



Physical Therapy & Rehabilitation Department

Dear MOS patient,

The physicians at Muir Orthopedic Specialists are owners of the physical therapy and rehabilitation departments at: 2405 Shadelands (Walnut Creek), 5201 Norris Canyon Rd #300 (San Ramon) and 350 John Muir Parkway (Brentwood). The medical group has individually selected and trained the staff in this department. Clinicians who are employed by MOS typically spend a half day a month observing surgery and participate in monthly physician lectures. These are some of the educational and training tools MOS uses to enhance patient care and develop strong communication between patients, physicians, and rehabilitation staff.

However, the MOS physicians realize that this community offers several therapy locations and you are under no obligation to have your rehabilitation take place at our facility. Furthermore, if you feel the distance you have to travel to attend appointments at any of our locations is too great, we would be happy to provide you with a list closer to your home or work.

Sincerely,

Dr. Miranda
President of Muir Orthopedic Specialists

_____ I understand the above statement and would like to receive treatment at this facility.

_____ I understand the above statement and would like to receive treatment at a different facility.

Patient signature

Leading Edge Care, Old Fashioned Caring

Mailing Address P.O. Box 31396 – Walnut Creek, CA 94598

CONFIDENTIAL COMMUNICATIONS PREFERENCE

Please select all that applies to your needs. Date and sign below.

PROTECTED HEALTH INFORMATION

Please see checked boxes below for authorization of release of PHI: (i.e. surgery type, date, location, Diagnostic type, date, location, etc.)

DO NOT LEAVE A MESSAGE OTHER THAN TO RETURN CALL.

Y N Leave results/PHI on answering machine and/or voice mail.

Y N Number(s) authorized to leave messages regarding PHI.

1. (____)_____

2. (____)_____

3. (____)_____

Addresses to mail PHI information to:

Persons authorized to receive PHI

Name (____) Phone Relationship

Name (____) Phone Relationship

Billing statements and correspondence:

Any correspondence related to your health information will be automatically mailed to your home address unless indicated otherwise. Do you agree to this? Yes No

If No, please provide alternative address:

Address City State Zip Code

I _____ acknowledge in signing this document, then I am giving Muir Orthopedic Specialists permission to release PHI (Private Health Information) to specified people and places listed above.

Parent/Guardian Signature

Date

Patient Medical History and Health Risk Profile

Patient Name: _____ Date: _____
 Age: _____ Height: _____ Weight: _____ Gender: Male () Female ()

Emergency contact:

Name: _____ Phone: _____
 Relationship: _____

1) Problems to be treated today: _____

Have you had treatment for this problem before? () Yes () No When: _____

Please describe the type of treatment: _____

Have you had surgery associated with this problem? () Yes () No

If so, please list date and type: _____

2) Do you have any other condition that is aggravated by exercise? _____

3) Please list the names of any primary care physician / internist / cardiologist that you are seeing, or have seen in the past:

Name: _____ Name: _____

Phone: _____ Phone: _____

4) Are you currently pregnant? () Yes () No

5) Do you need assistance with any of the following?:

Transportation	Yes	No	Meals	Yes	No
Shopping/Errands	Yes	No	Personal Care	Yes	No
Domestic chores	Yes	No	Other _____	Yes	No

6) Has your illness / disability caused any of the following:

Financial Problems	Yes	No	Family Problems	Yes	No
Emotional Problems	Yes	No	Other _____	Yes	No

7) Do you have or have you had any of the following:

Feel faint or dizzy	Yes	No	Osteoporosis	Yes	No
Frequent pain in heart or chest	Yes	No	Known heart disease	Yes	No
Pacemaker	Yes	No	Diabetes	Yes	No
Headaches	Yes	No	Swollen ankles	Yes	No
Nervous disorders	Yes	No	Kidney problems	Yes	No
Allergies	Yes	No	Heat sensitivity	Yes	No
Seizures	Yes	No	Hernia	Yes	No
Balance problems	Yes	No	Metal implants	Yes	No
Hearing Problems	Yes	No	Vision problems	Yes	No
High cholesterol	Yes	No	High blood pressure	Yes	No
Cancer	Yes	No	Low blood pressure	Yes	No
			Tuberculosis	Yes	No
			Hepatitis	Yes	No

8) Please circle the closest answer or leave item blank if you do not know:

Cigarettes (per day)	Never	1-5	10-20	30-40	>50
Alcoholic drinks (per week)	Never	1-5	10-20	>20	
Cardiovascular Fitness (per week)	None	Occasional/Recreational		3+ days/week for at least 15 min.	

9) Respiratory Status: Normal Moderate Severe (shortness of breath with mild exertion)

For office use only: I have reviewed the Health Risk Profile and the following is appropriate:

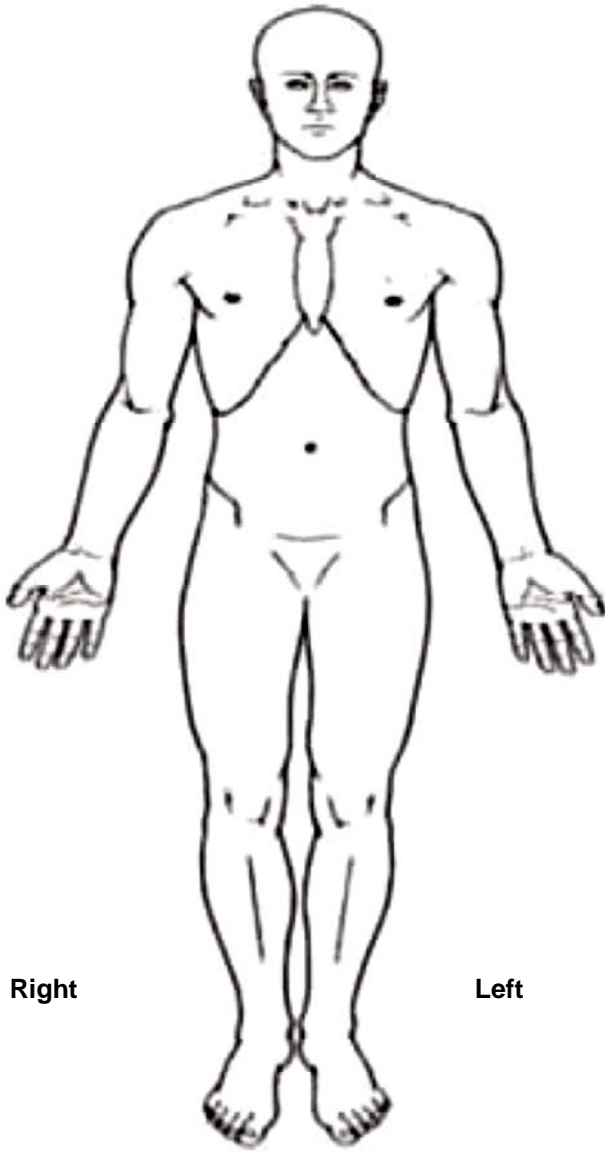
- Contact MD with CV Screening Request Form or request results of exercise test within last 2 years;
- Further cardiovascular screening is not necessary at this time.

Clinician Signature: _____

WHERE IS YOUR PAIN NOW?

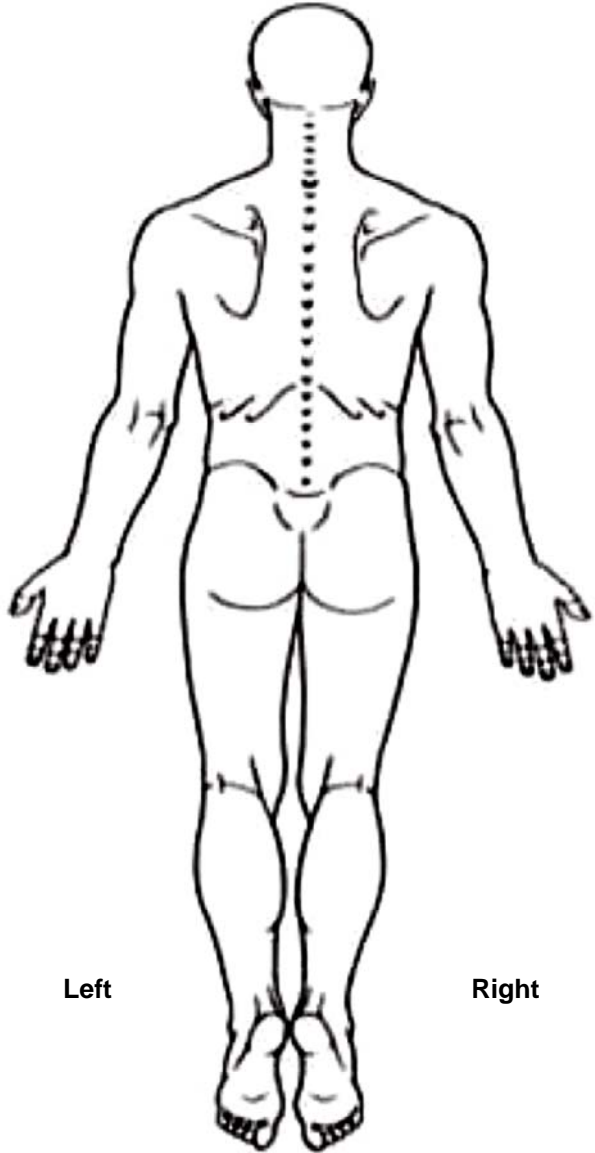
Mark the areas on your body where you feel the described sensations.

ACHE	NUMBNESS	SPINS & NEEDLES	BURNING	STABBING
AAA	OOO	---	XXX	///
AAA	OOO	---	XXX	///
AAA	OOO	---	XXX	///



Right

Left



Left

Right

PLEASE MARK ON THE LINE WITH AN X THE DEGREE OF PAIN NOW

NO PAIN WORST PAIN

ARE YOU NOW: BETTER _____ WORSE _____ SAME _____ SINCE THE PROCEDURE

Name: _____ Date: _____

