coverage under the appropriate health plan, pre-certification and pre-authorization of services or review of services for purposes of reimbursement. This information may also be used for billing, claims management and collection purposes together with related health care data processing through our system.

Operations: Your medical records may be used in our business planning and development operations, including improvement in our methods of operation, and general administrative functions. We may also use the information in our overall compliance planning, medical review activities, and arranging for legal and auditing functions.

Use and Disclosure Without Acknowledgement or Authorization

There are certain circumstances under which we may use or disclose your medical information without first obtaining your Acknowledgement or Authorization. Those circumstances generally involve public health and oversight activities, law enforcement activities, judicial and administrative proceedings and in the event of death. Specifically, we are required to report to certain agencies information concerning certain communicable diseases, sexually transmitted diseases and HIV/AIDS status. We are also required to report instances of suspected or documented abuse, neglect or domestic violence. We are required to report to appropriate agencies and law enforcement officials information that you or another person are in immediate threat of danger to your health or safety as a result of violent activity. We must also provide medical record information when ordered by a court of law to do so.

Authorization for Use or Disclosure Except as outlined in the above sections, your medical information will not be used or disclosed to any other person or entity without your specific Authorization, which may be revoked at any time. In particular, except to the extent disclosure has been made to governmental entities required by law to maintain the confidentiality of the information, information will not be further disclosed to any other person or entity with respect to information concerning mental health treatment, drug and alcohol abuse, HIV/AIDS, or sexually transmitted diseases which may be contained in your medical records without your specific written consent and authorization. We likewise will not disclose your medical record information to an employer for purposes of making employment decisions, to a liability insurer or attorney as a result of injuries sustained in an automobile accident, or to educational authorities, without your written authorization. Your medical information will not be disclosed for marketing purposes or sold to any third party without your authorization.

Other uses and disclosures of your medical record 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 with permission to use or disclose information about you, you may revoke that permission, in writing, at any time. You understand that we are unable to "take back" any disclosures that we have already made with your permission and that we are required to keep any records of the care that we provided to you.

Additional Uses and Disclosures

Advice of Appointment and Services: The Practice may, from time to time, contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may interest you. The following appointment reminders may be used by the Practice: a) postcard mailed to you at your address provided by you; and b) telephoning your home and leaving a message on your answering machine or with the individual answering the phone.

Individual Rights

You have certain rights with respect to your medical record information, as follows:

1. You may request that we restrict the uses and disclosures of your medical records information for treatment, payment and operations, or restrictions involving your care or payment related to that care. We are not required to agree to the restriction; however, if we agree, we will comply with it, except with respect to emergencies, disclosure of the information to you, or if we are otherwise required by law to make a full disclosure without restriction.

2. You may also request a restriction on disclosure of protected health information to a health plan for purpose of payment or health care operations if you paid for the services out of your own pocket, in full. This does not apply to services that are covered by insurance. You are required to pay cash, in full, for the services before the restriction applies.
3. With respect to ePHI, we agree to give you your ePHI in the form and format requested by you, if it is readily producible in that form or format. If it is not readily producible in the form or format requested, we will give you a readable hard copy form. Any directive given to us by you to transmit ePHI must be done in writing by you, signed and clearly identify the designated person and location to send the ePHI. We will provide you access to your PHI or ePHI within thirty (30) days from the date of request.
4. You have the right to request receipt of confidential communications of your medical information by an alternative means or at an alternative location. If you require such an accommodation, you will be charged a fee for the accommodation and will be required to specify the alternative address or method of contact and how payment will be handled.
5. You have the right to inspect, copy and request amendment to your medical records. Access to your medical records will not include psychotherapy notes contained in them, or information compiled in anticipation of or for use in a civil, criminal or administrative action or proceeding or for which your access is otherwise restricted by law. We will charge a reasonable fee for providing a copy of your medical records, or a summary of those records, at your request, which includes the cost of copying, postage, or preparation of an explanation or summary of the information.
6. We may deny any request for amendment of your PHI or ePHI if the information was not created by us (unless the originator of the information is no longer available to act on your request); is not part of the designated record set maintained by us; is not part of the information to which you have a right of access; or is already accurate and complete, as determined by us. If we deny your request for an amendment, we will give you a written denial including the reasons for the denial and the right to submit a written statement disagreeing with the denial.
7. All requests for inspection, copying and/or amending information in your medical records must be made in writing and be addressed to "Privacy Officer" at our address. We will respond to your request in a timely fashion.
8. You have a limited right to receive an accounting of all disclosures we make to other persons or entities of your medical records information except for disclosures required for treatment, payment and health care operations, disclosures that require an Authorization, disclosures incidental to another permissible use or disclosure, and otherwise as allowed by law. We will not charge you for the first accounting in any 12-month period; however, we will charge you a reasonable fee for each subsequent request for an accounting within the same 12-month period.
9. You have the right to obtain a paper copy of this notice if the notice was initially provided to you electronically, and to take one home with you if you wish.
10. All requests related to your rights herein must be made in writing and addressed to "Privacy Officer" at the address noted below.
11. You have the right to receive notification from us if any breach of your unsecured protected health information occurs.

Our Duties

We have the following duties with respect to the maintenance, use and disclosure of your medical records:

1. We are required by law to maintain the privacy of the protected health information in your medical records and to provide you with this Notice of its legal duties and privacy practices with respect to that information.
2. We are required to abide by the terms of this Notice currently in effect.
3. We reserve the right to change the terms of this Notice at any time, making the new provisions effective for all health information and medical records we have and continue to maintain. All changes in this Notice will be prominently displayed and available at our office.

Complaints

You may file a written complaint to us or to the Secretary of Health and Human Services if you believe your privacy rights with respect to confidential information in your medical records have been violated. All complaints must be in writing and must be addressed to the Privacy Officer (in the case of a complaint to us) or to the person designated by the U.S. Department of Health and Human Services if we cannot resolve your concerns. You will not be retaliated against for filing such a complaint. More information is available about complaints on line at the government's website: http://www.hhs.gov/ocr/hipaa.

This Notice of Privacy Practices shall not be construed as a contract or legally binding agreement. Any non-compliance with any provision of this Notice shall not be construed as a breach of contract, breach of confidentiality, invasion of privacy, misappropriation of name or likeness, violation of any consumer protection law, negligence or violation of any state law. By signing the Acknowledgment of Receipt of this Notice, you agree that the sole legal recourse for our non-compliance with this Notice is to file a written complaint to the Secretary of the U.S. Department of Health and Human Services, and that no complaint or cause of action may be filed in any federal or state court for breach of contract, breach of confidentiality, invasion of privacy, misappropriation of name or likeness, violation of any consumer protection law, negligence or violation of any state law, or under any tort theory.

Contact Person

All questions concerning this Notice, or requests made pursuant to it, should be addressed to the Privacy Officer:
Dr. Birgit Reher, PT DPT at the following address:
105 Bellamy Court, Cary NC, 27511 or E-mail: birgit@synergyfitnessforher.com

Effective Date

This Notice is effective **April 14, 2003 and revised September 23, 2013** and applies to all protected health information contained in your medical records maintained by us.