Notice of Privacy Practices

1) Core Health Strategies PLLC is dedicated to keep all of your health information confidential. We keep records in order to provide you with quality care.

2) We use your health information ONLY:
- for treatment purposes
- for billing purposes
- for the operation of the practice - as required by law
- to avert a serious threat to health, safety
- to send to military departments as required by law
- to send to workers' compensation programs
- to send to law enforcement agencies as required by law

3) Your rights regarding the health information we maintain about you include the rights to:
- inspect your health information used to make decisions about your care by submitting a written request
- amend information that you feel is incorrect by submitting a written request
- request a list of accounting of any disclosures of your information not listed above
- request a restriction or limitation on health information that we disclose by submitting a written request
-

Please ask the administrative staff if you have any further questions regarding your privacy.

Please sign below to acknowledge receipt of this notice.

Signature: _____**Date:** _____

Cancellation / No Show Policy:
If you need to cancel your appointment, please call or cancel ASAP (at least 24 hours notice) so that we have the opportunity to offer your appointment to another client. ***If less than 24 hours notice is given or you do not show up, you will be charged for the amount of time you were scheduled at the rate of $95 per 45 minute treatment session / $180 per 90 minute treatment session / $120 per initial session. Follow up visits will not be scheduled until the NO SHOW / Late cancellation fee has been paid. Thank you for your understanding!***

Initial _____

Consent for Care and Treatment:
Your Occupational Therapist will complete an evaluation process via interview and examination. From these findings, a treatment plan will then be designed, utilizing a variety of treatment techniques. I, the undersigned, do hereby agree and give consent for Core Health Strategies, PLLC, to provide Occupational Therapy care and treatment identified as proper and necessary in addressing my physical condition.

Initial _____

Financial Policy
Core Health Strategies, LLC, accepts payments via cash, check or credit card.

Services in our office are charged at a rate of:
Occupational Therapy Evaluation $120
Occupational Therapy Treatment session (45 minutes) $95
Occupational Therapy Treatment session (90 minutes) $180

A frequency specific microcurrent unit can be rented for $15/day or $90/week so you can use microcurrent more frequently to support your recovery. This is a great way to maximize your therapy sessions.

PEMF and Healy microcurrent devices can be rented for $25/day—these devices do not have weekly rental options and have very limited availability.

I agree that the information above is accurate. I understand the terms of this form and realize that I am financially responsible for charges incurred from cancellations or no shows.

Microcurrent therapy **cannot** be offered to anyone who:
1) is undergoing cancer treatment in the area of the body that is to be treated,
2) has a pacemaker/defibrillator,
3) is pregnant, or
4) Is planning to have or has had an organ transplant

By signing below, I am affirming that I can safely receive microcurrent therapy based on this statement.

Patient Name: _____

Patient Signature or Guardian for minors: _____

Date: _____/_____/____

Occupational Therapy

Core Health Strategies, PLLC, is dedicated to giving each client an individualized, personal service that they can rely on and trust. To help us meet your needs, please fill out these forms completely. If you have any questions or need help, please ask, we will be happy to assist you.

Patient Intake Form

Patient Name: _____ **Date:** _____

Address: _____

_____

Home #: _____ **Cell #:** _____

Email: _____

DOB: ____/_____/_____ Age:

Emergency Contact Person: _____

Relationship to you: _____ **Contact #:** _____

Employer: _____

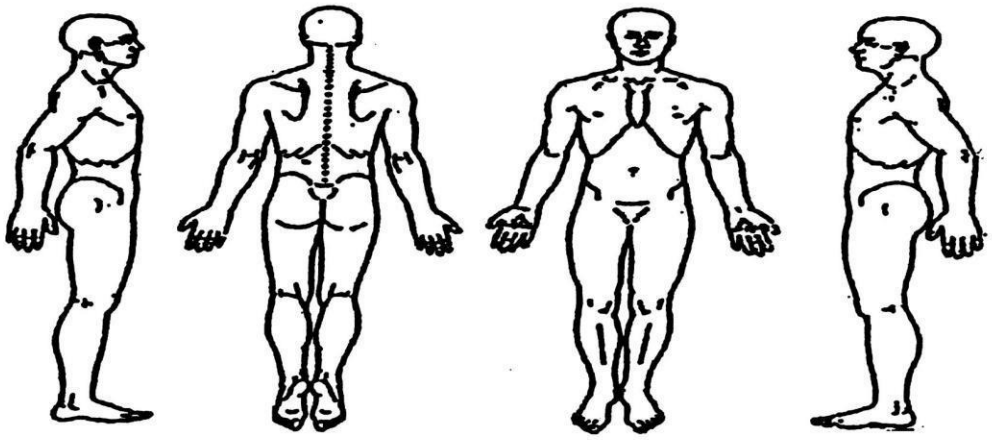
Your Occupation: _____

Primary Care Physician: _____ **Telephone:** _____

How did you hear about our office? _____

1. Reason you are seeking Occupational Therapy: _____

2. Indicate on the drawings below where you have pain/symptoms



3. How often do you experience your symptoms?

□ Constantly (76-100% of the time) □ Occasionally (26-50% of the time)
□ Frequently (51-75% of the time) □ Intermittently (1-25% of the time)

4. How would you describe the type of pain?

□ Sharp □ Numb
□ Dull □ Tingly
□ Diffuse □ Sharp with motion
□ Achy □ Shooting with motion
□ Burning □ Stabbing with motion
□ Shooting □ Electric like with motion
□ Stiff □ Other:_ _____

5. How are your symptoms changing with time?

□ Getting Worse □ Staying the Same □ Getting Better

6a Using a scale from 0-10 (10 being the worst), how would you rate your pain NOW?

0 1 2 3 4 5 6 7 8 9 10 (Please circle)

6b. Using a scale from 0-10 (10 being the worst), how would you rate your pain AT BEST?

0 1 2 3 4 5 6 7 8 9 10 (Please circle)

6c. Using a scale from 0-10 (10 being the worst), how would you rate your pain AT WORST?

0 1 2 3 4 5 6 7 8 9 10 (Please circle)

7. How much has the problem interfered with your work?

□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

8. How much has the problem interfered with your social activities?

□ Not at all □ A little bit □ Moderately Quite a bit □ Extremely

9. Who else have you seen for your problem?

□ Chiropractor □ Neurologist □ Primary Care Physician

□ Acupuncturist □ Orthopedist
□ Massage Therapist □ Physical Therapist □ No one

10. How long have you had this problem? _____

11. How do you think your problem began? _____

12. Do you consider this problem to be severe? □ Yes □ Yes, at times □ No

13. What aggravates your problem? _____

14. What concerns you the most about your problem; what does it prevent you from doing?

_____

15. What is your: Height_____ Weight _____

16. How would you rate your overall Health? (circle one) Excellent very good good fair poor

17. What type of exercise do you do?

□ Strenuous □ Moderate □ Light □ None

18. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "NOW" column.

Past	Now		Past	Now		Past	Now	
□	□	Headaches	□	□	High Blood Pressure	□	□	Diabetes
□	□	Neck Pain	□	□	Heart Attack	□	□	Excessive Thirst
□	□	Upper Back Pain	□	□	Chest Pains	□	□	Frequent Urination
□	□	Mid Back Pain	□	□	Stroke	□	□	Smoking/Tobacco Use
□	□	Low Back Pain	□	□	Angina	□	□	Drug Dependence
□	□	Shoulder Pain	□	□	Kidney Stones	□	□	Alcohol Dependence
□	□	Elbow Pain	□	□	Kidney Disorders	□	□	Depression
□	□	Wrist Pain	□	□	Bladder Infection	□	□	Systemic Lupus
□	□	Hand Pain	□	□	Painful Urination	□	□	Epilepsy
□	□	Hip Pain	□	□	Loss of Bladder control	□	□	Allergies
□	□	Upper Leg Pain	□	□	Prostate Problems	□	□	HIV/AIDS
□	□	Knee Pain	□	□	Abnormal Weight Gain	□	□	Brain injury
□	□	Ankle/Foot Pain	□	□	Abnormal Weight Loss	□	□	Concussion
□	□	Jaw Pain	□	□	Loss of Appetite	□	□	Whiplash
□	□	Asthma	□	□	Abdominal Pain	□	□	
□	□	Joint Pain	□	□	Ulcer	□	□	
□	□	Arthritis	□	□	Hepatitis	□	□	
□	□	Rheumatoid arthritis	□	□	Liver disorder	□	□	
□	□	Tumors / cancer	□	□	Dizziness			***FOR FEMALES ONLY***
□	□	Scoliosis	□	□	Visual disturbances	□	□	Birth Control Pills
□	□	Chronic Sinusitis	□	□	Gallbladder Disorder	□	□	Pregnancy
□	□	Muscle Incoordination	□	□	Dermatitis/Eczema/Rash	□	□	Hormonal Replacement

19. List all prescription medications you are currently taking

Medication	Dosage / frequency

20. List all of the over-the-counter medications / supplements you are currently taking:

Medication / supplement	Dosage / frequency

21. List all surgical procedures you have had:

Surgery	Date		Surgery	Date

22. What activities do you do at work?

	Most of the day	Half the day	A little of the day or None
Sit			
Stand			
Computer work			
On the phone			
Lifting/carrying: #s=____			
Other:_____			

23. What activities do you do outside of work? (Circle all that apply)

Bike: road / mtn	Hike/walk	Fly Fish	Bait / Cast Fish	Jog/run	Boating
Ski: xc / alpine	Snow shoe	ATV	Hunt	Photography	Arts/crafts
TV	Tennis	Gardening	Golf	Volleyball	Weight lifting
Bowling	Traveling	Triathlons	Other: _____		

24. What do you know about your birth? Any difficulties? How long was your birth? Did your mother experience any high stress or trauma during your pregnancy? :_____

_____

_____

25. Have you ever been hospitalized? □ No □ Yes
If yes, when? And why?

_____

_____

_____

26. Please describe physical &/or emotional traumas you have experienced (often times our body's pain started because of some sort of trauma—if you're not comfortable listing this information now, please at least indicate that you have had some sort of trauma & we can attempt to address this if you're not progressing in your therapy as quickly as you hope for): _____

_____

_____

27. Have you had any previous motor vehicle accidents (REGARDLESS IF YOU SUFFERED INJURY OR NOT)?
□ No □ Yes If yes, please explain:_____

_____

_____

28. How many concussions have you had? _____
Describe how you received your concussion(s):

_____

29._____

_____

30. Do you have any of the following implanted devices?

i. Morphine / pain pump
ii. Insulin pump
iii. Baclofen pump
iv. Spinal cord stimulator
v. Temporary cardiac monitors?

If yes, if you have the ability to turn off the device, please bring that with you to your appointment.

31. **Describe your typical sleep (circle all that apply and comment):**
Restless Deep sleep Dream a lot Never dream

I wake up _____# of times per night. I get approximately _____# of hours of sleep each night

I sleep on my: BACK LEFT SIDE RIGHT SIDE STOMACH

I use pillows or positioning cushions when sleeping—if yes, please describe: -
_____

32. **Describe ALL exposures to chemicals you have had including pesticides, herbicides, motor oils, etc.**
_____
_____

33. **Anything else pertinent to your visit today:** _____

34. ***ALLERGIES: MEDICATIONS & FOODS*** **(INCLUDING ANY PLANT ALLERGIES SINCE WE USE ESSENTIAL OILS DURING YOUR TREATMENT SESSION):** _____

(FOR THERAPIST USE ONLY) ASSESSMENT / GOALS:

VISION/HEARING:

Strength / ROM	**R**	**L**	
L1-3			
L4/L5			
S1			
C5			
C5/6			
C6			
C7			
C8			
Reflex			
C5, C6, C7			
L4, S1			

BALANCE	Comments	FASCIA	Tilt	Shift	Rotation	
BLE		Head r/t shoulders	R L	R L	R L	
RLE—Shift		Shoulder r/t pelvis	R L	R L	R L	
LLE—Shift		Pelvis r/t feet	R L	R L	R L	
		Knees r/t feet	R L	R L	R L	

GOALS
Decrease pain Increase function / independence normalize movement patterns