Essex Pro Therapy

410 Centre Street
Nutley, NJ 07110
Office: 551.235.9200

Date: ____/____/____

Nombre: _____ # de Social: _____-_____-_____

Direccion: _____ Ciudade: _____ Estado: _____ Codigo Postal: _____

Fecha de Nacimieno: ____/____/____ Genero: **M / F** Edad: _____ Estado Civil: _____ # de Hijos:_____

Empleador: _____ Correo Electronico: _____

Ocupacion: _____ Tiempo Completo Medio Tiempo, Discapacitado/a

de Casa: _____ # de Trabajo: _____ # de Celular: _____

Nombre de Doctor: _____ Ciudad: _____ # de Telefono: _____

Queja principal: _____

El problema empezo? ☐ una semana ☐ un mes ☐ un ano Fecha: _____

Varios episodios anteriores? ☒ Si ☐ No

Dolor peor ahora encomparacion con multiples episodes anteriores? ☐ Si ☐ No

Que actividades no puede hacer? *(caminar, correr, cepillar los dientes, levanter el brazo, etc)*_____

Tiene o ha tenido cancer en el passado? ☐ Si ☐ No HIV/AIDS? ☐ Si ☐ No

Estas embarazada o amamantando? ☐ Si ☐ No Hepatitis B or C? ☐ Si ☐ No

Anteriormente usted a visto un Quiropractico, Terapia Fisica, Especialista de Dolor ☐ Si ☐ No
Cuando? _____ Resultados? ☐ Bueno ☐ Malo ☐ Ningun Cambio _____

Ha hecho radiografias? ☐ Si ☐ No Area de imagem? _____
Nombre de la facilidad: _____ Cuando? _____

Ha hecho MRI? ☐ Si ☐ No Area de imagem? _____
Nombre de la facilidad: _____ Cuando? _____

Examen de los Nervios (NVC/EMG's) ☐ Si ☐ No Cuando? _____ Parte de Cuerpo? _____
Inyeccion epidural de esteroides? ☐ Si ☐ No Cuando? _____ Parte de Cuerpo? _____

Patient signature: _____ Date: _____

Financial Hardship Agreement

By virtue of my signature set forth below, I hereby request that my doctor and institutional provider reduce their usual and customary charges in order to allow me to receive care required by my current health care condition.

I represent and warrant that my financial status is such that I would be unable to receive diagnostic and treatment services if usual and customary charges were applied to the services required by my condition.

I recognize and acknowledge that this Agreement to reduce usual and customary charges is undertaken for my benefit, that this is dependent on my financial status as of the date of this Agreement, that it will result in a fee arrangement distinct from the one usually in place for the services in question and that the arrangement represents a confidential agreement entered into by the parties for the sole and exclusive benefit.

In light of the foregoing, I hereby agree to the following:

1. I will not seek reimbursement for the services rendered to me under this arrangement from any insurance company, employer, welfare program, government entitlement program (Medicare or Medicaid), Workers' Compensation program or other third-party payor.
2. If any third party payor responsible for all or part of the payment due as a result of services rendered under this Agreement contacts me, I will notify such payor of this arrangement and the reduced fees achieved as a result of the Agreement.
3. If the financial circumstances which cause me to qualify for financial hardship under this Agreement change, I will immediately notify my doctor and institutional provider in order to allow them to determine whether my financial status will then allow me to pay usual and customary charges for the services which I receive from that date forward.

Patient Name: _____

Patient Signature: _____

Date Signed: _____

Witness Signature: _____

Date Signed: _____

Essex Pro Therapy

410 Centre St
Nutley, NJ
07110

ASSIGNMENT OF BENEFITS & ADVANCE PATIENT NOTIFICATION FORM FOR ALL SERVICES

Signing this form helps ensure payment and acknowledges notification of your rights and coverage.

Your healthcare services are provided by Doctors, Physician Assistants, Acupuncturists and Physical Therapists of Spine. The healthcare providers are licensed in the State of New York and/or New Jersey.

I hereby assign to Essex Pro Therapy my right to receive reimbursement for medically necessary health care services, including surgical services, provided to me and/or to any beneficiary under my health benefits policy. I hereby authorize and direct my insurance carrier to make all such payments directly to for all claims. Such payments should be forwarded by my insurance carrier directly to Essex Pro Therapy at the address below. In the form of a check payable to Essex Pro Therapy and me, as joint payee. In alternative, a check payable to Essex Pro Therapy. I understand that I have the right, upon request, to be provided the amount, or estimated amount, I will be billed. Please note that such estimates cannot account for unforeseen medical circumstances that may arise while the services are performed. Please further note that such estimates are as of the date of provision of the information to you, and may be subject to change. I understand and agree that, if the check from the insurance company is made payable to Essex Pro Therapy and me as joint payees, that I promptly will endorse and deliver the check to Essex Pro Therapy, or will write a personal check for the full payment that is due within one week of receiving payment. I am aware that my health care provider will accept my insurance plan's out of network benefits as assigned if the provider does not participate in the plan. I will provide the entire Explanation of Benefits from my insurance carrier relating to the services provided.

Office address

Essex Pro Therapy

410 Centre Street

Nutley, NJ 07110

My signature below acknowledges my accepted information above and confirms my voluntary choice to obtain services from this provider at (by) Essex Pro Therapy I understand that I am responsible for payment for all services rendered and I agree to pay all charges denied or not covered by my insurance carrier. This assignment in no way releases me from this responsibility and imposes no obligation on Essex Pro Therapy upon my behalf.

I have read and understand and agree to the above. A photocopy of this agreement shall be considered as effective and valid as the original.

Sign Name here

Print Name Here

Date

Patient Name if Signing as Legal Representative

Type of Representative Authority

410 Centre Stree:
Nutley, NJ 0711C

Essex Pro Therapy

Surprise Billing Protection Form

The purpose of this document is to let you know about your protections from unexpected medical bills. It also asks whether you would like to give up those protections and pay more for out-of-network care.

IMPORTANT: You aren't required to sign this form and shouldn't sign it if you didn't have a choice of health care provider when you received care. You can choose to get care from a provider or facility in your health plan's network, which may cost you less.

If you'd like assistance with this document, ask your provider or a patient advocate. Take a picture and/or keep a copy of this form for your records.

You're getting this notice because this provider or facility isn't in your health plan's network. This means the provider or facility doesn't have an agreement with your plan.

Getting care from this provider or facility could cost you more.

If your plan covers the item or service you're getting, federal law protects you from higher bills:

- When you get emergency care from out-of-network providers and facilities, or
- When an out-of-network provider treats you at an in-network hospital or ambulatory surgical center without your knowledge or consent.

Ask your health care provider or patient advocate if you need help knowing if these protections apply to you. If you sign this form, you may pay more because:

- You are giving up your protections under the law.
- You may owe the full costs billed for items and services received.
- Your health plan might not count any of the amount you pay towards your deductible and out-of-pocket limit. Contact your health plan for more information.

You shouldn't sign this form if you didn't have a choice of providers when receiving care. For example, if a doctor was assigned to you with no opportunity to make a change.

Before deciding whether to sign this form, you can contact your health plan to find an in-network provider or facility. If there isn't one, your health plan might work out an agreement with this provider or facility, or another one.

Prior authorization or other care management limitations

Except in an emergency, your health plan may require prior authorization (or other limitations) for certain items and services. This means you may need your plan's approval that it will cover an item or service before you get them. If prior authorization is required, ask your health plan about what information is necessary to get approval.

Understanding your options

You can also get the items or services described in this notice from providers who are in-network with your health plan.

More information about your rights and Protections

Visit http://www.cms.gov/nosurprises/consumers for more information about your rights under federal law.

By signing, I give up my federal consumer protections and agree to receive out-of-network care.

With my signature, I am saying that I agree to get the items or services from (select all that apply):

☐ Essex Pro Therapy

With my signature, I acknowledge that I am consenting of my own free will and am not being coerced or pressured. I also understand that:

- I'm giving up some consumer billing protections under federal law.
- I may get a bill for the full charges for these items and services, or have to pay out-of-network cost-sharing under my health plan.
- I was given a written notice today explaining that my provider or facility isn't in my health plan's network, the estimated cost of services, and what I may owe if I agree to be treated by this provider or facility.
- I get the notice either on paper or electronically, consistent with my choice.
- I fully and completely understand that some or all amounts I pay might not count toward my health plan's deductible or out-of-pocket limit.
- I can end this agreement by notifying the provider or facility in writing before getting services.

IMPORTANT: You don't have to sign this form. But if you don't sign, this provider or facility might not treat you. You can choose to get care from a provider or facility in your health plan's network.

Patient's signature

Or

Guardian/authorized representative signature

Print name of patient

Print name of guardian/authorized representative

Date and time of signature

Date and time of signature

Take a picture and/or keep a copy of this form.

It contains important information about your rights and

Essex Pro Therapy

480 Centre Street
Nutley, NJ 07110

HIPAA Omnibus Notice of Privacy Practice

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors may use and disclose your "Protected Health Information" (PHI) to carry out treatment, payment or healthcare operations, and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI. PHI is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

Notice is provided to you as a requirement of HIPAA. There are several other privacy laws that also apply to HIV-related information, family planning information, mental health information, psychotherapy notes, and substance abuse information. These laws have not been superseded, and the disclosure of such information is specifically subject to more strict privacy standards and most uses and disclosures require express authorization from you.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION:

The following describes the ways we may use and disclose your PHI. Except for the purposes described below, we will use and disclose PHI only with your written permission.. You may revoke such permission at any time by writing to our practice Privacy Officer.

For Treatment - We may use and disclose PHI for your treatment and to provide you with treatment-related health care services. For example, we may disclose PHI to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

For Payment - We may use and disclose PHI so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your Appointment.

For Health Care Operations- We may use and disclose PHI for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the orthopedic or physical therapy care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services - We may use and disclose PHI to contact you to remind you that you have an appointment with us. We also may use and disclose PHI to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

HOW WE MAY USE AND DISCLOSE PHI IN THE FOLLOWING CIRCUMSTANCES:

Required by Law We may use or disclose your PHI if law or regulations requires the use or disclosure.

Public Health - We may disclose your PHI to a public health authority who is permitted by law to collect or receive the information. For example, the disclosure may be necessary to prevent or control disease, injury or disability; report births deaths; or report reactions to medications or problems with medical products.

Communicable Diseases- We may disclose your PHI, if authorized by law, to a person who might have been exposed to a communicable disease or might otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight- We may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. These health oversight agencies might include government agencies that oversee the health care system, government benefit programs, or other regulatory programs.

Food and Drug Administration - We may disclose your PHI to a person or company required by the Food and Drug Administration to report adverse events; track products; enable product recalls; make repairs or replacements; or conduct post-marketing reviews.

Legal Proceedings - We may disclose PHI during any judicial or administrative proceeding, in response to a court order or administrative tribunal (if such disclosure is expressly authorized), and in certain condition in response to a subpoena, discovery request, or other lawful process.

Law Enforcement - We may disclose PHI for law enforcement purposes, including information requests for identification and location; and circumstances pertaining to victims of a crime.

Coroners, Funeral Directors, and Organ Donations - We may disclose PHI to coroners or medical examiners for identification to determine the cause of death or for the performance of other duties authorized by law. We may also disclose PHI to funeral directors as authorized by law. PHI may be used and disclosed for cadaver organ, eye or tissue donations.

Research - We may disclose PHI to researchers when authorized by law, for example, if their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your PHI.

Threat to Health or Safety- Under applicable Federal and State laws, we may disclose your PHI to law enforcement or another health care professional if we believe in good faith that its use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose PHI if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security- When the appropriate conditions apply, we may use or disclose PHI of individuals who are Armed Forces personnel for activities believed necessary by appropriate military command authorities to ensure the proper execution of the military mission, including determination of fitness for duty, or to a foreign military authority if you are a member of that foreign military service. We may also disclose your PHI under specified conditions, to authorized Federal officials for conducting national security and intelligence activities including protective services to the President or others.

Workers' Compensation- We may disclose your PHI to comply with workers' compensation laws and similar government programs.

Inmates- We may use or disclose your PHI, under certain circumstances, if you are an inmate of a correctional facility.

Parental Access- State laws concerning minors permit or require certain disclosure of PHI to parents, guardians, and persons acting in a similar legal status. We will act consistently with the laws of this State (or, if you are treated by us in another state, the laws of that state) and will make disclosures following such laws.

are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract. Data Breach Notification Purposes: We may use or disclose your PHI to provide legally required notices of unauthorized access to or disclosure of your PHI.

USES & DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT AND OPT OUT:

Individuals Involved in Your Care or Payment for Your Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your PHI that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

Disaster Relief: We may disclose your PHI to disaster relief agencies that seek your PHI to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

Fundraising: In the event you are contacted for fundraising purposes, you have been opted out of such fundraising communications with each solicitation.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OUR USES AND DISCLOSURES:

The following uses and disclosures of your PHI will be made only with your written authorization:

1. Uses and disclosures of PHI for marketing purposes; and
2. Disclosures that constitute a sale of your PHI.

Other uses and disclosures of PHI not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose PHI under the authorization. But any disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

YOUR RIGHTS:

You have the following rights regarding PHI we have about you:

Right to Inspect and Copy: You have a right to inspect and copy PHI that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this PHI, you must make your request, in writing, to: Essex Pro Therapy HIPAA Privacy Officer, 410 Centre St, Nutley, NJ 07110. We have up to 30 days to make your PHI available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Medical Records: If your PHI is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your PHI in the form or format you request, if it is readily producible in such form or format. If the PHI is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

Right to Get Notice of a Breach: You have the right to be notified upon a breach of any of your unsecured PHI.

Right to Amend: If you feel that PHI we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to: Essex Pro Therapy 410 Centre Stree, Nutley, NJ 07110

Right to an Accounting of Disclosures: You have the right to request a list of certain disclosures we made of PHI for purposes other than treatment, payment and health care operations or for which you provided us with an authorization. To request an accounting of disclosures, you must make your request, in writing, to: Essex Pro Therapy 410 Centre St Nutley, NJ 07110

Right to Request Restrictions: You have the right to request a restriction or limitation on the PHI we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the PHI we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request restrictions, you must make your request, in writing, to: Essex Pro Therapy 410 Centre St Nutley, NJ 07110

We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your PHI to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If we agree, we will comply with your request, unless the information is needed to provide you with emergency treatment. Essex Pro Therapy 410 Centre St Nutley, NJ 07110

Out-of-Pocket-Payments: If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your PHI with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request. Essex Pro Therapy 410 Centre St Nutley, NJ 07110

Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we contact you by mail or at work. To request confidential communications, you must make your request, in writing, to: Essex Pro Therapy 410 Centre St Nutley, NJ 07110. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice: You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, please ask the front desk at any of our locations.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice and make the new notice apply to PHI we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, or for more information about the complaint process, contact: HIPAA Privacy Officer, 410 Centre St, Nutley, NJ 07110. All complaints must be made in writing. You will not be penalized for filing a complaint.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to PHI. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number (855-993-3331.

Essex Pro Therapy

41c Centre Street
Nutley, NJ 07110

HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

1. I, _____ authorize all medical service sources and health care providers to use and/or disclose the protected health information (PHI) described below to my Personal Representative(s) named as follows:

Essex Pro Therapy

2. This authorization for release of PHI covers the period of healthcare (check one):

a. ☐ from (date) _____ to (date) _____

OR b. ☐ all past, present, and future periods.

3. I hereby authorize the release of PHI as follows (check one):

a. ☐ I authorize the release of my complete health record (including records relating to mental healthcare communicable diseases, HIV or Arbs, and treatment of alcohol or drug abuse) OR

b. ☐ I authorize the release of my complete health record with the exception of the following information:

- ☐ Mental health records
- ☐ Communicable diseases (including HIV and AIDS)
- ☐ Alcohol/drug abuse treatment
- ☐ Other (please specify) _____

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as may direct.
5. This authorization to release information to my Personal Representative will automatically expire two (2) years following the termination of my enrollment with the Health Plan.
6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ _____

Signature of Member or Personal Representative Date

410 Centre Street
Nutley, NJ 07110

Essex Pro Therapy

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The privacy of your protected health information is important to us. We have provided you with a copy of our Notice of Privacy Practices. It describes how your health information will be handled in various situations. We ask that you sign this form to acknowledge you received a copy of our Notice of Privacy Practices.

If your first date of service with us was due to an emergency, we will try to give you this notice and get your signature acknowledging receipt of this notice as soon as we can after the emergency.

I have received the Privacy Notice for:

Print Name

Date

Patient Signature or Personal Representative

If personal representative, Describe relationship

☐ Initial ☐ Re-Eval ☐ Final

Date: _____/_____/_____

Name: _____ Age: _____ Gender: M / F

Height: _____ Weight: _____ Mechanism of Onset: ☐ Auto ☐ Acute ☐ Chronic ☐ Relapse

*History Remarks: _____

Range of Motion:

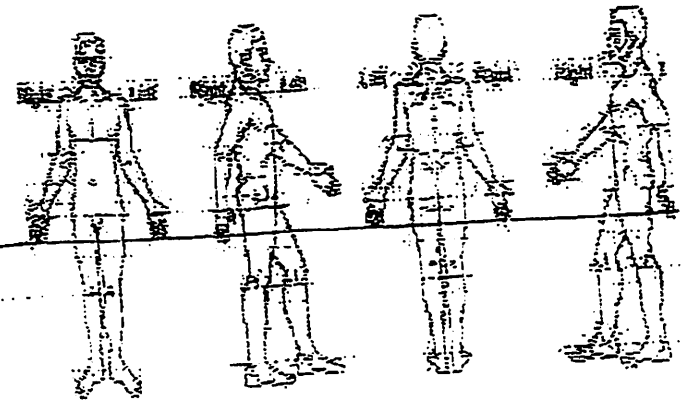
Cervical Spine:

Flexion	_____/80
Extension	_____/60
Lat Flxn-R	_____/45
Lat Flxn-L	_____/45
Rotation-R	_____/80
Rotation-L	_____/80

*Remarks: _____

Lumbar Spine:

Flexion	_____/90
Extension	_____/30
Lat Flxn-R	_____/25
Lat Flxn-L	_____/25
Rotation-R	_____/30
Rotation-L	_____/30



Reflexes: Bicep _____ Brachioradialis _____ Triceps _____ Patellar _____ Achilles _____

Dematomes: (Pinwheel Exam) Cervical: ☐ Hypoesthesia ☐ Hyperesthesia _____

Thoracic: ☐ Hypoesthesia ☐ Hyperesthesia _____

Lumbar: ☐ Hypoesthesia ☐ Hyperesthesia _____

Motor Muscle Testing:

Deltoid (C5)	Right _____/5 Left _____/5	Hip Flex (L2,3)	Right _____/5 Left _____/5
Biceps (C5-6)	Right _____/5 Left _____/5	Hip Ext (L4,5)	Right _____/5 Left _____/5
Triceps (C6-7)	Right _____/5 Left _____/5	Knee Ext (L3,4)	Right _____/5 Left _____/5
Wrist Ext (C6-7)	Right _____/5 Left _____/5	Knee Flex (L5-S1)	Right _____/5 Left _____/5
Wrist Flex (C7)	Right _____/5 Left _____/5	Ankle Dorsi (L4,5)	Right _____/5 Left _____/5
Finger Flex (C8)	Right _____/5 Left _____/5	Ankle Plant (S1,2)	Right _____/5 Left _____/5
Finger Abd (T1)	Right _____/5 Left _____/5		

*Remarks: _____

Orthopedic Tests:

Cervical
Foramnal Compression: ☐ R ☐ L
Distraction: ☐ R ☐ L

Shoulder Depression: ☐ R ☐ L
SOTO HALL: _____

Valsalva's Test: ☐ R ☐ L

Lumbar

Bechterew's Sign: ☐ R ☐ L
Minor's Sign: ☐ R ☐ L
Valsalva's ☐ R ☐ L
Kemp's Test ☐ R ☐ L

Fabre-Patrick: ☐ R ☐ L
Milgram's Test: ☐ R ☐ L
Nachlas Test: ☐ R ☐ L
Yeoman's Test: ☐ R ☐ L

Braggard's: ☐ R ☐ L
Ely's Test: ☐ R ☐ L
SLR: ☐ R ☐ L
Hibbs: ☐ R ☐ L

Remarks: _____

Shoulder

Bechterew's Sign: ☐ R ☐ L
Minor's Sign: ☐ R ☐ L
Valsalva's ☐ R ☐ L
Kemp's Test ☐ R ☐ L

	R	L
Flexion	____/180	____/180
Extension	____/50	____/50
Adduction	____/50	____/50
Abduction	____/180	____/180
Ext Rot	____/90	____/90
Int Rot	____/90	____/90

Elbow

Abduction Stress Test: ☐ R ☐ L
Adduction Stress Test: ☐ R ☐ L
Tinel's Sign ☐ R ☐ L
Cozen's Test: ☐ R ☐ L

	R	L
Flexion	____/160	____/160
Extension	____/0	____/0
Supination	____/90	____/90
Pronation	____/90	____/90

Wrist

Phalen's Test: ☐ R ☐ L
Reverse Phalen's Test: ☐ R ☐ L
Tinel's sign of the wrist: ☐ R ☐ L

	R	L
Flexion	____/90	____/90
Extension	____/70	____/70
Radial Dev.	____/0	____/0
Ulnar Dev.	____/0	____/0

Knee

Anterior drawer test: ☐ R ☐ L
Posterior drawer test: ☐ R ☐ L
McMurray's Compression: ☐ R ☐ L
Apley's Compression: ☐ R ☐ L
Apley's Distraction: ☐ R ☐ L

	R	L
Flexion	____/130	____/130
Extension	____/0	____/0

Ankle

Anterior drawer test ☐ R ☐ L
Medial drawer test: ☐ R ☐ L
Lateral Stability Test: ☐ R ☐ L
Tinel's Sign ☐ R ☐ L

	R	L
Plantar Flex	____/50	____/50
Dorsiflexion	____/20	____/20
Inversion	____/0	____/0
Eversion	____/0	____/0

HTP

	R	L
Flexion	____/120	____/120
Extension	____/30	____/30
Adbuction	____/45	____/45
Adduction	____/30	____/30

Historia Familiar:

Diabetes: ☐ Si ☐ No
Problemas Hormonales: ☐ Si ☐ No
Cancer ☐ Si ☐ No

Hipertension ☐ Si ☐ No
Problemas Digestivos ☐ Si ☐ No
Otro: _____

Historia Personal:

Fumar: ☐ Si ☐ No
Drogas Recreativas: ☐ Si ☐ No
Diabetes ☐ Si ☐ No
Problemas Hormonales ☐ Si ☐ No
Cambios Menstruales ☐ Si ☐ No
Hipertension ☐ Si ☐ No
Dificultad Urinaria ☐ Si ☐ No
Colesterol Alto / Bajo ☐ Si ☐ No
Dolor de Cabeza ☐ Si ☐ No
Asma ☐ Si ☐ No
Alergias ☐ Si ☐ No
Problemas Digestivos ☐ Si ☐ No
Problemas Psicologicos ☐ Si ☐ No
Otras Condiciones ☐ Si ☐ No
Lista de Medicamentos ☐ Si ☐ No

Cuantos ano _____ Paquetes por dia _____

☐ Cirugias passada ☐ Huesos rotos

Altura _____ Peso _____

Le gustaria perder peso o tener mas energia ☐ Si ☐ No

Algun problemas con:

Orejas: ☐ Si ☐ No
Ojos: ☐ Si ☐ No
Nariz: ☐ Si ☐ No
Garganta ☐ Si ☐ No
Corazon: ☐ Si ☐ No
Pulmones: ☐ Si ☐ No
Digestivo: ☐ Si ☐ No
Reproductivo: ☐ Si ☐ No