Patient Health Questionnaire

Office Use Only

Name: _____ Date: _____

DOB / Age: _____ Next MD Appt: _____

Referring MD: _____ Primary Care Physician: _____

Primary Complaint: _____ Secondary Complaint: _____

Symptoms started / date? _____

How did symptoms begin? _____

How often do you feel symptoms? ◯ Constantly ◯ Frequently ◯ Occasionally ◯ Intermittently

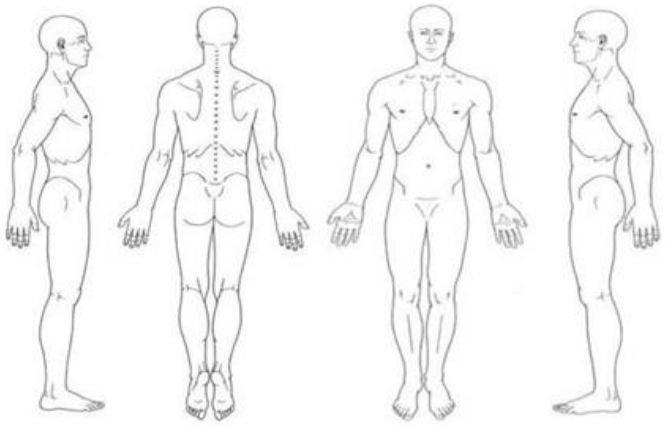
Since onset, are your symptoms? ◯ Better ◯ Worse ◯ Same Other _____

Rate your pain (0-10 as below): 0 **Today** 0 **Worst** 0 **Least** 0 **Average**

0	1	2	3	4	5	6	7	8	9	10
No Pain	**Very Mild**	**Discomfort**	**Tolerable**	**Distressing**	**Very Distressing**	**Intense**	**Very Intense**	**Utterly Horrible**	**Excruciating**	**Unbearable**

Mark body with:

- **+ For pain**
- **− For numbness**
- **↓ For radiating pain**
- **◯ For tightness**



Description of your pain (check all that apply):

☐ Dull Ache ☐ Burning ☐ Cramping
☐ Deep Ache ☐ Throbbing ☐ Soreness
☐ Sharp ☐ Nagging ☐ Numbness
☐ Shooting ☐ Squeezing ☐ Tingling
☐ Electrical ☐ Zinging ☐ Radiating
☐ Stabbing ☐ Twinge Other _____

Pain over course of day:
◯ Increases ◯ Decreases ◯ Same

Pain at night:
◯ No ◯ Yes (if yes check below)
☐ While lying still
☐ When changing positions
☐ Both

How do you sleep?
☐ Stomach ☐ Back
☐ Right Side ☐ All Positions
☐ Left Side ☐ Chair / Recliner

Other: _____

Additional Symptoms (if not described above): _____

What makes it worse? _____

What makes it better? _____

Patient Health Questionnaire Continued

Since onset of symptoms have you experienced any of the following (check all that apply):

☐ Difficulty with Bowel / Bladder Control ☐ Fever or Chills ☐ Numbness

☐ Unexplained Weight Loss ☐ Vision or Hearing Problems ☐ Numbness in Genital /Anal Area

☐ Dizziness or Fainting ☐ Weakness Other_____

Have you been treated for this condition before? ☐ No ☐ Yes

(if yes) ☐ MD ☐ PT ☐ Chiropractor Other: _____

Have you had diagnostics / tests for your current condition?

☐ None ☐ X-Ray ☐ MRI ☐ CT Scam

☐ Bone Scan ☐ EMG / NCV Other: _____

Where: _____ Results: _____

How would you rate your general health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

How often do you exercise: ☐ Everyday ☐ Frequently ☐ Occasionally ☐ Never

What type of exercise? _____

Dominant Hand: ☐ Right ☐ Left Do you use tobacco: ☐ No ☐ Yes ☐ Former User

Are you currently pregnant? ☐ No ☐ Yes

Please indicate if you have had or currently have any of the following:

	Yes	Year		Yes	Year		Yes	Year
Stroke	☐	____	Degenerative Joint Disease	☐	____	Asthma	☐	____
Heart Attack	☐	____	Osteoporosis / Osteopenia	☐	____	Headaches	☐	____
High Blood Pressure	☐	____	Multiple Sclerosis	☐	____	COPD	☐	____
Diabetes	☐	____	Lupus / SLE	☐	____	Hernia	☐	____
Bowel / Bladder Issues	☐	____	ALS / Lou Gehrig's	☐	____	AIDS / HIV	☐	____
Sensitivity to Heat / Cold	☐	____	Tuberculosis	☐	____	Skin Conditions	☐	____
Peripheral Vascular Disease	☐	____	Depression	☐	____	Alzheimer's	☐	____
Deep Vein Thrombosis / Clots	☐	____	Parkinson's	☐	____	Hepatitis	☐	____
Arthritis	☐	____	Polio	☐	____	Alcoholism	☐	____
Thyroid (Hyper / Hypo)	☐	____	Epilepsy / Seizures	☐	____	Drug Abuse	☐	____
Cancer: _____		____	Other: _____		____	Other: _____		____

List any surgeries and dates: _____

_____

List any prescribed medications and what they are for: _____

_____

List any over the counter medication or vitamin supplements: _____

_____

List any allergies: _____

Patient Health Questionnaire Continued

Living Situation:
_◯_ Live Alone _◯_ Live with Spouse / Significant Other _◯_ Live with Family _◯_ Live with Caregiver
Other: _____

Functional Activity:
_◯_ Independent with Normal Daily Activities
_◯_ Require Assistance with Normal Daily Activities
_◯_ Minimal _◯_ Moderate _◯_ Maximal _____% of the Time

Work History:
Occupation (Current or Former): _____

_☐_ Full Time _☐_ Part Time _☐_ Unemployed _☐_ Retired
_☐_ Self Employed _☐_ Student Other: _____

Job Requirements (check all that apply):

_☐_ Sitting _☐_ Standing _☐_ Phone Use _☐_ Computer Use
_☐_ Driving _☐_ Bending _☐_ Repetitive Lifting _☐_ Prolonged Position
_☐_ Heavy Lifting _☐_ Twisting Other: _____

Are you currently receiving or seeking disability benefits for this condition? _☐_ No _☐_ Yes
Do you have a previous disability from another condition? _☐_ No _☐_ Yes
Does your current condition limit normal work activities? _☐_ No _☐_ Yes
Do you plan to return to work? _☐_ No _☐_ Yes

Have you had physical therapy before? _☐_ No _☐_ Yes
What for? _____
Did you have a good prior physical therapy experience? _☐_ No _☐_ Yes

What would you like to achieve in physical therapy?

_☐_ Pain Relief _☐_ Increase Range of Motion _☐_ Increase Flexibility
_☐_ Return to Work _☐_ Improve Walking Tolerance / Ability _☐_ Improve Sleeping
_☐_ Return to Sport _☐_ Improve Activity Tolerance _☐_ Increase Strength
_☐_ Improve Posture _☐_ Improve Balance Other: _____

I understand by signing this medical intake form I have provided correct information to the best of my knowledge and give my written consent for physical therapy evaluation and treatment.

_____ _____
Patient Signature Date

Demographics

Date: _____/_____/_____

Patient Name: _____ Date of Birth: _____/_____/_____ ○Male ○Female

Social Security #: _____ Employer: _____ Marital Status: ○S ○M ○W ○D

Mailing Address: _____ City / State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____

Date Last Seen by Doctor: _____ Follow Up Date: _____

Referring Doctor: _____ Family Doctor: _____

Emergency Contact: _____ Relation: _____ Phone: _____

Please list any individuals we are authorized to speak with regarding your care / account: (Include the last four digits of their Social Security Number *or* their Mother's Maiden Name for verification purposes. Thank you.)

Name: _____ Last Four Digits of SSN# or Mother's M.N.: _____

Responsible Party

Name: _____ Relation: _____ Phone: _____

Address: _____ City / State: _____ Zip: _____

To the best of my knowledge, all of the above information is true and complete. I understand I am responsible to pay for all services rendered to me, and that I am willing to make specific arrangements to pay whatever part is not covered by insurance in a timely manner. **(PLEASE REMEMBER, INSURANCE IS CONSIDERED A METHOD OF REIMBURSING THE PATIENT FOR FEES PAID TO THE DOCTOR, AND IS NOT A SUBSTITUTE FOR PAYMEN**T). If this account is assigned to an attorney for collections and / or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection. I hereby assign all medical benefits to which I am entitled to my physical therapist for services rendered to my dependent or me. This assignment will remain in effect until revoked, by me, in writing. A photocopy of this assignment is to be considered as valid as the original.

Patient Signature: _____ Date: _____

MEDICARE ASSIGNMENT / SIGNATURE ON FILE: I request that payment of authorized Medicare benefits be made either to me, or on my behalf to IN TOUCH PHYSICAL THERAPY AND SPORTS MEDICINE for any services furnished me by that medical / healthcare provider / supplier. I authorize the release of any holder of medical information about me needed to determine these benefits, or the benefits payable for related services, to the Centers for Medicare and Medicaid Services, formerly the Health Care Financing Administration, and its agents.

Signature: _____ Date: _____

Notice of Privacy Practices

_____ _____

Patient's Name (Please Print) **Date**

_____ _____

Patient's Signature (or Legal Representative) **Legal Representative's Relationship**

By signing I acknowledge I have received or been offered a copy of In Touch Physical Therapy and Sports Medicine Notice of Privacy Practices / HIPAA Privacy Act.

Office Use Only:

- ☐ A good faith effort was made to obtain the patient's acknowledgment of the receipt of the Notice of Privacy Practices.
- ☐ The patient's identity has been verified with driver's license, state identification, student identification, or other.

The following identifies the efforts made and the reason the acknowledgment was not obtained or the patient's identity was not verified:

_____

_____ _____

In Touch Physical Therapy and Sports Medicine Staff Member (Signature) Date

Patient Responsibility

Thank you for selecting In Touch Physical Therapy and Sports Medicine (ITPTSM) to assist you with your therapy. We are committed to providing you with the utmost compassion and professionalism throughout your care and we look forward to assisting you with your physical therapy needs.

By initialing and signing below you are acknowledging you have read and understand the following information:

_____ **Notice of Privacy Practices:**
For your convenience a laminated copy of the ITPTSM Notice of Privacy Practices / HIPAA Privacy Act are displayed on this clipboard or it is available on our website at www.intouchphysicaltherapy.org for you to read. You may obtain a personal copy at any time.

_____ **Insurance:**
As a courtesy, your claims will be filed directly with Medicare, Medicaid, or your primary insurance carrier by ITPTSM. Insurance companies often have limits on the amount of physical therapy they will pay for in a year. Limits may be imposed monetarily or by number of visits.

- It is the patient's responsibility to know and understand their insurance plan.
- Failure to present correct and current insurance information at the time of service may result in a fee of up to 15% of the billable amount.
- If insurance sends correspondence, please reply as to not delay or negate your benefits.
- Having insurance is in no way a guarantee of benefits. If your benefits are exhausted at any point during treatment, there are alternative payment options available.

_____ **Co-Payments:**
All co-payments are due at the time of service.

_____ **Account Balances:**
All patient balances are the patient's responsibility.

- A $100 minimum payment or Co-Pay equivalent is required monthly.
- All co-payments are due at the time of service. If your co-payments for the month exceed $100, then the $100 minimum may be waived.
- Any patient balance remaining after 60 days will be subject to a 2% finance charge per month.

_____ **Cancellation / No Show Policy:**

- A $50.00 No Show Fee may be charged to your account, if you fail to show up for an appointment or cancel without 4 business hours prior notice.
- No Show Fees are the patient's responsibility and cannot be billed through your insurance company.

_____ _____
Signature Date

Print Forms