Patient Health Questionnaire

Name: _____ Nickname: _____ Date:_____

Age: _____ Date of Birth: _____Height: _____ Weight: _____

Occupation:_____ Employer:_____

Do you have a Health savings account (HSA)? [ ] Yes, [ ] No

How did you hear about our facility? [ ] Physician Referral [ ] You Are a Past Patient

[ ] Signage [ ] Friend or Family [ ] TV Commercial [ ] Website [ ] Other

How did problem occur? _____ [ ] Unknown

When did symptoms begin? Month _____ Day_____ Year_____

[ ] Within the past month [ ] Within the past year [ ] Ongoing for over a year

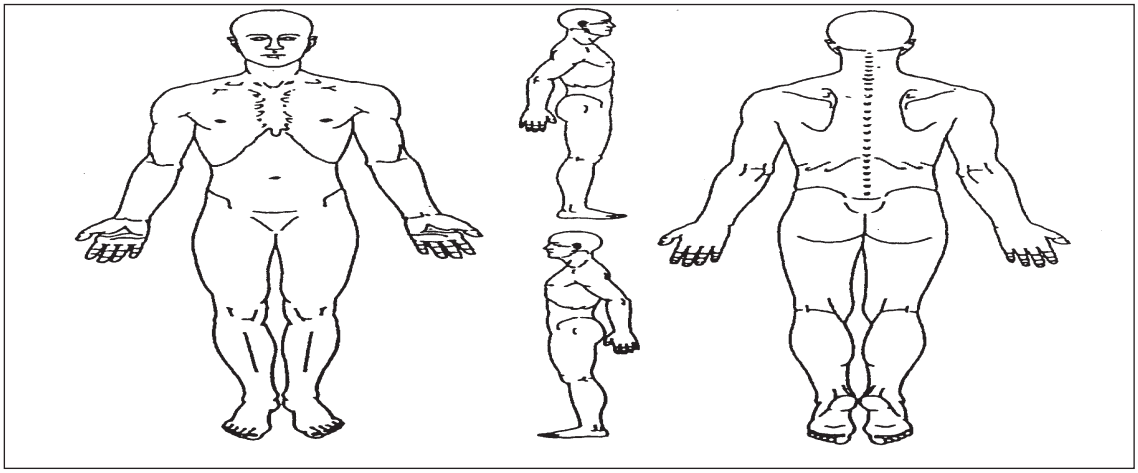
Have you had a MRI of your injury? [ ] Yes, [ ] No

Which body part(s) _____,What MRI Facility_____

Did you have surgery for this condition? [ ] Yes, [ ] No Surgeon Name _____

Date of surgery: Month _____ Day_____ Year_____

***On below chart please mark (X) location of your injury that you were referred for treatment**:



Please rate your pain on a scale of 0 – 10 with (0) being no pain and (10) being the worst.

At Worst:	0	1	2	3	4	5	6	7	8	9	10
Current:	0	1	2	3	4	5	6	7	8	9	10
At Best:	0	1	2	3	4	5	6	7	8	9	10

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Aggravating Factors: [ ] Sitting, [ ] Standing, [ ] Walking, [ ] Stairs, [ ] Sit to stand, [ ] Bending, [ ] Lifting, [ ] Sleeping, [ ] Squatting, [ ] Carrying, [ ] Reaching Overhead, [ ] Handling objects, [ ] Pushing, [ ] Pulling, [ ] Running, [ ] Jumping, [ ] Exercise

What other treatment have you received for this condition? [ ] Medication [ ] Injections [ ] Chiropractic [ ] Surgery [ ] Other _____ Doctor's Name_____

Medications related to your injury: [ ] Prescription pain, [ ] Over the counter pain, [ ] Anti-inflammatory, [ ] Other _____

Check if you have, or have ever had any of the following conditions:

[ ] Abdominal Aneurysm, [ ] Pacemaker, [ ] Diabetes Type 1, [ ] Diabetes Type 2 [ ] Stroke [ ] High Blood Pressure, [ ] HIV (+), [ ] Heart Attack, [ ] Fibromyalgia, [ ] Rheumatoid Arthritis, [ ] Osteo Arthritis [ ] Currently Pregnant [ ] Cancer, What type_____ [ ] Are you in remission

Please list other pertinent medical conditions that might affect your treatment:

_____

Patient Name:_____

PHYSICAL THERAPY SPECIALISTS
Patient Information

_____ _ _ _____/___/__ _____
Patient First Name Middle Initial Last Name Gender Date of Birth Age Marital Status

_____
Street Address City State Zip

(____) _____-_____(____)_____-_____ _____-_____-_____
Cell Phone number Home Phone Number E-mail Address Social Security Number

If you like to receive a reminder by text, email or voice call for your visits please circle one: Text E-mail Voice

_____(____)_____-_____
Emergency Contact Name Relation to Patient Phone Number

_____(____)_____-_____
Patient Employer's Name Employer's Phone

_____(____)_____-_____
Name of Primary Care Physician Primary Care Physicians Phone Number

_____(____)_____-_____
Referring Doctor Referring Doctor Phone Number

_____
How did you hear about our facility?

SPOUSE/ PARENT *(IF NOT MARRIED)* **INFORMATION**

_____/___/_____
Last Name First Name Initial Date of Birth

***** Is my referral due to a Workers Comp, Auto Accident, or Slip and Fall Personal Injury?**
Yes No Circle one of the above if Yes

RESPONSIBILITY STATEMENT & RELEASE OF INFORMATION
I understand that I am responsible for paying for all medical services not covered by an authorization/agreement between Physical Therapy Specialists and my insurance carrier or attorney. I authorize the release of any or all of the patient's medical records for this period of care to any person/corporation liable for any part of the physician charges and the patient's attorney. Oklahoma state law requires that we advise "The information authorized for release may include information which may be considered a communicable or venereal disease including but not limited to Hepatitis, Syphilis, Gonorrhea, Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (AIDS)."

_____
Print Patient or Legal Guardian Name

_____
Patient or Legal Guardian Signature Date