MISHOCK PHYSICAL THERAPY - PATIENT DATA SHEET

DO NOT EMAIL. The electronic form is provided for your convenience. With respect to responding to this form, please do not send via email. Please populate, print and sign a hardcopy that may be faxed, mailed or hand delivered to the clinic.

First: **MI:** **Last:**

EMERGENCY AND OTHER CONTACTS. Please provide us with the most updated information below.

Contact Name	**Phone #**	**Type** (Home, Cell, etc.)
		Select One
		Select One

May we send you text messages for your appointment reminders to the number(s) listed above? **By marking "Yes" below, you understand that text messages may NOT be secure, with a risk of unauthorized access to your information.**

☐ Yes ☐ No

May we send you emails relating to your care with us? ☐ Yes ☐ No

By providing your email address below, you understand that email communications may NOT be secure, with a risk of unauthorized access to your information.

Email:

Are you currently receiving or have you received Home Health Services (including any therapy, nursing, bathing & dressing, etc) in the last 60 days? ☐ Yes ☐ No

Are you currently receiving or have you received other therapy services in the last 60 days? ☐ Yes ☐ No

How did you hear about us?

☐ Physician
☐ Employer
☐ Case Manager
☐ Former Patient
☐ Adjustor
☐ School
☐ Hospital
☐ Cross Referral
☐ Friend - Word of Mouth
☐ Attorney
☐ Self
☐ Screens - Open Houses
☐ Marketing Ad – Print
☐ Marketing Ad – TV
☐ Marketing Ad – TV
☐ Marketing Ad - Billboard
☐ Marketing Ad - Direct Mail -Email
☐ Marketing Ad – Facebook
☐ Marketing Ad –Other: _____

Specify, if other:

DISCLOSURE OF MEDICAL RECORDS

I authorize the following individuals to have access to my medical and billing records:

Name_____ Relationship _____

Name_____ Relationship _____

Signature of Patient _____ Date _____

PATIENT INTAKE AND CONSENT FORM

Internal Use Only: A/C# Name A/C Type Office #

CONSENT TO TREATMENT

I consent to rehabilitation and related services at: **MISHOCK PHYSICAL THERAPY**

In doing so, I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touch and/or direct contact of a sensitive nature. **Initials: _____**

TREATMENT OF MINORS

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. **Initials: _____**

LIABILITY

I know and agree that: **MISHOCK PHYSICAL THERAPY** is not responsible for loss or damage to personal valuables. **Initials: _____**

WAIVER AND RELEASE

I hereby release, discharge and acquit: **MISHOCK PHYSICAL THERAPY** its agents, representatives, affiliates, employees, or assigns, of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency and or medical services including but not limited to ambulance service, Emergency Medical Technician, physician or urgent care services. **Initials: _____**

AUTHORIZATION OF PAYMENT

I hereby assign all benefits directly to: **MISHOCK PHYSICAL THERAPY**

I also authorize release of any medical records to other healthcare providers as necessary to facilitate my treatment and to other third parties as necessary to process medical claims and otherwise permitted or required in the **Notice Of Privacy Practices**. **Initials: _____**

FINANCIAL POLICY

I understand fully that, in the event my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment.

To assist in establishing your account, please:

- Supply all necessary information for accurate billing of your claim, including your insurance card, driver's license, employer information, and demographic information.
- Satisfy all insurance co-payments, co-insurance, deductibles, and non-covered services on the day services are rendered.
- Provide your insurance company and us with any additional information requested to complete the processing of claims filed on your behalf. **Initials: _____**

NOTICE OF PRIVACY/PATIENT BILL OF RIGHTS

I acknowledge receipt of Notice of Privacy Practices. **Initials: _____**

I acknowledge receipt of the Statement of Patient Rights. **Initials: _____**

I certify that all of the information provided herein is true and correct.

Patient/Guardian Signature Witness Signature

MISHOCK PHYSICAL THERAPY - MEDICAL HISTORY FORM

Patient Name: _____

Referring Physician's Name: _____Primary Care Physician's Name: _____

Cause Of Injury Or Onset: _____

Do you have any open cuts, lesions or wounds? ☐ Yes ☐ No If yes, where: _____

Have you recently been hospitalized or had surgery? ☐ Yes ☐ No If yes, when: _____

And why?: _____

Current Medications: _____

_____

Allergies: Medication _____ Reaction_____ Other _____ Reaction_____

Are you allergic to Latex? ☐ Yes ☐ No If yes, what is the reaction: _____

Are you allergic to Dexamethasone? ☐ Yes ☐ No If yes, what is the reaction: _____

DO YOU CURRENTLY HAVE OR HAVE A HISTORY OF ANY OF THE FOLLOWING CONDITIONS? (Check All That Apply):

- ☐ Anemia
- ☐ Arthritis
- ☐ Cancer
- ☐ Cardiovascular Problems
- ☐ Holter Monitor
  - ☐ Currently Wearing?
- ☐ Pacemaker
- ☐ High Blood Pressure
  - ☐ Controlled ☐ Uncontrolled
- ☐ Low Blood Pressure
- ☐ Currently Pregnant
- ☐ Diabetes
  - ☐ Controlled ☐ Uncontrolled
- ☐ Depression
- ☐ Dizziness / Fainting
- ☐ Fractures
- ☐ Headaches
- ☐ Hepatitis / HIV
- ☐ Kidney Problems
- ☐ MRSA (Methicillin Resistant Staphylococcus Aureus)
- ☐ Osteoporosis
- ☐ Respiratory Problems
  - ☐ Asthma
    - ☐ Controlled ☐ Uncontrolled
  - ☐ COPD
    - ☐ Controlled ☐ Uncontrolled
- ☐ Seizures
  - ☐ Controlled ☐ Uncontrolled
- ☐ Thyroid Problems
- ☐ Blood Thinners (Anticoagulants)
- ☐ Other:

If Checked Any Above, Explain: _____

_____

☐ Any Other Medical Problems: _____

_____

Signature Of Patient: _____ Reviewed By Therapist: _____ Date_____

Patient Health Questionnaire • PHQ

Patient Name: _____ Date: _____

1. Describe your symptoms: _____

_____

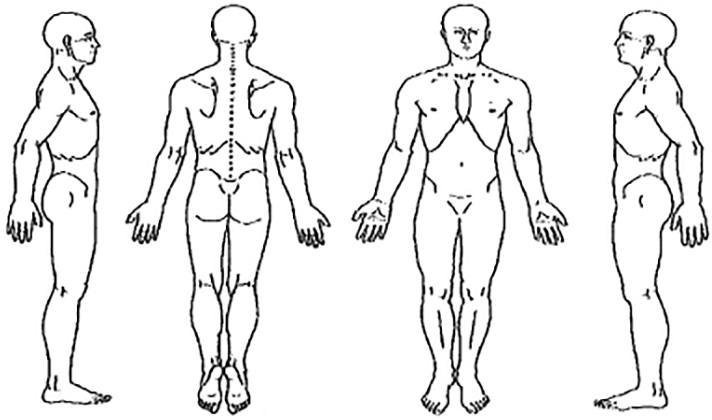
a. When did your symptoms start? _____

b. How did your symptoms begin? _____

2. How often do you experience your symptoms?

- ☐ 1. Constantly (76-100% of the day)
- ☐ 2. Frequently (51-75% of the day)
- ☐ 3. Occasionally (26-50% of the day)
- ☐ 4. Intermittently (0-25% of the day

Indicate where you have pain or other symptoms:



3. What describes the nature of your symptoms?

- ☐ 1. Sharp
- ☐ 2. Dull Ache
- ☐ 3. Numb
- ☐ 4. Shooting
- ☐ 5. Burning
- ☐ 6. Tingling

4. How are your symptoms changing?

- ☐ 1. Getting Better
- ☐ 2. Not Changing
- ☐ 3. Getting Worse

5. During the <u>past 4 weeks</u>:

a. indicate the average intensity of your symptoms.

None — Unbearable

0	1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

b. How much has pain interfered with your normal work (including both work outside the home, and housework)

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

6. During the <u>past 4 weeks</u> how much of the time has your condition interfered with your social activities?

(like visiting with friends, relatives, etc.)

☐ All of the time ☐ Most of the time ☐ Some of the time ☐ A little of the time ☐ None of the time

7. In general would you say your overall health right now is...

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

8. Who have you seen for your symptoms?

☐ No One ☐ Medical Doctor ☐ Other:
☐ Chiropractor ☐ Physical Therapist

a. What treatment did you receive and when? _____

b. What tests have you had for your symptoms and when were they performed?

☐ **X-Rays** *date:*_____ ☐ **CT Scan** *date:*_____
☐ **MRI** *date:*_____ ☐ **Other** *date:*_____

9. Have you had similar symptoms in the past? ☐ Yes ☐ No

a. If you have received treatment In the past for the same or similar symptoms, who did you see?

☐ No One ☐ Medical Doctor ☐ Other:
☐ Chiropractor ☐ Physical Therapist

10. What Is your occupation?

_____

☐ Professional/Executive ☐ Laborer ☐ Retired
☐ White Collar/Secretarial ☐ Homemaker ☐ Other:
☐ Tradesperson ☐ FT Student

a. If you are not retired, a homemaker, or a student, what is your current work status?

☐ Full-time ☐ Self-employed ☐ Off work
☐ Part-time ☐ Unemployed ☐ Other:

Patient Signature_____ **Date** _____