Susan Underwood Physical Therapy
Patient Health Questionnaire

Name: _____ DOB: _____ /_____ /_____ Age: _____
Occupation: _____ Height: _____ Weight: _____
Referred by whom: _____ (Patient Client Staff)
Are you aware of your diagnosis? Yes No If yes, what is it? _____

Therapist Initials

PLEASE CIRCLE ONE

What is your primary concern:
Back Neck Shoulder Arm Hand
Hip Knee Ankle Foot
Core strengthening Balance issues Headache
Fibromyalgia Pelvic Floor Women's health
Other:

Have you seen a physician for this problem?	Yes	No
Have you had similar conditions in the past?	Yes	No

If your condition is painful, please rate your pain on a scale of **0-10** with **0** being no pain and **10** being pain for which you would go to the emergency room (circle the appropriate number):

Current pain **0 1 2 3 4 5 6 7 8 9 10**
Worst pain **0 1 2 3 4 5 6 7 8 9 10**

Describe your pain: SHARP SHOOTING RADIATING ACHING TINGLING DULL OTHER:

Have you had any of the following tests for THIS condition?
If yes, please list date:
MRI _____ CT scan_____ Bone Scan_____ X-ray_____
Nerve/Muscle test Other None

Are you aware of the results of the procedures? *Please list results*:	Yes	No

Does your problem/condition affect your ability to function normally? Yes No *How does your condition affect your function?*

Have you had any treatment for your problem/condition?
Medication Physical Therapy
Chiropractic Acupuncture Other:

Did treatment help?	Yes	No

What makes your symptoms worse?

What makes your symptoms better?

Please indicate goals for therapy.

Have you experienced any falls in the last year?	Yes	No
Have you had any major illnesses, surgeries, and/or hospitalizations?	Yes	No

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

HEART CONDITION	PACEMAKER
PULMONARY DISEASE	STROKE
HIGH BLOOD PRESSURE	ULCER
LOW BLOOD PRESSURE	BLOOD CLOT
PAIN/PRESSURE IN CHEST	DIABETES
CHEMICAL DEPENDENCY	SEIZURES
SHORTNESS OF BREATH	ASTHMA
FREQUENT / SEVERE HEADACHES	BLACKOUTS
CIRCULATION PROBLEMS	ANEMIA
RHEUMATOID ARTHRITIS	HEPATITIS
OSTEOARTHRITIS	OSTEOPOROSIS
BOWEL or BLADDER PROBLEMS	KIDNEY DISEASE
THYROID PROBLEMS	ALLERGIES
DIFFICULTY SLEEPING	DEPRESSION
MULTIPLE SCLEROSIS	
MENSTRUAL IRREGULARITIES	
CANCER (if yes, please describe):	

Have you recently noted any of the following?

Weight Loss/Gain	YES	NO
Fever/Chills/Sweats	YES	NO
Nausea/Vomiting	YES	NO
Dizziness/Lightheadedness	YES	NO
Weakness	YES	NO
Numbness/Tingling	YES	NO
Fatigue	YES	NO

WOMEN: Are you currently pregnant or think you might be pregnant? YES NO

Comments:

I hereby state that the above information is accurate and true to the best of my knowledge.
Patient Signature: Date:

Medication List

Patient Name:

Medication Name:	Dosage:	Frequency:	Administration:

***If changes are made (please note, sign and date)**

Miscellaneous:

Susan Underwood Physical Therapy
Patient Information

Last Name: _____First Name: _____ MI: _____

Date of birth: _____ Social Security #: _____

Street Address: _____ City: _____ State: _____

Zip: _____ Email Address: _____

Please indicate the preferred contact phone number by circling.

Home #: _____ Work #: _____

Cell #: _____ Fax #: _____

Sex: ☐ Male ☐ Female **Marital Status**: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Other

Emergency Contact Information

Name: _____ Relationship to Patient: _____

Home #: _____ Cell #: _____

Patient Employment Information: ☐ Full time ☐ Part Time ☐ Retired ☐ Student

Employer Name: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Phone #: _____ Fax #: _____

Insurance Policyholder and/or Responsible Party Information

Primary Insurance: _____ Policy Holder: _____ DOB: _____

Secondary Insurance: _____ Policy Holder: _____ DOB: _____

Tertiary Insurance: _____ Policy Holder: _____ DOB: _____

Billing Information: ☐ Same as Patient ☐ If different please fill out the following information:

Last Name: _____First Name: _____ MI: _____

Street Address: _____City: _____State: _____Zip: _____

Home #: _____ Work #: _____

Date of Birth: _____ Sex: ☐ Male ☐ Female Social Security #: _____

Relationship to Patient: _____

Employer Name: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Fax #: _____

Patient Medical Information

Physician Referral: _____ Phone#: _____ Fax#: _____

Location: _____

You are being treated for: Work Injury / Auto Accident / Other _____

I consent to treatment necessary for the care of the above named patient.

I authorize the release of any medical or other information necessary to process this claim if applicable.
I also request that government benefits or other medical benefits be assigned to Susan Underwood Physical Therapy Clinic for procedures and/or services rendered.

_____ _____

Patient Signature **Date**

_____ _____

Patient Representative/Guardian Signature **Date**

Susan Underwood Physical Therapy
Consent for Treatment

1. **Informed consent**: I understand that as a patient of Susan Underwood Physical Therapy:
    - I have the right to receive complete and current information concerning my diagnosis (to the degree known by Susan Underwood Physical Therapy), treatment, and any known prognosis. This information will be communicated to me by my therapist.
    - I have the right to accept medical care or to refuse treatment to the extent permitted by law and to be informed of the medical consequences if I refuse treatment. I understand that if I refuse recommended treatment, Susan Underwood Physical Therapy has the right to terminate the relationship with me.
    - I will be informed if Susan Underwood Physical Therapy wishes to participate in or perform any research or educational projects that would affect my care. I understand that I have the right to choose whether I participate, and that regardless of my participation, I will receive the most effective care the clinic provides.
    - Patient's Rights are posted in a prominent location at the clinic for my review, and I can discuss any questions or concerns with my therapist.
2. I understand that as a courtesy to patients, Susan Underwood Physical Therapy is contracted with and files claims to Blue Cross Blue Shield and Medicare. In the event that a patient has medical insurance through another company, claim forms will be provided in order to help the patient receive reimbursement**. It is in my best interest to call my insurance to confirm my "Outpatient Physical/Occupational Therapy" benefits, for the purpose of understanding any limitations or restrictions.**

3. I understand that Susan Underwood Physical Therapy does not accept responsibility for the collection of my insurance benefits or negotiating the settlement of a disputed claim**. I am responsible for all charges, regardless of anticipated insurance coverage.**

4. I understand that once my therapist has determined the nature of my issue, treatment plans will be discussed. The office staff may provide the estimated cost of treatment, at my request**. At the time of service, the patient is responsible for all deductibles, co-pays, co-insurance, and other charges not paid by the insurance company.**

5. **I understand that Susan Underwood Physical Therapy requests a 24 hour cancellation notice. Failure to attend an appointment may result in a $50 fee.**

6. I understand that if I feel my privacy rights have been violated, I have the right to make a complaint to Susan Underwood Physical Therapy in writing without fear of retaliation.

7. **Privacy Policy**: I understand that a copy of the Susan Underwood Physical Therapy Privacy Policy is posted in the clinic, and I can receive a copy of this privacy notice upon request or download from website. I also understand that as part of this organization's treatment, payment or health care operations, it may become necessary to disclose my health information to another entity (my doctor, insurance company, etc.) and I consent to such disclosure for these permitted uses, including via fax.

Is there anyone (i.e. family, spouse, children, or friend) involved in your care, or payment related to your care, with whom we may share your health information? Please list.

_____

Would you be interested in text message/email reminders? ◯ Yes ◯ No ◯ Text ◯ Email

If you chose text message, who is your cell phone provider? _____

I have read, understand, and agree to all the above.

Patient's Signature: _____ **Date:** _____