Move to Mend Physical Therapy
1060 Lincoln Ave, Suite 20 #1205
San Jose, CA 95125

Patient Intake Form

Patient Information

Last Name: _____ First Name: _____

Date of Birth: _____ (MM/DD/YYYY)

Street Address: _____

City: _____ State: _____ Zip Code: _____

Mailing Address (*if different than home address*): _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Mobile Phone: _____

Email Address: _____

Prefrred Method of Contact: mobile phone ☐ home phone ☐ text ☐ email ☐

Emergency Contact/Legal Guardian: _____

Relationship to Patient: _____ Contact Phone Number: _____

Profession (if retired, what did you do?): _____

How did you hear about Move to Mend Physical Therapy? _____

Name of Primary Care or Referring Physician/Dentist: _____

Contact Information for Primary Care/Referring Physician/Dentist:

_____

_____

Heather Toma, PT, DPT, OCS, FAAOMPT
Licensed Physical Therapist (CA License #41983)
Email: heathertoma.dpt@gmail.com
Phone: 530-263-1724

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Reason for Visit: Injury ☐ Accident ☐ Surgery ☐ Tune Up ☐

Describe your current reason(s) for coming to physical therapy: _____

_____

When did your symptoms start: _____

Describe your symptoms: _____

_____

Since the onset of your symptoms, have they become: Worse ☐ Better ☐ Same ☐

What increases your symptoms: _____

What eases your symptoms: _____

Describe any relevant previous injuries: _____

_____

List any other relevant past medical history: _____

_____

Have you undergone any diagnostic testing (i.e. MRI, X-rays, CT scan, Nerve Conduction, etc)? Yes ☐ No ☐

_____

Are you taking any medications/supplements? If "yes", please list _____

_____

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Past Medical History

Please answer the below questions to the best of your ability prior to your initial visit

Review of Systems
Please mark the appropriate yes or no box (Describe "yes" answers on page 3)

Yes:	No:	
☐	☐	General: (e.g. fever, chills, unexplained weight loss, fatigue)
☐	☐	Skin: (e.g. rashes, new skin lesions, change in moles)
☐	☐	Eyes: (e.g. blurred vision, change in visual acuity)
☐	☐	Ears: (e.g. pain, difficulty hearing, tinnitus)
☐	☐	Mouth/Throat: (e.g. difficulty swallowing, dry mouth)
☐	☐	Nose: (e.g. congestion, bleeding, pain)
☐	☐	Respiratory: (e.g. shortness of breath, wheezing, coughing, pain with breathing)
☐	☐	Cardiovascular: (e.g. high/low blood pressure, irregular heartbeat, nausea)
☐	☐	Gastrointestinal: (e.g. diarrhea, less than 1 bowel movement/day, vomiting, constipation)
☐	☐	Genitourinary: (e.g. difficulty with initiating/controlling bladder, urgency, infrequency)
☐	☐	Endocrine: (e.g. weight loss or gain, increased thirst, heat or cold intolerance)
☐	☐	Bone Health: (e.g. osteopenia, osteoporosis, etc)
☐	☐	Mental Health: (e.g. depression, anxiety, suicidal thoughts/attempts)
☐	☐	Smoking: (e.g. frequency of, how much daily, when stopped, how long did you smoke)
☐	☐	Past Surgeries: (e.g. orthopedic, hernia, cardiac, etc)

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Please describe any "yes" answers from the previous page:

Anything else you would like to share? _____

What to Expect at Your First Visit: Your initial evaluation will be approximately 55 minutes and may include treatment as time permits. Please wear comfortable clothing that allows access to the area being treated. Move to Mend Physical Therapy is a mobile, cash-based practice. A superbill can be provided for you to submit to your insurance for possible out-of-network reimbursement, but reimbursement cannot be guaranteed. No referral is required for initial evaluation or treatment unless required by your insurance plan.

Direct Access Notice: California Law Under California law (B&P; Code §2620), patients may receive physical therapy services directly without a physician referral for up to 45 calendar days or 12 visits, whichever occurs first. After that, a dated signature on the treatment plan from a licensed physician, surgeon, podiatrist, or chiropractor is required to continue care. Patients are encouraged to inform their healthcare providers of their participation in physical therapy.

By signing below, I certify all information on this form is valid and correct to the best of my knowledge.

Signature:_____ Date: _____

Printed Name:_____

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Physical Therapy Consent, Waiver, and Release of Liability

Effective Date: January 1, 2025

In agreeing to receive care provided by Move to Mend Physical Therapy, a professional practice of Heather Toma, PT, DPT, OCS, FAAOMPT, I acknowledge and agree to the following:

I fully understand and acknowledge that (a) the activities in which I will engage as part of my physical therapy treatment, and the equipment or exercises involved, may carry inherent risks of injury; (b) my participation may result in bodily injury, illness, strain, fracture, partial or total paralysis, or other serious conditions; and (c) these risks may arise from my own actions, the actions or negligence of others, or unforeseen circumstances.

By choosing to participate in treatment provided by Move to Mend Physical Therapy, I voluntarily assume all risks and accept full responsibility for any personal injury, illness, or damage to myself or my property. I, for myself and my representatives, hereby release, waive, discharge, and hold harmless Move to Mend Physical Therapy and its representatives from any and all claims, demands, or causes of action arising out of or related to my participation in treatment or use of equipment.

Consent to Treatment

I consent to and authorize Move to Mend Physical Therapy to administer physical therapy evaluation and treatment. I understand that, as in the practice of medicine, physical therapy may involve risks and that results are not guaranteed. I understand that I may ask questions about my treatment at any time and that it is my responsibility to inform my therapist of any health problems, allergies, or medications that could affect my care.

Mobile Practice Notice

Move to Mend Physical Therapy operates as a mobile physical therapy practice. Treatment sessions may occur in the patient's home, workplace, gym, or other agreed-upon safe environment. The therapist will maintain professional standards of privacy, cleanliness, and safety during all sessions. Patients are responsible for ensuring that the treatment environment (e.g., home, gym, office) is free of hazards or obstacles that could increase the risk of injury. The therapist reserves the right to discontinue a session if the setting is unsafe or inappropriate for care.

I HAVE READ AND UNDERSTAND THE ABOVE WAIVER, CONSENT, AND RELEASE. BY SIGNING BELOW, I AGREE TO THESE TERMS AND INTEND TO RELEASE MOVE TO MEND PHYSICAL THERAPY AND HEATHER TOMA, PT, DPT, OCS, FAAOMPT FROM LIABILITY FOR ANY PERSONAL INJURY, PROPERTY DAMAGE, OR OTHER LOSS THAT MAY OCCUR DURING OR RESULTING FROM TREATMENT.

Signature (Patient): _____

Date: _____

Printed Name: _____

If Patient is a Minor (under age 18):

Signature (Parent/Guardian): _____

Date: _____

Printed Name (Parent/Guardian): _____

I understand that my signature confirms I have had the opportunity to ask questions and that I voluntarily consent to receive physical therapy services from Move to Mend Physical Therapy.

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HIPAA Privacy and Disclosure Notice

Effective Date: January 1, 2025

This notice describes how Move to Mend Physical Therapy, owned and operated by Heather Toma, PT, DPT, OCS, FAAOMPT, may use and disclose your protected health information (PHI) and how you can access this information. Please review it carefully.

Federal Law (the Health Insurance Portability and Accountability Act, HIPAA) requires health care providers to inform patients of their rights regarding how the provider may use and disclose protected health information (PHI). This notice describes how Move to Mend Physical Therapy may use and disclose your PHI to carry out treatment, payment, or health care operations and for other purposes permitted or required by law. It also describes your rights to access and control your PHI.

Your Health Record and Protected Health Information

Each time you receive care from Move to Mend Physical Therapy, a record is created. This record includes information such as your name, address, medical history, symptoms, test results, treatment provided, and care plans. This record helps ensure quality care and compliance with HIPAA regulations.

Uses and Disclosures of Protected Health Information

Move to Mend Physical Therapy may use your information for treatment, payment, and health care operations. For example, your PHI may be used to coordinate care, process superbills or receipts, or maintain quality assurance. We may disclose limited PHI to other providers, insurers, or agencies when required by law or as authorized by you.

Treatment

Your PHI may be shared among health care professionals involved in your care to ensure coordinated treatment and follow-up.

Payment

Your PHI may be used to process payment for services or to provide documentation necessary for reimbursement or health savings accounts. Move to Mend Physical Therapy is an out-of-network provider; payment is due at the time of service.

Health Care Operations

We may use your PHI for administrative, quality improvement, or training purposes. These uses help us improve the effectiveness and efficiency of care provided through our mobile and in-home services.

Law Enforcement and Public Health

PHI may be disclosed to comply with legal requirements, such as public health reporting or law enforcement requests when required by law.

Appointment Reminders and Health-Related Communication

We may contact you via phone, email, or text for appointment reminders or to share health-related information. Communications may originate from a secure mobile device, and identifiable health details will not be shared electronically unless you authorize it in writing.

Your Rights Regarding Protected Health Information

You have the right to: request restrictions on the use of your PHI, receive confidential communications, inspect and copy your PHI, request amendments, obtain an accounting of disclosures, and receive a printed copy of this notice at any time. Requests must be made in writing to Move to Mend Physical Therapy.

Revisions to this Notice

Move to Mend Physical Therapy reserves the right to modify these privacy practices as permitted by law. Updated versions will be available upon request and will apply to all PHI maintained by the practice.

Complaints

If you believe your privacy rights have been violated, you may file a complaint or direct privacy questions in writing to Heather Toma, PT, DPT, OCS, FAAOMPT, Privacy Officer, Move to Mend Physical Therapy, or to the U.S. Department of Health and Human Services.
You will not face retaliation for filing a complaint.

Your Responsibilities

Please notify us promptly if your contact information changes or if you believe information we have is incorrect. Keeping your records up to date helps us protect your privacy.

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Patient Acknowledgment of Receipt of HIPAA Privacy Notice

Effective Date of Privacy Notice: January 1, 2025

By signing below, I acknowledge that I have received and reviewed the Move to Mend Physical Therapy HIPAA Privacy and Disclosure Notice, which explains how my health information may be used and disclosed, and how I may access this information. I understand that I may request a copy of this notice at any time and that Move to Mend Physical Therapy may revise this notice as permitted by law.

Patient Name: _____

Signature: _____

Date: _____

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Email and Text Communication Consent

I, _____ , consent to Move to Mend Physical Therapy contacting me via email, text message, or phone for the purposes of appointment reminders, payment receipts, electronic exercise programs or digital home exercise resources (e.g., via email or app link), physical therapy related handouts, telehealth coordination, and additional updates. I acknowledge that appointment reminders via email/text are an additional service and that the responsibility of attending or canceling appointments still rests with me. I understand that I can modify or cancel this email/text communication agreement at any time.

I understand that email and text messages are transmitted over a public network and may not be secure. Move to Mend Physical Therapy complies with HIPAA privacy and security standards and will not transmit identifiable health information via text or email unless I have provided explicit written authorization. I understand that this practice operates as a mobile physical therapy service, and that communications may originate from a secure mobile phone. No identifiable health information will be transmitted via standard text message unless I explicitly authorize it. All devices used by Move to Mend Physical Therapy are password-protected and comply with HIPAA security standards to the extent applicable. I agree to inform Move to Mend Physical Therapy if my mobile number or email address changes, if I wish to cancel this service, or if my phone is no longer in my possession. The practice does not share mobile phone or email information with any external organization. Standard text message rates may apply.

Mobile Telephone Number: _____
Carrier: _____
Email Address: _____
Preferred method for appointment reminders: Email Text Phone Call

Signature: _____
Date:_____

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