intouch PHYSICAL THERAPY AND SPORTS MEDICINE

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

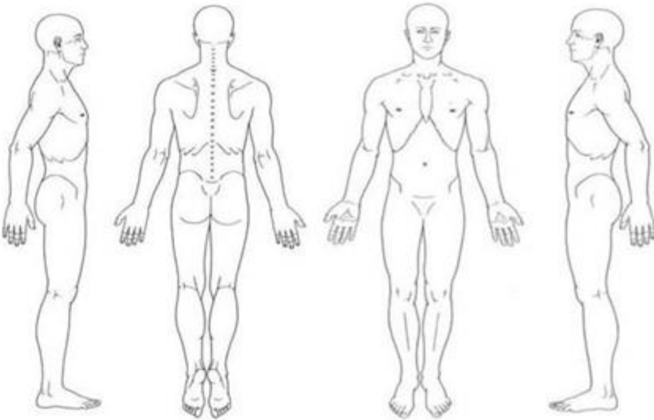
Since onset, are your symptoms? _____ Better _____ Worse _____ Same Other ____________

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

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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