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

BRANSON PHYSICAL THERAPY, LLC.
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

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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!

PATIENT NAME: _____ ID#: _____ DATE: _____

Description: This survey is meant to help us obtain information from our patients regarding their current levels of discomfort and capability. **Please circle the answers below that best apply.**

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

MODIFIED OSWESTRY DISABILITY SCALE – INITIAL VISIT

1. Pain Intensity
(0) I can tolerate the pain I have without having to use pain medication.
(1) The pain is bad, but I can manage without having to take pain medication.
(2) Pain medication provides me with complete relief from pain.
(3) Pain medication provides me with moderate relief from pain.
(4) Pain medication provides me with little relief from pain.
(5) Pain medication has no effect on my pain.

2. Personal Care (washing, dressing, etc.)
(0) I can take care of myself normally without causing increased pain.
(1) I can take care of myself normally, but it increases my pain.
(2) It is painful to take care of myself, and I am slow and careful.
(3) I need help, but I am able to manage most of my personal care.
(4) I need help every day in most aspects of my care.
(5) I do not get dressed, wash with difficulty, and stay in bed.

3. Lifting
(0) I can lift heavy weights without increased pain.
(1) I can lift heavy weights, but it causes increased pain.
(2) Pain prevents me from lifting heavy weights off the floor, but I can manage if the weights are conveniently positioned (eg, on a table).
(3) Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
(4) I can lift only very light weights.
(5) I cannot lift or carry anything at all.

4. Walking
(0) Pain does not prevent me from walking any distance.
(1) Pain prevents me from walking more than 1 mile.
z(2) Pain prevents me from walking more than ½ mile.
(3) Pain prevents me from walking more than ¼ mile.
(4) I can only walk with crutches or a cane.
(5) I am in bed most of the time and have to crawl to the toilet.

5. Sitting
(0) I can sit in any chair as long as I like.
(1) I can only sit in my favorite chair as long as I like.
(2) Pain prevents me from sitting more than 1 hour.
(3) Pain prevents me from sitting more than ½ hour.
(4) Pain prevents me from sitting more than 10 minutes.
(5) Pain prevents me from sitting at all.

6. Standing
(0) I can stand as long as I want without increased pain.
(1) I can stand as long as I want but, it increases my pain.
(2) Pain prevents me from standing more than 1 hour.
(3) Pain prevents me from standing more than 1/2 hour.
(4) Pain prevents me from standing more than 10 minutes.
(5) Pain prevents me from standing at all.

7. Sleeping
(0) Pain does not prevent me from sleeping well.
(1) I can sleep well only by using pain medication.
(2) Even when I take pain medication, I sleep less than 6 hours.
(3) Even when I take pain medication, I sleep less than 4 hours.
(4) Even when I take pain medication, I sleep less than 2 hour
(5) Pain prevents me from sleeping at all.

8. Social Life
(0) My social life is normal and does not increase my pain.
(1) My social life is normal, but it increases my level of pain.
(2) Pain prevents me from participating in more energetic activities (eg. sports, dancing).
(3) Pain prevents me from going out very often.
(4) Pain has restricted my social life to my home.
(5) I have hardly any social life because of my pain.

9. Traveling
(0) I can travel anywhere without increased pain.
(1) I can travel anywhere, but it increases my pain.
(2) My pain restricts my travel over 2 hours.
(3) My pain restricts my travel over 1 hour.
(4) My pain restricts my travel to short necessary journeys journeys under 1/2 hour.
(5) My pain prevents all travel except for visits to the physician/therapist or hospital.

10. Employment / Homemaking
(0) My normal homemaking/job activities do not cause pain.
(1) My normal homemaking/job activities increase my pain, but I can still perform all that is required of me.
(2) I can perform most of my homemaking/job duties, but pain prevents me from performing more physically stressful activities (eg, lifting, vacuuming).
(3) Pain prevents me from doing anything but light duties.
(4) Pain prevents me from doing even light duties.
(5) Pain prevents me from performing any job or homemaking chores.

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)

ICD9 Code: _____