THE SHEPHERD CENTER FOR INTEGRATIVE HEALTH

Appointment Information and Forms

Below is important information you will need regarding your upcoming appointment. Please call or email if you have any questions prior to your appointment.

- **Parking:** Enter parking lot off Center Ridge or turn on Linden and park on west side. Disabled parking available
- **Check in:** Have a seat inside waiting room. Restroom keys are on the table inside our waiting room. We may be finishing a prior appointment and will be with you soon.
- **Payments:** Payment is due at the time services in the form of cash, check, (please make out to Shepherd Physical Therapy), or credit card. I accept HSA and FSA cards.
- **Insurance:** We are not contracted with any medical insurers, however, you may be eligible for insurance reimbursement depending on your **Out of Network Outpatient Physical Therapy** benefits. I will provide invoices for insurance reimbursement, as well as Flexible Spending Account and Health Savings Account reimbursement, **upon request**. **Patients with Medicare**: I am **not** a Medicare Provider, please contact me by phone prior to your appointment to discuss treatment and paperwork policies.
- **Cancellation Policy:** If you must cancel or change an appointment, I request that you give a **48 hour notice** prior to your scheduled appointment time by calling 216-772-1636. There will be a **$75.00** cancellation/no show fee if not given 24 hour notice. Emergency situations will be taken into consideration.
- **What to bring/wear**: Bring any relevant medical reports including CDs of xrays/MRIs. Bring or wear flexible comfortable clothes that allow us to view and treat your body…i.e. workout shorts/pants, tank tops for women, old and new (running/walking/cycling/etc.), and any orthotics.
- **Home Exercise Photos**: Many clients have found it helpful to have photos taken of them doing prescribed home exercises during their appointments to ensure memory of proper form/technique. Bring a cell phone or camera to your session if you are interested in having photos available for your personal use.
- **PT and PT Student Observation**: On occasion, we have other therapists and students who wish to observe our treatment approach. we will ask your permission prior.

Office
20525 Center Ridge Road. Suite 137
Rocky River, OH 44116

Contact
info@tscfih.com
216.772.1636

The Shepherd Center for Integrative Health/Shepherd Physical Therapy, LLC

1. Physical Therapy Consent to Treatment

Informed Consent for Treatment: The term "informed consent" means that the potential risks, benefits, and alternatives of physical therapy treatment have been explained to me. The therapist provides a wide range of services and I understand that I will receive information at the initial visit concerning the treatment and options available for my condition.

Potential Benefits: May include an improvement in my symptoms and an increase in my ability to perform my daily activities. I may experience increased strength, awareness, flexibility and endurance in my movements. I may experience decreased pain and discomfort. I should gain a greater knowledge about managing my condition and the resources available to me.

Potential risks: I understand I may experience an increase in my current level of pain or discomfort, or an aggravation of my existing injury. This discomfort is usually temporary; if it does not subside in 24 hours, I agree to contact my physical therapist.

No warranty: I understand that my physical therapist cannot make any promises or guarantees regarding a cure for or improvement in my condition. I understand that my physical therapist will share with me her opinions regarding potential results of physical therapy treatment for my condition and will discuss treatment options with me before I consent to treatment.

Alternatives: If I do not wish to participate in the therapy program, I will discuss my medical, surgical or pharmacological alternatives with my physician or primary care provider.

2. Cancellation Policy:

If you must cancel or change an appointment, we request that you give us **48 hour notice** prior to your scheduled appointment time by calling 216.772.1636. There will be a $75.00 cancellation fee if we are not given **48 hour notice.** Emergency situations excepted.

I have read the above information and I consent to physical therapy evaluation and treatment. By initialing above and signing below, I acknowledge that I have read, understood and will abide by the conditions and policies noted on this consent form.

Patient's signature: _____

Print name: _____

Date: _____

Therapist's Signature/Date: _____

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HIPAA REGULATIONS

Privacy Practices

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

Legal Duty

The law requires us to: 1) Keep your medical information private. 2) Give you notice describing our legal duties and privacy practices. 3) Notify you of any changes in our privacy practices.

Use and Disclosure

To follow are different ways that we are permitted to use and disclose medical information. We will not use or disclose any medical information not listed without specific written authorization from you.

Treatment: We may use medical information about you to provide you with medical treatment or other services related to your care. We may disclose medical information about you to doctors, nurses, technicians or other people involved in your care. We may also share medical information about you to your other health care providers to assist them in treating you.

Billing: If you submit an invoice to your health plan for reimbursement, your health plan will be informed of dates of services and the procedure codes on that invoice. We will not use or disclose any medical information to your health plan without specific written authorization from you.

If you have any question about any of our policies or your rights, please feel free to ask us.

Your signature below indicates your understanding and acceptance of the above privacy practices.

Patient's signature: _____

Print name: _____

Date: _____

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The Shepherd Center for Integrative Health

Questionnaire

Date:_____

Name: _____

Address:_____City:_____State: _____Zip:_____

Best Contact Phone Number: _____ Alternate number: _____

Email: _____

Emergency Contact: Name/phone:_____

Date of Birth/Age:_____

Occupation: _____

Marital Status: _____

Primary Care Physician:_____ Phone:_____

Other Health Providers (chiropractor, orthopedist, pilates instructor, personal trainer, etc)

Provider: _____Phone:_____

Provider: _____Phone:_____

Provider: _____Phone:_____

Whom can I thank for you referring you? _____

Health Questionnaire

How do you feel you health is?	Poor	Fair	Good	Great
How well do you sleep?	Poor	Fair	Good	Great
Do you smoke?	Yes	No		
Do you consume alcohol?	Yes	No		
Do you use recreational drugs?	Yes	No		
Do receive regular physicals?	Yes	No	Date of last physical _____	

Medications/Supplements: List medications, prescriptions, and nonprescription drugs taken regularly. Please include dosage, frequency, and how long you have taken them. You may attach a separate sheet if preferred

_____

_____

_____

_____

_____

_____

Medical/Trauma History: Consider chronological history of trauma and illness, beginning at birth and include dates

Personal history of past injuries (falls, car accidents, fractures, sprains, concussions):

_____
_____
_____
_____
_____

History of hospitalizations or surgeries:

_____
_____
_____
_____

Major illnesses:

_____
_____
_____
_____

Please check and describe (with dates) if you have experienced any of the following:

_____ Numbness/Tingling/Weakness
_____ Cancer
_____ Shortness of Breath/Cough/Asthma
_____ Gastrointestinal disorders/ulcers/
_____ Acid reflux
_____ Rupture or hernia
_____ Chest Pain/Heart/Blood Pressure
_____ Anemia
_____ Kidney/Liver/Gallbladder disorders
_____ Urinary Tract Infections, Stones
_____ Communicable Disease (Hepatitis, TB)
_____ Vision/Hearing Loss
_____ Skin Lesions or Rash
_____ Frequent colds, sinus or nose trouble
_____ Diabetes
_____Chronic or recurrent eye/ear trouble
_____ Concussion or hit to the head
_____ Depression/Anxiety
_____ High/Low Metabolism
_____ Weight Loss or Gain
_____ Thyroid Trouble
_____ Fatigue
_____ Insomnia
_____ Snoring
_____ Fainting Spells
_____ Stroke
_____ Paralysis
_____ Epilepsy, seizures, convulsions
_____ Varicose veins
_____ Hemorrhoids
_____ Painful or difficult urination
_____ UTI/kidney stones

Do you frequently have cold hands and feet? Yes No

Do your nail break easily? Yes No

Is your skin dry? Yes No

Does the cold weather bother you? Yes No

Does the hot weather bother you? Yes No

Are there any other medical conditions that I should be aware of?

_____
_____

Are you receiving treatment for any other medical conditions?

Please list any activities that you used to do but you are unable to do now

Nutritional History

Do you have any food allergies or sensitivities?

Do you follow any particular dietary programs? What? _____

Please share an example of what you eat and when during a typical weekday

For each food item, mark the column that indicates how often you eat that food.
(D=Daily, W=Weekly, M=Monthly, N=Never)

	3XD	D	3XW	W	3XM	M	N
Dairy products							
Caffeinated Coffee/Tea							
Artificial sugar							
Add Salt to foods							
Bread/grains							
Sugar							
Regular Soft Drinks							
Diet Soft Drinks							
Alcohol							
Fresh Vegetables							

Please list and date chronologically any change in occupation, residence, or relationships in the last ten years (i.e. death of spouse, divorce, separation, death in family, change of financial status, etc)

_____
_____
_____

How many hours per week do you exercise?

a. Biking: _____ b. Running: _____ c. Swimming: _____d. Weights: _____

e. Other (please describe): _____

Please list your hobbies and other activities you participate in:

_____
_____
_____

What are your goals for therapy?

_____
_____
_____
_____

Symptom/Specific Complaint Information

Concern #1:

a. When did this concern/pain start? How did this concern/pain start? What do you think caused it?
_____
_____
_____

b. What activities or positions bring on symptoms? How long can you do that activity before onset of symptoms?
_____

c. Does it last after activity? With which activities and how long?
_____

d. Are there any positions/activities that help ease the pain, e.g., rest, ice?
_____

e. Do symptoms wake you up at night? What time or after how many hours of laying down?

_____

f. Do you wake up with it? Doe you go to bed with it? _____

g. Since onset are your symptoms better, worse, the same? _____

h. Have you had treatment for this condition in the past? Yes No 5

If so, what type? _____
Was it helpful? Yes No

i. What is the intensity of your pain/symptoms? (Please circle)

None 1 2 3 4 5 6 7 8 9 10 Worst imaginable

j. Please indicate anything else about yourself that you suspect maybe related to your condition.

_____
_____
_____

Symptom/Specific Complaint Information

Concern #2:

a. When did this concern/pain start? How did this concern/pain start? What do you think caused it?
_____
_____
_____

b. What activities or positions bring on symptoms? How long can you do that activity before onset of symptoms?
_____

c. Does it last after activity? With which activities and how long?
_____

d. Are there any positions/activities that help ease the pain, e.g., rest, ice?
_____

e. Do symptoms wake you up at night? What time or after how many hours of laying down?

_____

f. Do you wake up with it? Doe you go to bed with it? _____

g. Since onset are your symptoms better, worse, the same? _____

h. Have you had treatment for this condition in the past? Yes No

If so, what type? _____
Was it helpful? Yes No

i. What is the intensity of your pain/symptoms? (Please circle)

None 1 2 3 4 5 6 7 8 9 10 Worst imaginable

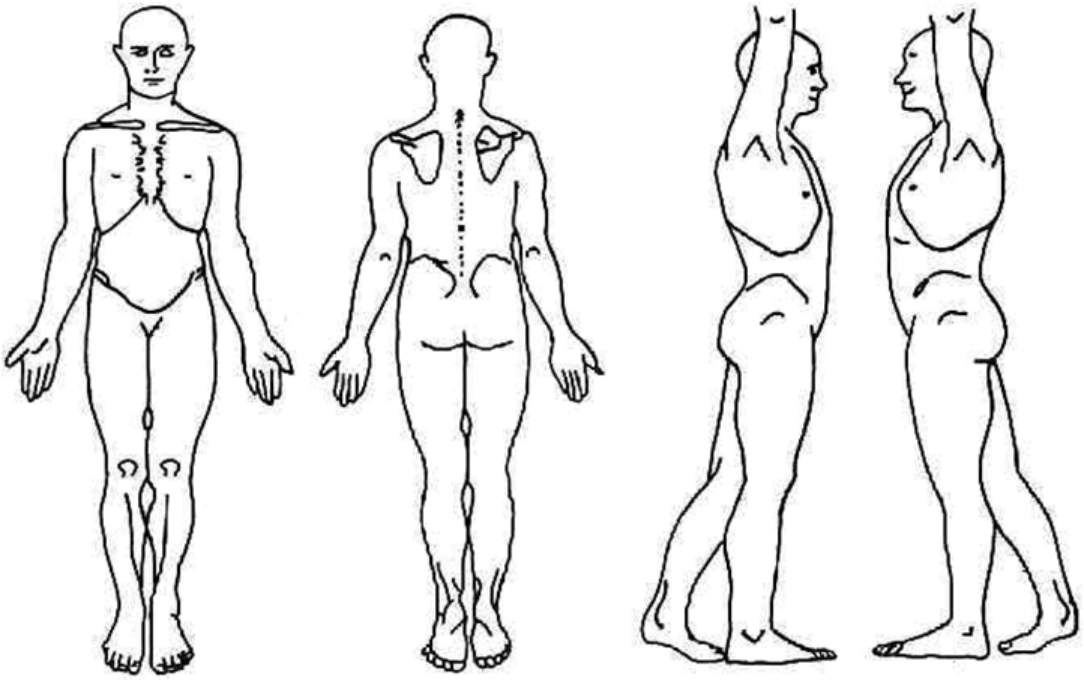
j. Please indicate anything else about yourself that you suspect maybe related to your condition.

_____

_____

_____

Please mark the locations of you pain/symptoms on the diagrams below.



Patient Signature: _____ Date: _____

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