# Patient Information Form

**Today's Date_____**

## PLEASE PRINT AND COMPLETE ALL ENTRIES

| Patient Name (Last, First, Middle Initial) | Date of Birth / / | Sex M F | Martial Status S M W |
|---|---|---|---|
| Patient Address<br>Street City State Zip | | | |
| Home Phone ( ) | Cell Phone ( ) | | |
| Name of Employer | FULL-TIME ☐ | Work Phone ( ) | |
| Employer Address<br>Street_____<br>City_____State_____Zip_____ | PART-TIME ☐ | Social Security # (Patient)<br>- - | |
| Spouse/Parent Name (If patient under 18 yrs old) | Date of Birth | Social Security # | |
| Spouse/Parent Address<br>Street City State Zip | | Employer | |
| Emergency Contact | Phone( ) | Relationship | |

**How did you hear about us?** Dr. Referral ___ Newspaper ___ Phone Book ___
TV Ad ___ Welcome Wagon ___ Website/Internet ___ Friend/Family _____
Employee ___ Other _____ (Friend/Family Name)

Print your Email address if you give permission to be added to our email list: (Company News, Discounts, & Promotions)

## INSURANCE INFORMATION

☐ **Check box if the (Primary) Patient Insurance info is the same as above.** If not, then please fill out the info below.

| Primary Ins Company Name | Address (Street, City, State, Zip) | | Phone ( ) |
|---|---|---|---|
| Name of Insured: | Relationship | I.D.# | Group # |
| Secondary Ins Company Name | Address (Street, City, State, Zip) | | Phone ( ) |
| Name of Insured: | Relationship | I.D.# | Group # |

Is your condition work related?_____If Yes, are you insured through your work?_____
Is your condition the result of an auto accident?_____If Yes, on what date did the accident occur?_____

## ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assigned directly to Marion Physical Therapy all insurances benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges if not paid by insurance. I hereby authorize Marion Physical Therapy to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature | Relationship | Date

***(If minor, parent or legal guardian must sign)***

## CONSENT FOR PHYSICAL THERAPY SERVICES

I understand that I have a condition requiring physical therapy evaluation, treatment, and rehabilitation. I do voluntarily consent to such physical therapy services recommended by the physical therapist or their designees. I am aware that the practice of physical therapy is not an exact science. I acknowledge that no guarantees have been made to me as to the result of these services.

Patient Signature | Physical Therapist Signature | Date

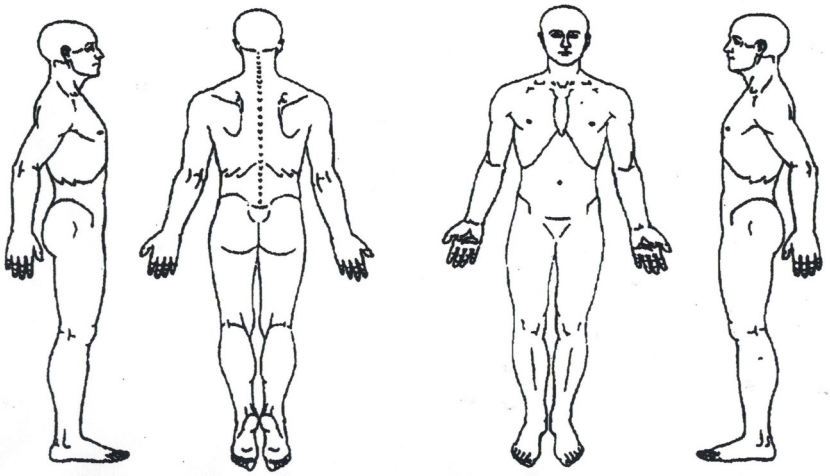
***(If minor, parent or legal guardian must sign)***

# MARION PHYSICAL THERAPY - Patient Health Questionnaire PHQ

Patient Name: _____

1. Describe you symptoms:_____
2. When did your symptoms start?_____
3. How did your symptoms begin?_____
4. 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)
5. What describes the nature of your symptoms?
   1. Sharp
   2. Dull Ache
   3. Numb
   4. Shooting
   5. Burning
   6. Tingling
6. How are your symptoms changing?
   1. Getting better
   2. Not changing
   3. Getting worse

Indicate where you have pain or other symptoms



7. During the past four weeks, indicate the average intensity of your symptoms:
   (None) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable)
8. How much has pain interfered with your normal work, including both work outside the home and housework?
   1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
9. During the past four weeks how much of the time has your condition interfered with your social activities? (like visiting with friends, relatives, etc.)
   1. All of the time 2. Most of the time 3. Some of the time 4. A little of the time 5. None of the time
10. In general would you say your overall health now is…
    1. Excellent 2. Very good 3. Good 4. Fair 5. Poor
11. Who have you seen for your symptoms:
    1. No one 2. Chiropractor 3. Medical doctor 4. Physical Therapist 5. Other:_____

    What treatment did you receive and when?_____
    What tests have you had for your symptoms: 1. X-rays date:_____ 3. CT Scan date:_____
    2. MRI date:_____ 4. Other date:_____
12. Have you had similar symptoms in the past? Yes No
13. If you have received treatment in the past for the same or similar symptoms, who did you see?
    1. This office 2. Chiropractor 3. Medical Doctor 4. Physical Therapist 5. Other
14. What is your occupation?
    _____
    1. Professional/Executive 4. Medical doctor 7. Retired
    2. White collar/secretarial 5. Homemaker 8. Other
    3. Tradesperson 6. Full-time student
15. If you are not retired, a homemaker, or a student, what is your current work status?
    1. Full-time 2. Part-time 3. Self-employed 4. Unemployed 5. Off work 6. Other

Patient Signature:_____ Date:_____

***(If minor, parent or legal guardian must sign)***

Family Doctor:_____ Referring Doctor:_____

Have you ever been diagnosed as having any of the following conditions? (Please circle/comment)

Y / N Cancer. If yes, describe what kind:_____
Y / N Heart Problems, Do you have a pacemaker? Yes / No
Y / N High blood pressure
Y / N Circulation problems
Y / N Kidney disease / Chronic bladder infection
Y / N Emphysema / Bronchitis
Y / N Chemical dependence (i.e. alcoholism)
Y / N Thyroid problems
Y / N Diabetes
Y / N Multiple Sclerosis
Y / N Rheumatoid Arthritis
Y / N Other Arthritis conditions:_____
Y / N Gout
Other:_____

Y / N Hepatitis
Y / N Tuberculosis
Y / N Stroke / TIA
Y / N Anemia
Y / N Asthma
Y / N Epilepsy
Y / N Pneumonia
Y / N Blood clots
Y / N Fibromyalgia
Y / N Ulcers
Y / N Headaches / Migraines
Y / N Urinary Incontinence
Y / N Osteoporosis
Y / N Depression

**Do you use any assistive device in order to walk? YES / NO**

**During the past month, have you been feeling down, depressed, or hopeless? YES / NO**

**During the past month, have you been bothered by having little interest/pleasure in doing things? YES / NO**

**Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? YES / NO**

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

Please list any surgeries for which you have been hospitalized including the approximate date and reason:

| Date | Reason for Surgery | Date | Reason for Surgery |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

Please describe any significant injuries for which you have been treated (including fractures, dislocations, sprains) and the approximate date of injury.

| Date | Injury | Date | Injury |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

List any allergies:_____ Are you allergic to Latex? YES/NO

Which of the following over-the-counter medications have you taken in the last week? (please circle)

Aspirin Tylenol Advil/Motrin/Ibuprofen Laxatives Antacids
Decongestants Antihistamines Tagamet/Zantac/Pepcid Vitamins/Mineral Supplements
Other:_____

Please list any prescription medications you are taking (including pills, injections, and/or skin patches):

1._____ 3. _____ 5._____
2._____ 4._____ 6._____

What are your goals in coming for treatment?_____

_____

| Have you recently noted: | | | | |
|---|---|---|---|---|
| | Yes / No | Weight loss/gain | Yes / No | Nausea/vomiting |
| | Yes / No | Weakness | Yes / No | Dizziness/lightheadedness |
| | Yes / No | Numbness/tingling | Yes / No | Fever/Chills/Sweats |