PHYSIOFIT PHYSICAL THERAPY

First Name: ___________________________ Date of injury/onset: ________________ Today's Date: ______________

Last Name: __________________________ Date of Birth: _________________ Age: _______

Social Security: ________-_____-_________ Sex: M F Marital Status: S M D W

Address: ____

City: __________________________ State: ________________ Zip: ____________

Employer: ____

Home Phone: ( ) _____-________________ Work Phone: ( ) _________-____________

Cell Phone: ( ) _____-___________________ Email: ____

Injury Area: ____________________________ Accident Related? Yes No If yes, Auto Work

Who should we thank for this referral: ____

Referring Physician: ____ Phone: ( ) _____-______________________

Primary Care Physician: ______________________________________ Phone: ( ) _____-______________________

Primary Insurance:_________________________________ Insured Name:____

Group #:____ Policy #:____

Emergency Contact: _________________________________Phone: ( ) _______-_______________

Are you receiving or have you recently received home health services? Yes No

Are you receiving or have you received other therapy services? Yes No **Please**

Initial after reading statements:

1. **Consent to Treatment:** I consent to rehabilitation and related services at PhysioFit Physical therapy. In so doing, I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touching, and/or direct contact of a sensitive nature. __________

2. **Treatment of Minor:** I, as a parent/guardian of a minor receiving treatment hereunder, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so. _________

3. **Liability:** I know and agree that PhysioFit Physical Therapy is not responsible for loss or damage to personal valuables. ________

4. **Authorization of Payment:** I hereby assign all benefits directly to PhysioFit Physical Therapy and authorize release of any medical records necessary to facilitate my treatment to process medical claims and as otherwise permitted or required in the Notice of Privacy Practices. I understand fully that in the

event my insurance company or financially responsible party does not pay for the services I received, I will be financially responsible for payment. __________

5. **Appointment:** I understand that I need to inform the office of any cancellations24 hrs prior to any scheduled appointment. There is a mandatory fee of $40 for no shows. The fee must be paid before making any future appointments with us. (Don't be rude and inconsiderate of others who want to make an appointment). __________

Patient Signature: ____ Date: __________________________

PATIENT HEALTH QUESTIONNAIRE

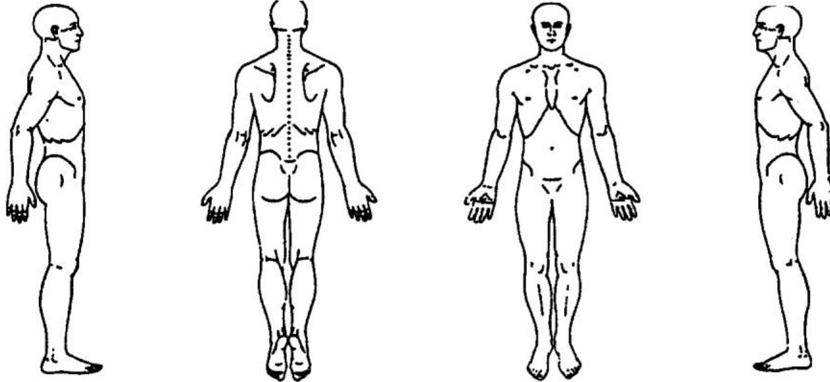
Name ______________________________ ID # ________________ Date ____/____/____

In the space below, please describe your major complaint.
Please describe your Current Complaint or Limitation: ______________________________

Please describe how your problem began: ______________________________

Please tell us when your condition started: ______________________________ Specific Date if possible: __/__/__

Did you have surgery? ☐ No ☐ Yes Date ____/____/____



Please describe the nature of your pain:

☐ Sharp Pain	☐ Constant (76 - 100%)
☐ Dull (Pain) Ache	☐ Frequent (51 - 75%)
☐ Throbbing	☐ Occasional (26 - 50%)
☐ Numbness	☐ Intermittent (25% or less)
☐ Shooting	
☐ Burning	
☐ Tingling	

→→→→→ MARK ON PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.

Indicate the intensity of your ***pain at rest***: **(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable Pain)**

Indicate the intensity of your ***pain with movement***: **(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable Pain)**

Since this condition began your symptoms have: ☐ decreased ☐ not changed ☐ increased

Your Symptoms are worse in: ☐ morning ☐ afternoon ☐ night ☐ increased during the day ☐ same all day.

In the past have you been treated for the same problem? ☐ Yes ☐ No

If yes, who did you see for that condition? ☐ MD ☐ Physical Therapist ☐ Occupational Therapist ☐ Chiropractor ☐ Other

When and what treatment did you receive? ______________________________

Occupation ______________________________ Has your work status changed because of this condition ☐ YES ☐ NO

If you have ever had a listed condition in the past, please check it in the PAST column. If you are presently troubled by a particular condition, check it in the PRESENT column. The information you provide concerning past and present conditions and diseases assists your therapist in more thoroughly understanding your state of health.

PAST	PRESENT	
☐	☐	High Blood Pressure (401.9)
☐	☐	Angina (413.9)
☐	☐	Heart Attack (410.9)
☐	☐	Stroke (436)
☐	☐	Asthma (493.9)
☐	☐	HIV /AIDS (042)
☐	☐	Cancer (199.1) Location:__________ Date:________
☐	☐	Tumor (229.9)
☐	☐	Systemic Lupus (710.0)
☐	☐	Hepatitis (573.3)
☐	☐	Epilepsy (349.5
☐	☐	Diabetes (250.0
☐	☐	Rheumatoid Arthritis (714.0)
☐	☐	Arthritis (716.9)
☐	☐	Pregnancy
☐	☐	Other______________________
☐	☐	Tobacco (305.1) packs/day_______
☐	☐	Drug or Alcohol Dependence (303.9)

Hospitalization/Surgical Procedures (list if not described elsewhere):
____
____
____
____

Medications: ______________________________
____
____
____

Present: Weight_______ Height_____feet_____in.

____
Patient's Signature Date

Notice of Privacy For
Patient's Protected Health Information

This notice describes how health care information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This office abides by the terms described in this policy.

This office uses and discloses your protected health care information for the following reasons:
1.to share with other treating health care providers regarding your health care
2. to submit to insurance companies or workers' compensation claim to verify that treatment has been rendered
3.to determine patient's benefits in a health care plan
4.releasing information required by State or Federal Public Health Law
5.to assist in overcoming a language barrier when caring for a patient
6.emergency situations
7.abuse, neglect or domestic violence
8.appointment reminders to household members or answering machines

Any other uses of this disclosure will only be made with your specific written prior authorization.

You have the right to the following:
1. revoke authorization, in writing at any time by specifying what you want restricted and to whom
2.inspect, copy and amend your protected health information and amend it as allowed by law
3.obtain an accounting of disclosures of your protected health information
4.to render a complaint to our privacy officer or the Secretary of Health and Human Services

This office, reserve the right to change the terms of this notice and to make new notice provisions for all protected health information that it maintains. Patients may also get an updated copy upon request at any time by asking the staff.

I acknowledge that I have received and reviewed this notice with full understanding of the above.

____
Patient's Name (print)

____ _______________
Patient's Signature/Legal Representative Date