PHYSICAL THERAPY & WELLNESS CENTER

2490 S. Main Street, Red Bluff, CA 96080 phone (530) 529-3636 fax (530) 529-2241

Patient Information

Patient Name_____ Date of Birth_____
Marital Status: single/married/other_____ Home Phone_____ Cell_____
Street Address_____ City_____ State_____ Zip_____
Mailing Address_____ City_____ State_____ Zip_____
Employer/School_____ Message/Work Phone_____
Address_____ City_____ State_____ Zip_____
Email Address_____

Financial Responsibility

Person(s) who are ultimately responsible for payment of this account must fill out this area completely.
Same as above? Yes or No
Name_____ Relationship to Patient_____ SS#_____
Driver's License_____ Date of Birth_____ Address_____
City_____ State_____ Zip_____ School/Employer_____
Occupation_____ Address_____ City_____ State_____ Zip_____

Emergency Information

Who should we contact in case of emergency_____ Phone_____
Relationship to patient_____

Treating/Referring Information

Which Physician referred you to our office _____
Date of onset/date of injury_____ Are we treating you as a result of an accident/injury Yes or No?
If yes, please circle the type of injury: Work Auto Other
If Other, please explain _____ If auto, which state?_____

The undersigned agrees, whether he/she is as a patient or as a responsible party, that in consideration of the services to be rendered to the patient he/she hereby individually obligates him/herself to pay the account with physical therapist in accordance with the regular rules and terms of the physical therapist's bill. Should the account be referred to a collection agency or attorney, the undersigned shall be responsible for any charges necessary to collect the patient's account.

The undersigned certifies that he/she has read and understands the foregoing, received a copy if requested and is the patient or is duly authorized by the patient as the patient's general agent or responsible party to execute the above and accept the terms.

I, the undersigned authorize and demand the assignment of payment of my basic medical, major medical, third party medical, or any other medical benefits that my apply, herein specified and otherwise payable to me directly, to Physical Therapy & Wellness Center.

I authorize the release of any medical or billing information necessary to process my claims for payment. I have received, read and fully understand Physical Therapy & Wellness Center notice of information practices. I understand that Physical Therapy and Wellness Center may disclose my personal information for the purpose of carrying out treatment, obtaining, payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment, and administrative operation if I notify the practice, I also understand that Physical Therapy & Wellness Center will consider requests for restriction on a case-by-case basis, but does not have to agree to request restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Physical Therapy & Wellness Center Notice of Information Practice. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

In no way will I revoke the Assignment/Authorization without first obtaining written consent of Physical Therapy & Wellness Center. This Assignment/Authorization shall be as valid as my insurance form. A photocopy of this Assignment/Authorization shall be valid as the original. With my signature, I also give my consent to Physical Therapy & Wellness Center to administer treatment as outlined by my physician.

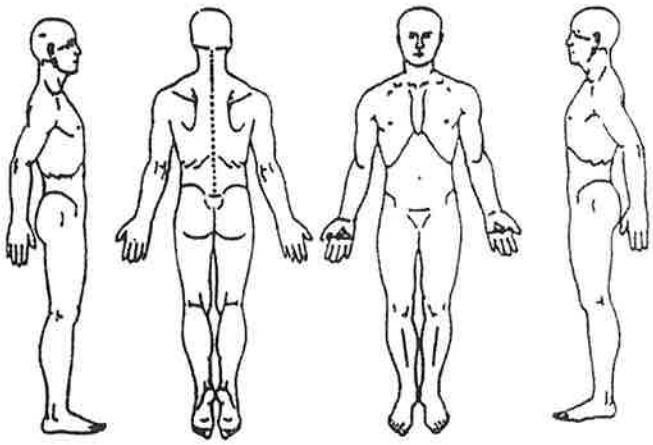
Signature_____ Date_____

Patient Health Questionnaire-PHQ

Patient Name: _____ Date_____

1. Describe your symptoms: _____
   a. When did your symptoms start? _____
   b. How did your symptoms begin? _____

2. Indicate where you have symptoms:



3. How often do you experience your symptoms?
   a. Constantly (76%-100% of the day)
   b. Frequently (51%-75% of the day)
   c. Occasionally (26%-50% of the day)
   d. Intermittently (0-25% of the day)

4. What best describes your symptoms?
   a. Sharp/Shooting ↓↓↓
   b. Dull/Ache OOO
   d. Burning XXX
   e. Numbness/Tingling ////

   Please indicate symbols on body chart

5. Are your symptoms:
   a. Getting better
   b. Not changing
   c. Getting worse

6. During the past 4 weeks indicate the intensity of your symptoms: Best, Average, Worst

BEST	AVERAGE	WORST
1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10
1=no pain	5= moderate/severe pain	10=worst pain imaginable

7. During the past 4 weeks how much have your symptoms interfered with your normal activities?

1 2 3 4 5 6 7 8 9 10

No problem at all — unable to perform

8. In general would you say your overall health right now is: Excellent Very good Good Fair Poor

9. Who have your seen for your symptoms? (Circle all that apply)

a. Medical Doctor
b. Physical therapist
c. Chiropractor
d. Other_____

10. Have you had similar symptoms in the past? Yes or No

11. Which diagnostic tests have been preformed? (Circle and provide date for all that apply)
   a. X ray / Date _____
   b. MRI / Date _____
   c. CT scan / Date _____
   d. Bone scan / Date _____
   e. Other / Date _____

12. Within the past year, have you had any of the following symptoms? (Check all that apply)

___ Bowel problems
___ Chest pain
___ Coordination problems
___ Cough
___ Difficulty sleeping
___ Difficulty swallowing
___ Difficulty walking
___ Dizziness or blackouts
___ Fever/chills/ sweats
___ Headaches
___ Hearing problems
___ Heart palpitations
___ Hoarseness
___ Joint pain or swelling
___ Loss of appetite
___ Loss of balance
___ Nausea/vomiting
___ Pain at night
___ Shortness of breath
___ Urinary problems
___ Vision problems
___ Weakness in arms or legs
___ Weight loss/gain
___ Other:_____

For Men: Have you been diagnosed with prostate disease _____ Yes _____ No

For Women: Have you been diagnosed with:

Pelvic inflammatory disease?
_____ Yes _____ No

Endometriosis?
_____ Yes _____ No

Trouble with your menstrual cycle?
_____ Yes _____ No

Complicated pregnancies or deliveries?
_____ Yes _____ No

Pregnant, or think you might be pregnant?
_____ Yes _____ No

13. Medical History: Please mark if you/family member have ever had:
You (Y) Family (F) Both (B)

_____ Infectious disease
_____ Arthritis
_____ Blood disorders
_____ Kidney problems
_____ Broken bones/fracture
_____ Hypoglycemia
_____ Cancer
_____ Lung problem
_____ Circulation
_____ Vascular problems
_____ Multiple sclerosis
_____ Muscular dystrophy
_____ Depression
_____ Osteoporosis
_____ Parkinson's disease
_____ Repeated infections
_____ Diabetes
_____ Seizures/epilepsy
_____ Skin diseases
_____ Eating Disorders
_____ Head injury
_____ Stroke
_____ Heart problems
_____ Thyroid problems
_____ High blood pressure
_____ Ulcers
_____ Other: _____

14. Have you ever had surgery?
____ Yes ____ No

If yes, please describe, and include dates:
_____
_____
_____
_____

15. What is your body weight? _____
height? _____

Medications:

Do you take any prescription medications?
___ Yes ___ No

If yes, please list:

Medication	Dosage/Frequency

☐ Patient Provided List

_____ PT Initials

Allergies:

Do you have any allergies? ___Yes ___No
If yes, please list:

_____
_____

Do you take any nonprescription medications or supplements?
_____ Yes _____No
If yes, what?

_____
_____

Health Habits:

Do you exercise regularly? ____Yes ____No
If yes, how often and what type of activities?

_____

Do you use tobacco ?____Yes ____No
Typed used?

_____

If no, have you used tobacco in the past?
_____ Yes _____ No
Year Quit:_____

How many days per week do you drink beer, wine, or other alcoholic beverages, on average?_____

Social History:

Where do you live?
____Private home
____Private apartment
____Rented room
____Hospice
____Board and care/assisted living
____Homeless(with or without shelter)
____Long-term care facility
Other:_____

With whom do you live?
____Alone
____Spouse only
____Spouse and others
____Child(not spouse)
____Other relative(s)
____Personal care attendant
____Group setting
Other: _____

Does your home have:
____Stairs, no railing
____Stairs, w/railing
____Ramps
____Elevator
____Uneven Terrain
Other Obstacles:_____

Do you use:
____Cane
____Walker or rollator
____Manual wheelchair
____Motorized wheelchair
Other_____

Do you have a history of Falls?___Yes ____No
I yes please describe including frequency and injury_____
_____

What is your current occupation and job duties?_____
_____
_____

What are your Hobbies?

_____
_____

Patient Signature _____ Date _____

Physical Therapy & Wellness Center
INTAKE REVIEW

As a courtesy to our patients, our office will bill your primary and secondary insurance. To assist in doing so, please provide us with a copy of your insurance card. We hold the patient responsible for knowing their insurance benefits. If you are unsure of your physical therapy benefits please contact your carrier for more information.

1. Make sure to inform front desk staff of your arrival to appointment.

2. All scheduled appointments are considered a commitment from you to participate in your health care. Please give a **24-hour notice of cancellation** of scheduled appointments. After two cancellations you will jeopardize your rescheduling, due to availability only. When you fail to keep your appointment or fail to call 24 hours of your scheduled appointment, you will be charged , not your insurance, for a **$30.00 fee**. You will be given one opportunity to keep your following appointments. After that we will no longer continue to schedule appointments for you. If you are more than 10 minutes late for an appointment, you maybe asked to reschedule your appointment.

3. A physician or other qualified healthcare providers referral and/or prescription is not an authorization for services.

4. It is the patient's responsibility to know their insurance benefits. If you are concerned about your coverage, please refer to your insurance handbook or phone your carrier.

5. The patient is responsible for any charges not paid by their insurance: deductibles, co-payments, non-covered services, equipment, share of cost, or denials not due to error on our part. Co-payments and share of costs will be collected each visit.

6. All equipment received is **nonrefundable**.

Attention Medicare patients: If you are currently receiving or have had physical therapy in the last 60 days, please inform the front desk.

WITH MY SIGNATURE AS A PATIENT OR RESPONSIBLE PARTY, I ACKNOWLEDGE THAT I AM AWARE OF AND FURTHER ACCEPT THE ABOVE CONDITIONS.

DATE:_____ SIGNATURE:_____