Campbell University Inc. Student Pro Bono Clinic

New Patient Paperwork

Name: _____ **DOB:** ____/_____/_____ **Age:** _____

Gender: M / F **Occupation:** _____

Phone number: _____ **email:** _____

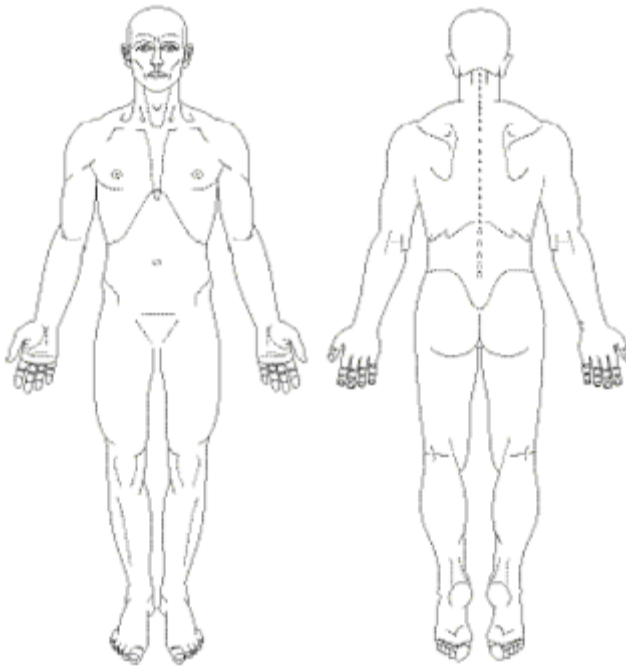
Address: _____

Reason for visit: _____ **Date of onset/injury:** _____

Have any diagnostic tests have been performed for this problem? (circle all that apply):

x-rays Bone scan Doppler ultrasound MRI EMG CT Scan Bloodwork Other: _____

Please circle where you hurt:



Since it has started, pain is (choose one):
getting worse improving unchanged

Describe your pain (circle all that apply):
sharp dull aching sore throbbing cramping burning stabbing squeezing constant intermittent

What makes it worse:
_____

What makes it better:
_____

Rate your pain on 0-10 scale (0 is no pain, 10 is the worst you can imagine):

Present: 0 1 2 3 4 5 6 7 8 9 10

List all medications/supplements/vitamins/over-the-counter you currently take including dosage and frequency:

Name: _____ Frequency: _____ Dose: _____
Name: _____ Frequency: _____ Dose: _____
Name: _____ Frequency: _____ Dose: _____
Name: _____ Frequency: _____ Dose: _____
Name: _____ Frequency: _____ Dose: _____

List all allergies you may have: _____

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Please circle yes or no if you have or have had any of the following conditions:

	Yes/No		Yes/No
Smoke/chew tobacco	Y/N	Emphysema	Y/N
Packs per day: ____		COPD	Y/N
Use of illegal substances	Y/N	Asthma	Y/N
Drink alcoholic beverages	Y/N	Kidney disease	Y/N
Amount per week: ____		Stroke	Y/N
High blood pressure	Y/N	Depression	Y/N
High cholesterol	Y/N	Lupus	Y/N
Bowel/bladder dysfunction	Y/N	Fibromyalgia	Y/N
Acid reflux or ulcers	Y/N	Osteoarthritis	Y/N
Thyroid disorder	Y/N	Rheumatoid arthritis	Y/N
Bleeding disorder	Y/N	Headaches or migraines	Y/N
Seizures/epilepsy	Y/N	Dizziness or fainting	Y/N
Lyme disease	Y/N	Cancer (site: _____)	Y/N
Diabetes	Y/N	Recent infection	Y/N
Heart attack	Y/N	Recent anticoagulant medicine use	Y/N
Cardiac bypass	Y/N	Recent antibacterial medicine use	Y/N
Cardiac stents	Y/N	Consistent steroidal medicine use	Y/N
Angina/chest pain	Y/N	Multiple sclerosis	Y/N
Hepatitis	Y/N	Congestive heart failure	Y/N

In the past 3 months have you experienced

	Yes/No		Yes/No
Persistent pain at night	Y/N	Change in/problems with bowel/bladder	Y/N
Fevers, chills or night sweats	Y/N		
Unexplained weight loss	Y/N	Changes in hearing	Y/N
Unwarranted fatigue	Y/N	Changes in mental abilities	Y/N
Unusual lumps or growths	Y/N	Frequent or severe headaches with no history of injury	Y/N
Shortness of breath	Y/N		
Constant and severe pain in leg/arm	Y/N	Problems with swallowing	Y/N
Frequent or severe abdominal pain	Y/N	Speech changes	Y/N
Frequent nausea or vomiting	Y/N	Changes in vision	Y/N
Ringing in ears	Y/N	Problems with balance/falling	Y/N
Sudden unexplained weakness	Y/N	Fainting spells/blackouts	Y/N
Tingling or numbness in both of your Arms or both legs	Y/N	New moles or skin lesions	Y/N

Patient Signature: _____
(Guardian if patient is under 18 years old)

Date: _____

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Attendance/No Show Policy

Welcome to Campbell University Inc. Student Pro Bono Clinic. We understand that sometimes you will need to either change or cancel a scheduled appointment. In order to provide care for all of our patients, we do have an attendance policy that we ask you to review and sign.

1. If you are unable to attend a scheduled appointment please call the clinic as soon as you are able. We do ask for 24-hours notice as this may allow the staff to provide services for another patient during the canceled time.

2. If you are more than 20 minutes late for your appointment, you will be asked to reschedule your appointment.

3. If you do not show for 3 appointments without giving a cancellation notice, rehabilitation services will be discontinued.

If you have any questions regarding this policy, please speak with your physical therapist.

I have read and understand the above policy.

_____ _____

Client Signature Date

Campbell University Inc. Student Pro Bono Clinic

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CONFIDENTIALITY AGREEMENT

Campbell University Inc. Student Physical Therapy Clinic provides physical therapy students with the opportunity to learn care of patients through experience, observation and participation. Per laws and professional ethics, it is required that all health science students maintain confidentiality of patient information to the greatest extent possible. The clinic upholds this commitment to confidentiality to the highest degree. There are a few scenarios in which confidential information may be disclosed.

1. When upholding confidentiality may result in physical harm to myself or others.
2. In the instance involving abuse (physical, sexual, psychological, etc.) of any individual.

AUTHORIZATION TO RELEASE INFORMATION (HIPAA)

I understand as part of my care, Campbell University Inc. Student Physical Therapy Clinic is in possession of health records. Under law, the use and disclosure of these records is prohibited. Signing this form gives authorization to students and faculty of the clinic to use and disclose my health information in order to carry out proper treatment as well as assist in academic advancement. My health information will not be disclosed to anyone else unless indicated below. If Campbell University Inc. Student Physical Therapy Clinic needs to contact me regarding services provided, I authorize this communication. I have the right to refuse to sign this authorization of release but in doing so, the clinic has a right to decline to provide me services.

Name:_____ Date of Birth:___/___/_____

[ ] I authorize the release of information obtained from Campbell University Inc. Student Physical Therapy Clinic to the following:

[ ] Spouse _____
[ ] Child(ren) _____
[ ] Other _____

[ ] My health information is NOT to be released to anyone

This Authorization to Release Information will remain in effect until terminated by me in writing.

Contact Information

Please communicate with me by:

[ ] Home phone _____
[ ] Cellphone _____
[ ] Email _____

The best time to reach me is (circle): Sun Mon Tue Wed Thurs Fri Sat
Morning Afternoon Evening

Signed:_____ Date:___/___/_____

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Release of Liability and Agreement to Treat

In exchange for participation/treatment in the Campbell University Inc. Student Physical Therapy clinic, I agree to the following:

1. I agree to adhere to any written rules or warnings within the clinic.
2. I agree to adhere to any oral instructions given to me by either the physical therapy students or the DPT faculty.
3. I understand there are certain risks associated to the above described activities and I assume full responsibility for personal injury. If an injury were to occur by fault of my own, my family, the DPT students, the DPT faculty, or third parties, I release Campbell University and the Campbell University DPT program from the injury, loss or damage arising from my use of or presence upon the facilities of Campbell University.
4. I understand that the therapy I will receive will be provided by physical therapy student who are supervised by licensed physical therapists.
5. I understand that this clinic is run fully by volunteers and I will not be charged for any service I receive.
6. I give my permission for Campbell University DPT students to care for me and provide physical therapy services.

I have read all of the above conditions and understand them. I further understand that by signing this release, I voluntarily surrender certain legal rights.

Signature: _____ Date: ___/___/_____

Photo Release

I give permission to use my image as marked in the section(s) below. This includes the display, distribution, publication, transmission, or other use of images, photographs, or videos taken of myself. These images will be used in brochures, newsletters, videos, digital images, etc. such as on the Campbell University DPT program website.

[ ] I deny permission to use my image at all.

[ ] I grant permission to use my image in the following scenarios (mark all that apply):

[ ] **Limited Usage:** My image is allowed to be used within the DPT program only and NOT within the larger community

[ ] **Limited Usage:** My image is allowed to be used in educational materials only. This includes within the DPT program and the larger community.

[ ] **Limited Usage:** My image is only to be used on printed material, NO digital or video use.

[ ] **Unrestricted Usage:** I give unrestricted usage of my images to be used in print, video, and digital media. I agree that my images will be used for a variety of purposes. I do not require further notification in order to use my images. I understand that my last name will not be used in conjunction with any of my images.

Signature: _____ Date: ___/___/_____