# 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
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PHONE (480) 983-1680
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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

## NECK DISABILITY INDEX – INITIAL VISIT

**1. Pain Intensity**
(0) I have no pain at the moment.
(1) The pain is very mild at the moment.
(2) The pain is moderate at the moment.
(3) The pain is fairly severe at the moment.
(4) The pain is very severe at the moment.
(5) The pain is the worse imaginable at the moment.

**2. Personal Care (washing, dressing, etc)**
(0) I can look after myself normally without extra pain.
(1) I can look after myself normally but it causes extra pain.
(2) It is painful to look after myself and I am slow and careful.
(3) I need some help but manage most of my personal care.
(4) I need help every day in most aspects of self care.
(5) I cannot get dressed, wash with difficulty and stay in bed

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

**4. Headache**
(0) I have no headaches at all.
(1) I have slight headaches which come infrequently.
(2) I have moderate headaches which come infrequently.
(3) I have moderate headaches which come frequently.
(4) I have severe headaches which come infrequently.
(5) I have headaches almost all the time.

**5. Recreation**
(0) I am able engage in all my recreational activities without pain.
(1) I am able to engage in my recreational activities with some pain.
(2) I am able to engage in most but not all of my usual recreational activities because of my neck pain.
(3) I am able to engage in a few of my usual recreational activities with some neck pain.
(4) I can hardly do any recreational activities because of neck pain.
(5) I can't do any recreational activities at all.

**6. Reading**
(0) I can read as much as I want with no pain in my neck.
(1) I can read as much as I want with slight neck pain.
(2) I can read as much as I want with moderate neck pain.
(3) I can't read as much as I want because of moderate neck pain.
(4) I can hardly read at all because of severe neck pain.
(5) I cannot read at all because of neck pain.

**7. Work**
(0) I can do as much as I want to.
(1) I can only do my usual work but no more.
(2) I can do most of my usual work but no more.
(3) I cannot do my usual work.
(4) I can hardly do any usual work at all.
(5) I can't do any work at all.

**8. Sleeping**
(0) Pain does not prevent me from sleeping well.
(1) My sleep is slightly disturbed (<1 hr sleep loss).
(2) My sleep is mildly disturbed (1-2 hr sleep loss).
(3) My sleep is moderately disturbed (2-3 hr sleep loss).
(4) My sleep is greatly disturbed (3-4 hr sleep loss).
(5) My sleep is completely disturbed (5-7 hr sleep loss).

**9. Concentration**
(0) I can concentrate fully when I want with no difficulty.
(1) I can concentrate fully when I want with slight difficulty.
(2) I have a fair degree of difficulty concentrating when I want.
(3) I have a lot of difficulty concentrating when I want.
(4) I have great difficulty concentrating when I want.
(5) I cannot concentrate at all.

**10. Driving**
(0) I can drive my car without neck pain.
(1) I can drive my car as long as I want with slight neck pain.
(2) I can drive my car as long as I want with moderate neck pain.
(3) I can't drive my car as long as I want because of moderate pain.
(4) I can hardly drive my car at all because of severe neck pain.
(5) I can't drive my car at all.



**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: _____