BRANSON PHYSICAL THERAPY, LLC.

850 S Ironwood Dr., 112 Apache Junction, AZ 85120-6242

Patient Information Form

Please read carefully and complete all questions as they are regulated by HIPPA.

Name: ______________________________ Home Phone: ____________________

Social Security #: ____________________ Date of Birth: ______________ Sex: ________ Age: _______

Local Address: ______________________________________ Apt(sp): ________________

City: ______________________________ State: ______________ Zip: ________________

Out of State Address: ________________________________ Apt(sp): ________________

City: ______________________________ State: __________ Zip: ________ Phone #: ____________

Spouse's Name: ________________________ Phone #: ________________________________

Spouse's Social Security #: __________________________ Date of Birth: ________________

Employed by: __________________________ Position: ______________________________

Business Address: ______________________ City: ______________ State: ______ Zip: __________

Business Phone #: __________________ Ext.: _______ Supervisor Name: ____________________

Who is responsible for this bill? ____

Referred by: ________________________________ Phone #: ______________________

Whom may we contact in the case of an emergency? ____________________________________

Phone #: ________________________ Relationship to patient: __________________________

I authorize Branson Physical Therapy to treat me for the following diagnosis/condition ________________

____

Is this injury related to an Auto accident or is this part of a litigation? ___Yes ___No

If you have answered Yes, please advise us right away, as we NO LONGER ACCEPT Litigation cases.

I understand and agree that (regardless of my insurance status); I am ultimately responsible for the balance of my account for any professional services rendered by Branson Physical Therapy, LLC. I have read all the information on this sheet and have completed all of the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

____ ________________________

Signature Date

____ ________________________

Parent/Guardian (if minor) Date

Branson Physical Therapy
850 S. Ironwood Dr, Suite 112
Apache Junction AZ 85120-6242
PHONE (480) 983-1680
FAX (480) 983-1681

Patient Questionnaire Form

This questionnaire is designed to help us obtain necessary information about your health problems and your activity level. If you have difficulties answering or understanding these questions, please ask for assistance.

Name ______________________________ Date: ____________

Age ______ Sex: **M** **F** Height ________ Weight ________ ☐ Right Handed ☐ Left Handed

Is your problem due to any of the following?

☐ Surgery ☐ Auto Accident ☐ Slip/Fall
☐ Sports Injury ☐ Gradual Onset of symptoms ☐ Lifting/Pulling
☐ Other Cause: ______________________________

Date of injury / onset of your problem: ____________ **or...**
How long have you experienced this present problem? (months/years) ____________

How you describe your symptoms? ☐ Ache/Dull ☐ Burning ☐ Numbness
☐ Spasm/ cramp ☐ Pins & Needles ☐ Stabbing/sharp
☐ No pain, I just can't do some things ☐ Stiffness ☐ Shooting
☐ Other ______________________________

Please place two checks on the line to rate your pain at it's **best** and **worst** in the past three days, on a zero to ten scale, with zero being no pain and ten as the worst your symptoms could be:

No Pain ______________________________ **Worst it could be**

0 1 2 3 4 5 6 7 8 9 10

What activities are you unable to do or are having difficulty with as a result of your problem?

A. ____________ D. ____________
B. ____________ E. ____________
C. ____________ F. ____________

Are there specific movements or treatments that *relieve* your symptoms? **Y** **N**
If yes, Specify ______________________________

Is your problem getting... ☐ better ☐ worse ☐ about the same

Have you experienced similar problems in the past? **Y** **N** **If** yes...
How frequently did you have flare-ups? ______________________________
Have you had previous treatment? **Y** **N** If yes...What type(s) of treatment? (include dates) ____________

Please continue on other side ->

0	1	2	3	4	5	6	7	8	9	10
Unable to Perform activity.										Able to perform activity at same level as before injury or problem.

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Past Medical History

(Please check if any of the following conditions apply to you)

- ☐ Asthma
- ☐ Allergies ____________
- ☐ Alcoholism
- ☐ Diabetes
- ☐ Heart Disease ____________
- ☐ High blood pressure
- ☐ Thrombophlebitis
- ☐ Lung Disease ____________
- ☐ Rheumatoid arthritis
- ☐ Osteoarthritis (degenerative joint disease)
- ☐ Joint/Bone infection
- ☐ Lupus Erthematosis
- ☐ Psoriasis
- ☐ Gout
- ☐ Cancer ____________
- ☐ Venereal Disease
- ☐ Seizure Disorder
- ☐ Faintness
- ☐ Muscle Weakness - Where? ____________
- ☐ Numbness - Where? ____________
- ☐ Joint Pain - Where? ____________
- ☐ Swelling - Where? ____________

Have you experienced unusual weight loss? ☐ Yes ☐ No

Have you been admitted to the hospital or undergone any surgical procedures during the past five years? ☐ Yes ☐ No

Please list, including dates ____________

____

____

Please list the medications you are currently taking:

____

____

____

Have you received any injections in the joints or muscles?

☐ Yes ☐ No If yes, please list with dates

____

____

Please list any special braces, orthotics, canes, etc, that you use ____________

____

Have you received any special tests recently? ☐ Yes ☐ No

Example: Xray, MRI, CAT scan, bone scan, EMG, EKG, Stress test: Please Specify ____________

____

Exercise History

How much exercise do you get?

- ☐ None
- ☐ Walk ____________ miles/week
- ☐ Jog/run ____________ miles/week

Please list the sport / recreational activities that you are involved in. ____________

____

____

____

____

____

____

____

____

____

____

____

How long have you been doing this?

- ☐ 3 to 6 months
- ☐ 6 months to one year
- ____________ years

Social History

Do you smoke? ☐ Yes ☐ No #per day: ____________

How much did you smoke in the past?

____

Do you drink alcholic beverages? ☐ Yes ☐ No

- ☐ Daily
- ☐ Socially
- ☐ Rarely

Do you drink caffeinated beverages? ☐ Yes ☐ No

Number of cups/beverages per day: ____________

Thank You!

QuickDASH - Initial Patient name:______________________ Date:__________

INSTRUCTIONS

This questionnaire asks about your symptoms as well as your ability to perform certain activities.
Please answer every question, based on your condition in the last week, by circling the appropriate number.
If you did not have the opportunity to perform an activity in the past week, please make your best estimate of which response would be the most accurate.
It doesn't matter which hand or arm you use to perform the activity; please answer based on your ability regardless of how you perform the task.

1. Please rate your pain level with activity: NO PAIN = 0 1 2 3 4 5 6 7 8 9 10 = VERY SEVERE PAIN

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. Open a tight or new jar	1	2	3	4	5
2. Do heavy household chores (e.g., wash walls, floors).	1	2	3	4	5
3. Carry a shopping bag or briefcase.	1	2	3	4	5
4. Wash your back	1	2	3	4	5
5. Use a knife to cut food.	1	2	3	4	5
6. Recreational activities in which you take some force or impact through your arm, shoulder or hand(e.g., golf, hammering, tennis, etc.).	1	2	3	4	5
	NOT AT ALL	SLIGHTLY	MODERATELY	QUITE A BIT	EXTREMELY
7. During the past week, to what extent has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbors or groups?	1	2	3	4	5
	NOT LIMITED AT ALL	SLIGHTLY LIMITED	MODERATELY LIMITED	VERY LIMITED	UNABLE
8. During the past week, were you limited in your work or other regular daily activities as a result of your arm, shoulder or hand problem?	1	2	3	4	5
Please rate the severity of the following symptoms in the last week. (circle number)	NONE	MILD	MODERATE	SEVERE	EXTREME
9. Arm, shoulder or hand pain.	1	2	3	4	5
10. Tingling (pins and needles) in your arm, shoulder or hand.	1	2	3	4	5
	NONE	MILD	MODERATE	SEVERE DIFFICULTY	SO MUCH DIFFFICULTY THAT I CAN'T SLEEP
11. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand? (circle number)	1	2	3	4	5

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Therapist Use Only

Comorbidities:

- ☐Cancer
- ☐Diabetes
- ☐Heart Condition
- ☐High Blood Pressure
- ☐Multiple Treatment Areas
- ☐Neurological Disorders (e.g., Parkinson's, Muscular Dystrophy, Huntington's, CVA, Alzheimer's, TBI)
- ☐Obesity
- ☐Surgery for this Problem
- ☐Systemic Disorders (e.g., Lupus, Rheumatoid Arthritis, Fibromyalgia)

ICD Code: ____________