PATIENT INFORMATION

PATIENT DEMOGRAPHICS / INFORMATION

DATE: ________________

LAST NAME: ______________________ FIRST NAME: ______________________

MIDDLE INT: __________ *NICKNAME: ______________________ MALE / FEMALE

ADDRESS: ____

APT NUMBER: ________ CITY: ______________________ STATE: ________ ZIP: __________

EMPLOYER: ____

HOME PHONE: (______) ______________ WORK PHONE: (______) ______________ Ext: ______

*ALTERNATE PHONE (______) ______________ SOCIAL SECURITY NUMBER: ______ - _____ - ______

DATE OF BIRTH: _____ / ______ / ______ AGE: ________ MARITAL STATUS: M / D / S / W

EMAIL: ______________________ REFERRING DOCTOR: ______________________

WAS THIS INJURY: ______ AUTO RELATED ______ EMPLOYMENT ______ OTHER

EMPLOYER INFORMATION / WORKERS COMP

EMPLOYER NAME: ____

ADDRESS: ____

____

____

EMPLOYER PHONE: ____

SUPERVISORS NAME: ____

DATE OF INJURY: ____

PATIENT HEALTH QUESTIONNAIRE

DATE: ____________ NAME: ______________________________

CURRENT SYMPTOM HISTORY

DESCRIBE YOUR SYMPTOMS: ______________________________

HOW DID SYMPTOMS BEGIN? ______________________________

DATE SYMPTOMS BEGAN: ______ / ______ / ______

NATURE OF SYMPTOMS:

- □ SHARP
- □ DULL ACHE
- □ NUMB
- □ SHOOTING
- □ BURNING
- □ TINGLING

HOW OFTEN ARE SYMPTOMS EXPERIENCED?

- □ CONSTANTLY (76-100% OF DAY)
- □ FREQUENTLY (51-75% OF DAY)
- □ OCCASIONALLY (26-50% OF DAY)
- □ INTERMITTENTLY (0-25% OF DAY)

HOW ARE YOUR SYMPTOMS CHANGING?

- □ GETTING BETTER
- □ NOT CHANGING
- □ GETTING WORSE

DURING PAST 4 WEEKS, INDICATE INTENSITY OF SYMPTOMS:

None — Unbearable

0 1 2 3 4 5 6 7 8 9 10

DURING PAST 4 WEEKS, HOW MUCH HAS PAIN INTERFERED WITH YOUR NORMAL WORK?

□ NOT AT ALL □ A LITTLE BIT □ MODERATELY □ QUITE A BIT □ EXTREMELY

DURING PAST 4 WEEKS, HOW MUCH HAS YOUR CONDITION INTERFERED WITH SOCIAL ACTIVITIES?

□ NOT AT ALL □ A LITTLE BIT □ MODERATELY □ QUITE A BIT □ EXTREMELY

IN GENERAL, HOW WOULD YOU SAY YOUR OVERALL HEALTH IS RIGHT NOW?

□ EXCELLENT □ VERY GOOD □ GOOD □ FAIR □ POOR

DO YOU USE A? (CHECK ALL THAT APPLY)

□ CANE □ WALKER/ROLLING WALKER/ROLLATOR □ MANUAL WHEELCHAIR □ MOTORIZED WHEELCHAIR

□ OTHER ____________

WHO HAVE YOU SEEN FOR YOUR SYMPTOMS?

□ NO ONE □ CHIROPRACTOR □ MEDICAL DOCTOR □ PHYSICAL THERAPIST □ OTHER ____________

What treatment did you receive and when? ______________________________

What tests did you have and when?

□ XRAYS date: ____________ □ MRI date: ____________ □ CT SCAN date: ____________

□ Other date: ____________

HAVE YOU HAD SIMILAR SYMPTOMS IN THE PAST? □ YES □ NO

If yes, who did you see?

□ THIS OFFICE □ CHIROPRACTOR □ MEDICAL DOCTOR □ PHYSICAL THERAPIST □ OTHER ____________

PAST MEDICAL HISTORY

LIST ALL HEALTH PROBLEMS, HOSPITALIZATIONS, SURGERIES AND ALLERGIES:

___

___

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING OR PROVIDE A LIST TO YOUR THERAPIST:

___

___

ARE YOU A DIABETIC? ☐ YES ☐ NO
IF YES, FOR HOW LONG? ___

DO YOU HAVE A PACEMAKER? ☐ YES ☐ NO

ARE YOU PREGNANT? ☐ YES ☐ NO
IF YES, HOW MANY MONTHS? ___

PLEASE LIST OTHER PHYSICIANS WHO ARE TREATING YOU AND FOR WHAT CONDITIONS?

___

___

DEMOGRAPHIC INFORMATION

WHERE DO YOU LIVE?

☐ PRIVATE HOME ☐ PRIVATE APT. ☐ RENTED ROOM ☐ BOARD AND CARE/ASSISTED LIVING/GROUP HOME
☐ HOMELESS(WITH OR WITHOUT SHELTER) ☐ LONG-TERM CARE FACILITY ☐ HOSPICE ☐ OTHER ___

WHO DO YOU LIVE WITH? (CHECK ALL THAT APPLY)

☐ ALONE ☐ SPOUSE/SIGNIFICANT OTHER ☐ CHILD/CHILDREN ☐ OTHER RELATIVE(S)
☐ GROUP SETTING ☐ PERSONAL CARE ATTENDANT ☐ OTHER ___

WHAT IS YOUR OCCUPATION?

☐ PROFESSIONAL/EXECUTIVE
☐ WHITE COLLAR/SECRETARIAL
☐ TRADESPERSON
☐ LABORER
☐ HOMEMAKER
☐ FT STUDENT
☐ RETIRED
☐ OTHER
☐ UNEMPLOYED

EMPLOYMENT/WORK STATUS (CHECK ALL THE APPLY)

☐ FULL-TIME, OUTSIDE HOME ☐ FULL-TIME, IN HOME
☐ PART-TIME, OUTSIDE HOME ☐ PART-TIME, IN HOME
☐ SELF-EMPLOYED ☐ OTHER
☐ WORKING WITH MODIFICATION BECAUSE OF CURRENT ILLNESS/INJURY
☐ NOT WORKING BECAUSE OF CURRENT ILLNESS/INJURY

HOW DID YOU HEAR ABOUT US?

☐ PHYSICIAN
☐ FAMILY/FRIEND NAME: ___
☐ INTERNET SEARCH
☐ LOCAL ATHLETIC TRAINER NAME: ___
☐ OTHER ___

TO THE BEST OF MY KNOWLEDGE THE ABOVE INFORMATION IS CORRECT AND ACCURATE

SIGNATURE: ___

DATE: ___

GREATERTHERAPYCENTERS

CONSENT FOR TREATMENT

HIPAA ACKNOWLEDGEMENT

CONSENT FOR TREATMENT AND ADMISSION:

I agree to be admitted to GREATER **THERAPY** CENTERS as an outpatient, and authorize the therapy staff to evaluate and treat within the scope of physical and occupational therapy practice as ordered by the referring physician. Initials ___________

RELEASE OF INFORMATION:

I hereby authorize GREATER **THERAPY** CENTERS to furnish medical records, via fax or mail, to my referring physician, insurance carrier and to the physician to whom I am referred concerning my evaluation and treatment.
Initials ___________

WORKER'S COMPENSATION PATIENTS RELEASE OF INFORMATION:

I authorize GREATER **THERAPY** CENTERS to discuss/forward any relevant vocational information, as related to my rehabilitation, with my worker's compensation/group insurance carrier/external case manager.
Initials if applicable _________

ASSIGNMENT OF BENEFITS:

I hereby assign all of my right, title, and interest to GREATER **THERAPY** CENTERS of insurance/health and welfare benefits otherwise payable to me, not to exceed the balance due of GREATER **THERAPY** CENTERS customary charges for the services provided. Initials ___________

FINANCIAL AGREEMENT:

I assume financial responsibility for the payment of all charges at the time of service unless covered under worker's compensation, Medicare, or a specific insurance carrier. As a courtesy to you, GREATER **THERAPY** CENTERS will file your claims to the insurance carrier that you have provided to us. By initialing below you agree for your insurance to be filed. All deductibles, co-insurances, and co-pays including non-covered services are your financial responsibility. Any account not paid will be referred to a third party collection agency to include all reasonable collection fees, not limited to attorney fees, investigative fees, and court costs. Initials ___________

CANCELLATION/NO-SHOW POLICY:

As a courtesy to our staff and other patients we ask that you keep your scheduled appointments. If you are unable to attend a scheduled appointment, please call and cancel at least two(2) hours prior to the appointment. Failure to cancel the appointment within the time frame will result in the assessment of a fee in the amount of $15 per incidence.
Initials ___________

HIPAA ACKNOWLEGEMENT:

I have received the Privacy Notice of GREATER **THERAPY** CENTERS on today's date. Initials ___________

The undersigned certifies that he/she has read the foregoing and is the patient, the patient's legal representative, or is duly authorized by the patient and his/her agent to execute the above and accept its terms. If patient's condition prohibits written consent, agent who is present when verbal consent is given should sign patient's name by agent's name. If patient is unable to consent or is a minor, complete the following:

If patient is a minor, how many years of age? _______________If patient is unable to give his/her consent,

why?____

____ ____________________

Patient/Relative/Authorized Agent Signature Date

____

Relationship to Patient (if signature is not the patient's)

____

Witness Signature