CREATIVE THERAPEUTICS
PHYSICAL THERAPY

2763 E. Shaw Ave. Suite #102 | Fresno, CA 93710 | (559) 294-8112 | Fax (559) 294-7805

Sandra Bausman, PT, WCS

Nancy Larson, PT, WCS

Welcome to Creative Therapeutics Physical Therapy. Your appointment has been scheduled on: _____
Please arrive 10 minutes before your appointment time. Thank you.

Please Note:

1. It is this office's protocol to have an RX/Referral from your doctor or dentist according to the diagnosis you will be treated for, in order for your visits to be processed through your health insurance.

2. If you are receiving physical therapy treatment at another Clinic, please arrange these appointments on different days when you have your appointment here. It can affect how your insurance plan may or may not pay if you have two physical therapy sessions on the same day.

As a courtesy to others with allergy sensitivities, we kindly ask you to please refrain from wearing colognes or perfumes during your visit here.

A fee of $75.00 will be charged for failure to cancel an initial evaluation appointment without a 24 hour notice. A fee of $50.00 will be charged for failure to cancel a follow-up appointment without a 4 hour notice.

If you have any questions, please feel free to call our office.

Thank you.
Creative Therapeutics Physical Therapy

MAP ON REVERSE SIDE

CREATIVE THERAPEUTICS
PHYSICAL THERAPY

Financial Policy

Communication with our clients regarding our financial policy assists us in providing the best possible service to you. Please read the following. Your signature is required at the bottom of the page.

PRIVATE PAY – Full payment is required when services are rendered to continue treatment.

DEDUCTIBLE, CO-PAYMENT AND/OR CO-INSURANCE – We will be contacting your health insurance to verify your coverage. It is important to remember that what the insurance company tells us is not a GUARANTEE of payment from them. All dates of service are billed promptly; however, you are responsible to pay in advance for your deductible if it has not been met. Co-payment and/or co-insurance are required to be paid at the time of service.

PURCHASING PRODUCTS – Payment for all products is the patient's responsibility and due at time of purchase.

Agreement To Pay

_____I understand that the Agreement with my insurance company is an Agreement between them and me. I take full responsibility for payment of all charges for professional services rendered. I understand the financial policy outlined above. I understand that I am responsible for all charges regardless of my existing medical coverage. (Please initial above if you understand these statements).

Consent for Treatment / Release of Insurance Assignment Medical Information:

YES____NO____I authorize the therapy services that the provider feels necessary or advisable in conjunction with my referral.
YES____NO____I assign payment of medical benefits directly to Creative Therapeutics P.T., Inc. (C.T.P.T., Inc.)
YES____NO____I hereby authorize C.T.P.T., Inc. to release to my insurance company or medical provider any medical records or information concerning the treatment to obtain reimbursement on my behalf for the treatment or service provided by C.T.P.T., Inc. I understand that I may revoke the consent to release information to third parties at any time and that the provision of services is not conditioned on my agreement to disclose information to the parties. If I revoke my consent, I will be responsible for paying all services rendered by C.T.P.T., Inc.

I have read, understand and agree to this financial agreement.

SIGNATURE _____ DATE _____

CREATIVE THERAPEUTICS
PHYSICAL THERAPY

Office No-Show and Late Arrival Policies

No-Show/Late Cancellations: Appointment time slots are precious and very much in demand for our office. In an effort to serve you better, we ask for proper notice for any cancellation. **Patients failing to provide at least a 24-hour notice will be charged $75.00 for the initial evaluation. Follow-up visits not cancelled 4 hours prior will be subject to a late cancellation fee of $50.00.**

Late Arrivals: We make every effort to be on time for all our appointments. Unfortunately, when even one patient arrives late, it can throw off the entire schedule for that session. In addition, rushing or "squeezing in" an appointment shortchanges the patient and contributes to decreased quality of care (and increases medical errors). In light of this, at the discretion of the treating therapist, **patients arriving more than 10 minutes late may be asked to reschedule for another day or may be offered another appointment time the same day if there is one available. The late arrival to the appointment will be considered a no-show, therefore the $50.00 fee will apply and will have to be paid before the next appointment.**

In addition, we reserve the right to terminate treatment after two no-shows, two late cancellations or three late arrivals.

I have read, understand and agree to this no-show, late cancelation and late arrival policy.

SIGNATURE _____ DATE _____

Patient Information Consent Form

I have read and fully understand *Creative Therapeutics Physical Therapy, Inc.*'s Notice of Information Practices. I understand that *Creative Therapeutics Physical Therapy, Inc.* may use or disclose my personal information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services probed and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that *Creative Therapeutics Physical Therapy, Inc.* will consider requests for restrictions on a by case bases, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in *Creative Therapeutics Physical Therapy, Inc.'s* Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

I have requested and/or been given a copy of *Creative Therapeutics Physical Therapy, Inc.'s* Notice of Information Practices, which describes how much my health information is used and shared. I may obtain a copy by contacting the Privacy Official or by visiting the web site at www.creativetherapeutics.com.

My signature below acknowledges that I have been provided with a copy of the notice of information practices.

_____
Patient Name

_____
Signature

_____
Date

Notice of Patient Information Practices

This notice describes how medical information about you may be used or disclosed and how you can get access to information. Please review it carefully.

LEGAL DUTY

Creative Therapeutics P.T., Inc. is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

Creative Therapeutics P.T., Inc. uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, *Creative Therapeutics, P.T., Inc.* may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

Creative Therapeutics P.T.. Inc. may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law.

In any other situation, *Creative Therapeutics, P.T., Inc.*'s policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop further disclosures at any time.

Creative Therapeutics P.T., Inc. may change its policy at any time. When changes made, a new Notice of Information Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specially authorized by you, when required by law or in emergency circumstances. *Creative Therapeutics P.T., Inc.* will consider all such requests on a case by case basis, but the practice is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that *Creative Therapeutics P.T.. Inc.* may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our Practice Administrator at the address listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. For further information on *Creative Therapeutics P.T., Inc.*'s health information practices or if you have a complaint, please contact the following person:

KATINKA YEPEZ, PRACTICE ADMINISTRATOR
2763 E. Shaw Ave., #102 Fresno, CA 93710
Telephone: 559-294-8112 FAX: 559-294-7805

CREATIVE THERAPEUTICS
PHYSICAL THERAPY

Medical History

The purpose of this questionnaire is to help us understand your health status. This form is considered part of your medical record.

Patient Name: _____ **Date of Birth:** _____

Referring Physician: _____ **Primary Physician:** _____

Last date of general checkup ____/_____/_____

Primary Diagnosis: _____ **Secondary:** _____

Occupation: _____ **Hours worked per week:** _____

If applicable, last date worked due to injury or condition: ____/____/_____ **Date returned to work:** ___/____/_____

1. **Allergy History(medications, food, latex, etc....)/ Drug sensitivity:**_____
2. **Surgeries:**_____
3. **Recent Hospitalization Date:**___/___/___
   Reason:_____
4. **List any prescription or non-prescription medications you are currently taking:**
   ☐ Non-steroidal ☐ Anti-inflammations ☐ Muscle Relaxer ☐ Pain Medication
   ☐Other:_____

5. **Have you had any of the following medical or rehabilitative care for this condition?**

	NO	Yes (when)
Chiropractor		
General Practitioner		
Orthopedist		
Podiatrist		
Massage Therapy		
Urologist		
Physical Therapy		

	No	Yes (when)
Occupational Therapy		
Ct Scan/ Bone Scan		
EMG or Nerve Test		
MRI X-Ray		
Ultrasound		
Bone Density		

6. **Have you had any of the following conditions or symptoms?**

	NO	YES (Onset)
Asthma/Bronchitis/Emphysema		
Chest pain/Shortness of Breath		
Heart Disease/Angina		
Pacemaker		
High/Low Blood Pressure		
Heart Attack/Heart Surgery		
Blood Clot/Emboli		
Stroke/TIA		
Parkinson's Disease		
Pins or Metal Implants		Where:
Joint Replacement		Where:
Diabetes		1 or 2:
Infectious Diseases Cancer/Radiation		Where:
Arthritis		Where:
Osteoporosis		
Hernia		

	NO	YES (Onset)
Epilepsy/Seizures		
Thyroid Condition		
Multiple Sclerosis		
Severe/Frequent Headaches		
Vision/Hearing Difficulty		
Numbness or Tingling		
Sleeping Problems Dizziness		
Weakness/Energy Loss		
Recent Weight Gain/Loss		
Bowel/Bladder problems		
Neck Injury/Surgery		
Elbow/Hand- Injury/Surgery		
Hip/Knee- Injury/Surgery		
Ankle/Foot- Injury/Surgery		
Shoulder Injury/Surgery		

7. **For Women Only:**

	NO	Yes(when)
Pelvic inflammatory Disease		
Complicated Pregnancies/Deliveries		
Endometriosis		
Are you pregnant?		

Current complaints/what brought you to Physical Therapy?

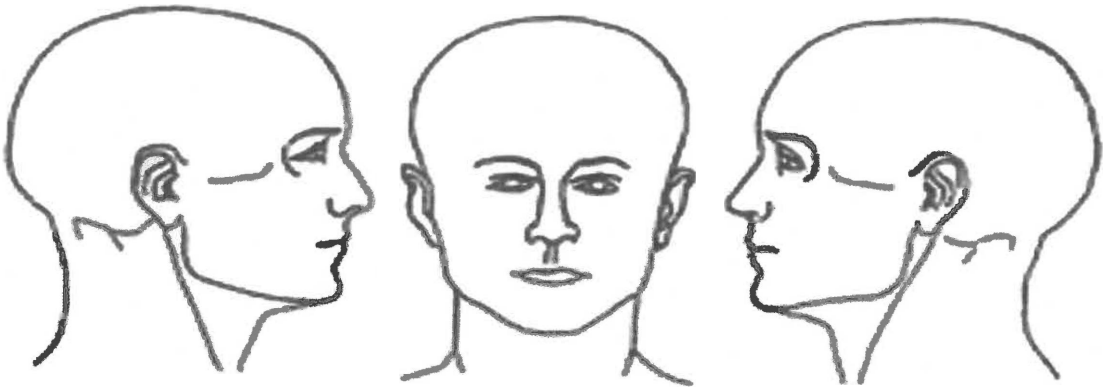
1. _____ **How long?** _____
2. _____ **How long?** _____
3. _____ **How long?** _____

My symptoms are currently:

☐ Getting Better ☐ Getting Worse ☐ The same

Do you expect to return to the activity levels prior to developing these symptoms? Yes No

On the Diagram below, please shade or mark the areas of your pain



My symptoms:

☐ Come and go ☐ Are Constant ☐ Are constant but change with activity

Please rate your jaw/headache pain

0 1 2 3 4 5 6 7 8 9 10

No Pain Worst pain imaginable

Please rate your current level of neck pain

0 1 2 3 4 5 6 7 8 9 10

No Pain Worst pain imaginable

Where is your pain?

☐ Right Side ☐ Left Side ☐ Both Sides

Where is the location of your pain?

☐ Temporal Region ☐ Cheek Region ☐ Lower Jaw ☐ Ear ☐ Teeth
☐ TMJ region (in front of the ear) ☐ Neck ☐ Shoulders
☐ Other:_____

Does your joint make any noises?

☐ Popping/clicking: ☐ Right Side ☐ Left Side ☐ Both Sides ☐ Not applicable
☐ Grinding: ☐ Right Side ☐ Left Side ☐ Both Sides ☐ Not applicable

Do you have limited mouth movement?

☐ Persistent ☐ Intermittent ☐ Difficult opening mouth ☐ Difficultly closing mouth
☐ Chewing ☐ Yawning or Laughing ☐ Other:_____ ☐ None of these symptoms

Do you have jaw locking episodes?

☐ Locked while mouth is open ☐ Locked while mouth is closed ☐ Neither

Do you have headaches?

☐ Frequently ☐ Not Frequently

If you do get headaches, where is the location of the headache?

☐ Right Side ☐ Left Side ☐ Both Sides ☐ Frontal (front of head) ☐ Temporal (side of the head)
☐ Occipital (back of head)

Do you have ringing in your ears?

☐ Right Side ☐ Left Side ☐ Both sides ☐ Not applicable

Do you have fullness in your ears?

☐ Right Side ☐ Left Side ☐ Both Sides ☐ Not applicable

Do you have any of the following symptoms?

☐ Dizziness ☐ Visual Changes ☐ Changes in hearing
☐ Other:_____

Are there any possible contributing factors to your pain?

☐ Facial Trauma/injury: _____ ☐ Bruxism (grinding teeth)
☐ Whiplash/Cervical Trauma: _____ ☐ Arthritis
☐ Sleeping Disorder:_____
☐ Stress (1-minor 10-severe) 1 2 3 4 5 6 7 8 9 10

Have you had or are currently having any other treatments related to your pain?

☐ Panoramic Radiograph ☐ TMJ Tomograms ☐ MRI of TMJ region
☐ Physical Therapy ☐ Massage ☐ Bite Splint or night guard, if yes how often do you use it?
☐ Always ☐ Occasionally ☐ Rarely/Never

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

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

When are your symptoms the worst?

☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ After Exercise

When are your symptoms the best?

☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ After Exercise

Using a 0 to 10 scale, with 0 being "no pain" and 10 being the "worst pain imaginable" please describes:

Your current level of pain while completing this survey: 1 2 3 4 5 6 7 8 9 10

The best your pain has been during the past 24 hours: 1 2 3 4 5 6 7 8 9 10

The worst your pain has been during the past 24 hours: 1 2 3 4 5 6 7 8 9 10

Patient/Guardians Signature: _____ **Date**: ___/____/____

TMD DISABILITY INDEX (STEIGERWALD/MAHER)

NAME _____ **M /F** _____ **AGE**_____ **DATE**_____ **SCORE** _____

Please check the one statement that best pertains to you (not necessarily exactly) in each of the following categories.

1. Communication (talking)

0 I can talk as much as I want without pain, fatigue or discomfort.
1 I talk as much as I want, but it causes some pain, fatigue and/or discomfort.
2 I can't talk as much as I want because of pain, fatigue and/or discomfort.
3 I can't talk much at all because of pain, fatigue and/or discomfort.
4 Pain prevents me from talking at all.

2. Normal living activities (brushing teeth/flossing).

0 I am able to care for my teeth and gums in a normal fashion without restriction, and without pain, fatigue or discomfort.
1 I am able to care for all my teeth and gums, but I must be slow and careful, otherwise pain/discomfort, jaw tiredness results.
2 I do manage to care for my teeth and gums in a normal fashion, but it usually causes some pain/discomfort, jaw tiredness no matter how slow and careful I am.
3 I am unable to properly clean all my teeth and gums because of restricted opening and/or pain.
4 I am unable to care for most of my teeth and gums because of restricted opening and/or pain.

3. Normal living activities (eating, chewing).

0 I can eat and chew as much of anything I want without pain/discomfort or jaw tiredness.
1 I can eat and chew most anything I want, but it sometimes causes pain/discomfort and/or jaw tiredness.
2 I can't eat much of anything I want, because it often causes pain/discomfort, jaw tiredness or because of restricted opening.
3 I must eat only soft foods (consistency of scrambled eggs or less) because of pain/discomfort, jaw fatigue and/or restricted opening.
4 I must stay on a liquid diet because of pain and/or restricted opening.

4. Social/recreational activities (singing, playing musical instruments, cheering, laughing, social activities, playing amateur sports/hobbies, and recreation, etc.).

0 I am enjoying a normal social life and/or recreational activities without restriction.
1 I participate in normal social life and/or recreational activities but pain/discomfort is increased.
2 The presence of pain and/or fear of likely aggravation only limits the more energetic components of my social life (sports, exercising, dancing, playing musical instruments, singing).
3 I have restrictions socially, as I can't even sing, shout, cheer, play and/or laugh expressively because of increased pain/discomfort.
4 I have practically no social life because of pain.

5. Non-specialized jaw activities (yawning, mouth opening and opening my mouth wide).

0 I can yawn in a normal fashion, painlessly.
1 I can yawn and open my mouth fully wide open, but sometimes there is discomfort.
2 I can yawn and open my mouth wide in a normal fashion, but it almost always causes discomfort.
3 Yawning and opening my mouth wide are somewhat restricted by pain.
4 I cannot yawn or open my mouth more than two finger widths (28-32 cm) or, if I can, it always causes greater than moderate pain.

6. Sexual function (including kissing, hugging and any and all sexual activities to which you are accustomed).

0 I am able to engage in all my customary sexual activities and expressions without limitation and/or causing headache, face or jaw pain.

1 I am able to engage in all my customary sexual activities and expression, but it sometimes causes some headache, face, or jaw pain, or jaw fatigue.

2 I am able to engage in all my customary sexual activities and expression, but it usually causes enough headache, face or jaw pain to markedly interfere with my enjoyment, willingness and satisfaction.

3 I must limit my customary sexual expression and activities because of headache, face or jaw pain or limited mouth opening.

4 I abstain from almost all sexual activities and expression because of the head, face or jaw pain it causes.

7. Sleep (restful, nocturnal sleep pattern).

0 I sleep well in a normal fashion without any pain medication, relaxants or sleeping pills.

1 I sleep well with the use of pain pills, anti-inflammatory medication or medicinal sleeping aids.

2 I fail to realize 6 hours restful sleep even with the use of pills.

3 I fail to realize 4 hours restful sleep even with the use of pills.

4 I fail to realize 2 hours restful sleep even with the use of pills.

8. Effects of any form of treatment, including, but not limited to, medications, in-office therapy, treatments, oral orthotics (e.g., splints, mouthpieces), ice/heat, etc.

0 I do not need to use treatment of any type in order to control or tolerate headache, face or jaw pain and discomfort.

1 I can completely control my pain with some form of treatment.

2 I get partial, but significant, relief through some form of treatment.

3 I don't get "a lot of" relief from any form of treatment.

4 There is no form of treatment that helps enough to make me want to continue.

9. Tinnitus, or ringing in the ear(s).

0 I do not experience ringing in my ear(s).

1 I experience ringing in my ear(s) somewhat, but it does not interfere with my sleep and/or my ability to perform my daily activities.

2 I experience ringing in my ear(s) and it interferes with my sleep and/or daily activities, but I can accomplish set goals and I can get an acceptable amount of sleep.

3 I experience ringing in my ear(s) and it causes a marked impairment in the performance of my daily activities and/or results in an unacceptable loss of sleep.

4 I experience ringing in my ear(s) and it is incapacitating and/or forces me to use a masking device to get any sleep.

10. Dizziness (lightheaded, spinning and/or balance disturbance).

0 I do not experience dizziness.

1 I experience dizziness, but it does not interfere with my daily activities.

2 I experience dizziness which interferes somewhat with my daily activities, but I can accomplish my set goals.

3 I experience dizziness which causes a marked impairment in the performance of my daily activities.

4 I experience dizziness which is incapacitating.

SCORE_____

PATIENT INFORMATION

PATIENT NAME: _____ DATE: _____

ADDRESS: _____ CITY: _____ ZIP: _____

D.O.B.: _____ SEX: MALE FEMALE

HOME PHONE: _____ CELL: _____

WORK PHONE: _____ E-MAIL: _____

EMERGENCY CONTACT: _____ PHONE: _____

RELATION TO PATIENT: _____

REFERRING PHYSICIAN: _____

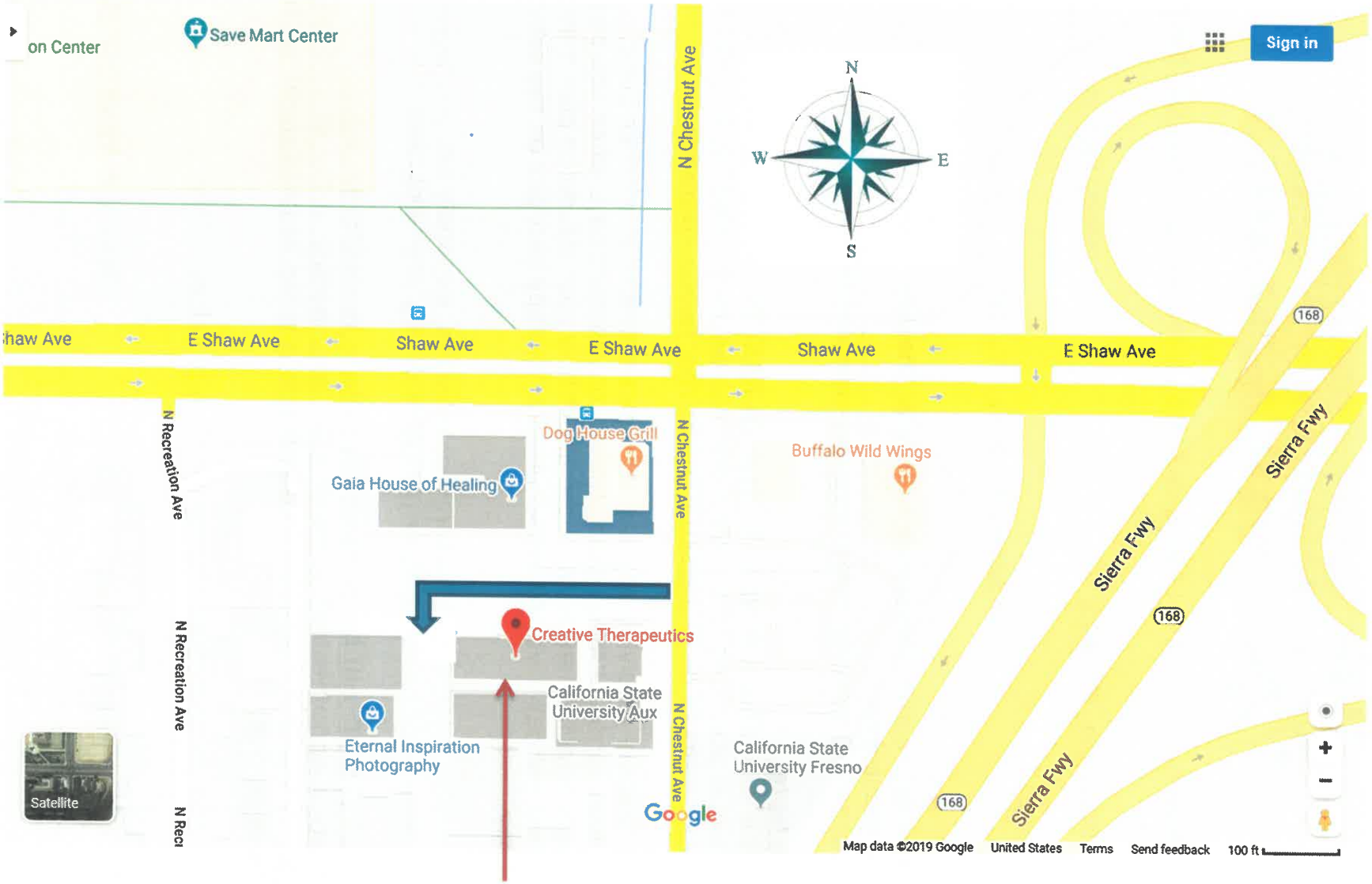
PRIMARY INSURANCE: _____

INSURED'S NAME AND D.O.B.: _____

SECONDARY INSURANCE: _____

Have you had physical therapy this year? Yes_____ No

If YES, How many times this current year and when? _____



MAIN ENTRANCE
2763 E. Shaw Ave Suite 102