Patient Health Questionnaire

Name: _____ Date: _____

Mailing Address: _____ City/State: _____

Zip: _____ Home Phone: _____ Cell Phone: _____

Gender: Male ☐ Female ☐ Marital Status: Married ☐ Single ☐ Widowed ☐ Divorced ☐

Work Phone:_____ DOB / Age: _____ Social Security #: _____

Email: _____Next Dr. Appt: _____

Referring MD: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Emergency Contact: _____Relation: _____ Phone: _____

Please list any individuals we are authorized to speak with regarding your care/account: _____

_____

WHAT CONDITION ARE WE TREATING YOU FOR: _____

DATE OF INJURY: _____ HOW WERE YOU INJURED: _____

_____

IS THIS CONDITION THE RESULT OF AN INJURY OR ACCIDENT? Yes ☐ No ☐

If no injury involved, please continue to Health Insurance Information in Block 3

DID THE INJURY OCCUR AT WORK? Yes ☐ No ☐ IS A CLAIM FILED WITH YOUR EMPLOYER? Yes ☐ No ☐

(if you answered yes to this please complete blocks 1 and 3 below)

INJURY DUE TO AUTO ACCIDENT? Yes ☐ No ☐ (if yes, complete blocks 2 & 3 below) STATE MVA OCCURRED ____

1.) WORK COMP INSURANCE INFORMATION

Claim Employer _____ phone _____

Claim insurance carrier _____

Claim Number _____ Claim Adjuster _____

2.) AUTO INSURANCE INFORMATION - Have you filed this with your own auto insurance? Yes ☐ No ☐

Patient's Automobile Insurance _____phone_____

Policyholder Name _____ Claim # _____

Responsible Party's Insurance _____ Policyholder name _____

3.) HEALTH INSURANCE INFORMATION

Name of Insurance : _____Subscriber Name _____

Subscriber Date of Birth: _____ Relationship to patient: _____

Subscriber ID#: _____Group #: _____

I AUTHORIZE MY INSURANCE COMPANY (OR ATTORNEY IF APPLICABLE) TO MAKE PAYMENT DIRECTLY TO BUTLER PHYSICAL THERAPY. I AUTHORIZE THE RELEASE OF INFORMATION NECESSARY TO PROCESS MY CLAIM AND I ACKNOWLEDGE I HAVE RECEIVED THE NOTICE OF PRIVACY PRACTICES. I UNDERSTAND IT IS MY RESPONSIBILITY TO HAVE ANY PRE-CERTIFICATION IN PLACE IF REQUIRED BY MY INSURANCE. I ACCEPT FULL RESPONSIBILITY FOR THE CHARGES INCURRED. I HAVE READ AND BEEN OFFERED A COPY OF THE HIPAA & NOTICE OF PRIVACY POLICY.

Signature: _____ Date: _____

Patient Health Questionnaire Continued

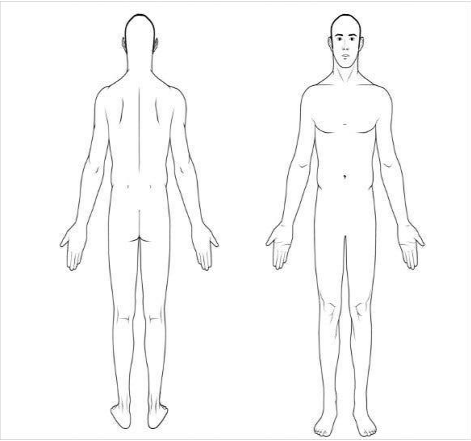
Primary Complaint: _____ Secondary Complaint: _____

Symptoms start date: _____ How did symptoms begin? _____

_____

How often do you feel symptoms? Constantly ☐ Frequently ☐ Occasionally ☐ Intermittently ☐
Since onset, are your symptoms? Better ☐ Worse ☐ Same ☐ Other _____
Rate your pain 0-10 (0 is no pain and 10 is emergency room pain): Today ____ Worst ____ Least _____

Where do you feel your pain?



Description of your pain: (check all that apply)

Ache ☐ Burning ☐ Cramping ☐ Throbbing ☐ Sharp ☐
Nagging ☐ Numbness ☐ Tingling ☐ Radiating ☐ Twinge ☐
Soreness ☐ Shooting ☐ Squeezing ☐ Electrical ☐ Zinging ☐
Stabbing ☐ Other _____

Pain over course of the day:
Increases ☐ Decreases ☐ Stays the same ☐
Do you have pain at night? Yes ☐ No ☐
If yes: While lying still? ☐ When changing positions? ☐

What is your sleeping position? Stomach ☐ Right Side ☐
Left side ☐ Back ☐ All positions ☐ Chair/Recliner ☐

Additional Symptoms (if not described above): _____

_____

What makes it worse? _____

_____

What makes it better? _____

_____

Since onset of symptoms, have you experienced any of the following (check all that apply):
Difficulty with bowel/bladder control ☐ Fever or chills ☐ Numbness ☐ Unexplained weight loss ☐
Vision or hearing problems ☐ Numbness in Genital/Anal area ☐ Dizziness or fainting ☐ Weakness ☐

Have you been treated for this condition before? Yes ☐ No ☐

Have you had any imaging or tests for your current condition? None ☐ X ray ☐ MRI ☐ CT Scan ☐
Bone Scan ☐ EMG/NCV ☐ PET Scan ☐ Other: _____

Patient Health Questionnaire Continued

Health History:

How would you rate your general health? Excellent ☐ Good ☐ Fair ☐ Poor ☐

Do you exercise? Yes ☐ No ☐ If yes, How often and type: _____

Dominant hand? Right ☐ Left ☐ Do you use tobacco? Yes ☐ No☐ Do you drink alcohol? Yes☐ No ☐

Do you use Marijuana? Yes ☐ No ☐ Are you currently pregnant? Yes ☐ How far along ____ No ☐

Please indicate if you have had or currently have any of the following:

	Yes/Year		Yes/Year		Yes/Year
Stroke	☐/____	Degenerative Joint Disease	☐/____	Asthma	☐/____
Heart Attack	☐/____	Osteoporosis/Osteopenia	☐/____	Polio	☐/____
Headaches	☐/____	Peripheral Vascular Disease	☐/____	COPD	☐/____
Diabetes	☐/____	Sensitivity to heat/cold	☐/____	Hernia	☐/____
Alzheimer's	☐/____	ALS/Lou Gehrig's	☐/____	AIDS/HIV	☐/____
Tuberculosis	☐/____	Skin Conditions	☐/____	Cancer	☐/____
Depression	☐/____	Bowel/Bladder Issues	☐/____	Lupus/SLE	☐/____
Blood Clots/DVT	☐/____	Thyroid (Hyper/Hypo)	☐/____	Hepatitis	☐/____
Alcoholism	☐/____	High Blood Pressure	☐/____	Arthritis	☐/____
Concussion	☐/____	Congestive Heart Failure	☐/____	Multiple Sclerosis	☐/____
Pacemaker	☐/____	Other: _____			

List any surgeries and dates:
_____
_____

List any medications/vitamins/supplements and what they are for:
_____
_____
_____
_____

List any allergies: _____
_____

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Patient Health Questionnaire Continued

Functional Activity:

Prior to your injury, were you limited in any of these areas? Self-Care ☐ Mobility ☐
Changing/Maintaining body position ☐ Carrying/Moving and Handling objects ☐

What areas are you limited in now? Self-Care ☐ Mobility ☐ Changing/Maintaining body position ☐
Carrying/Moving and Handling objects ☐

Do you live with anyone? Yes ☐ No ☐ If yes, whom? _____
Do you have any stairs where you live? Yes ☐ No ☐ If yes, how many? _____

Work History:

Occupation: _____

Full Time ☐ Part Time ☐ Unemployed ☐ Retired ☐ Self Employed ☐
Student☐ Other: _____

Job Requirements (check all that apply)

Sitting ☐ Standing ☐ Phone Use ☐ Computer Use ☐ Driving ☐ Prolonged Positions ☐
Bending☐ Repetitive Lifting ☐ Heavy lifting ☐ Twisting ☐ Other: _____

Are you currently receiving or seeking disability benefits for this condition? Yes ☐ No ☐

Do you have a previous disability from another condition? Yes ☐ No ☐

Does your current condition limit normal work activities? Yes ☐ No ☐

Do you plan to return to work? Yes ☐ No ☐

Previous Treatment:

Have you had Physical Therapy before? Yes ☐ No ☐ if yes, for what? _____

Was it a good experience? Yes ☐ No ☐ Explain: _____

What are your Physical Therapy Goals? _____

_____

_____

I understand by signing the medical intake form, I have provided correct information to the best of my knowledge and give my written consent for Physical Therapy evaluation and treatment.

Patient/Guardian Signature: _____ Date: _____

Patient Responsibility

Thank you for selecting Butler Physical Therapy, LLC to assist you with your therapy. We are committed to providing you with the utmost compassion and professionalism throughout your care and we look forward to assisting you with your physical therapy needs.

By initialing and signing below you are acknowledging you have read and understand the following information:

_____ Notice of Privacy Practices: For your convenience a laminated copy of the Butler Physical Therapy, LCC Notice of Privacy Practices / HIPAA Privacy Act is available for you to read. You may request a copy at any time.

_____ Insurance: As a courtesy, your claims will be filed directly with Medicare, Medicaid, or your primary insurance carrier by Butler Physical Therapy, LLC. Insurance companies often have limits on the amount of physical therapy they will pay for in a year. Limits may be imposed monetarily or by number of visits.

- It is the patient's responsibility to know and understand their insurance plan.
- Failure to present correct and current insurance information at the time of service may result in a fee of up to 15% of the billable amount.
- If insurance sends correspondence, please reply as to not delay or negate your benefits.
- Having insurance is in no way a guarantee of benefits. If your benefits are exhausted at any point during treatment, there are alternative payment options available.

_____ Co-Payments: All co-payments are due at the time of service.

_____ Account Balances: All patient balances are the patient's responsibility.

- A $100 minimum payment or Co-Pay equivalent is required monthly.
- All co-payments are due at the time of service. If your co-payments for the month exceed $100, then the $100 minimum may be waived.
- Any patient balance remaining after 60 days will be subject to a 2% finance charge per month.

_____ Cancellation / No Show Policy:

- A $50.00 No Show Fee may be charged to your account, if you fail to show up for an appointment or cancel without 6 business hours prior notice. If you give less than 6 hours notice and we are able to fill your appointment time, no fee will be issued.
- No Show Fees are the patient's responsibility and cannot be billed through your insurance company.

Signature: _____ Date: _____

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