Physical Therapy Care
REGISTRATION FORM

(Please Print)

Today's Date _____/_____/_____ Referring Physician_____

PATIENT INFORMATION

Last Name	First Name	Middle	❑ Mr. ❑ Mrs. ❑ Miss ❑ Ms.	Marital Status (Circle One) Single / Mar / Div / Sep / Widow

Home Address (Street Address, City, State, Zip Code)	Birth Date / /	Age	Sex ❑ M ❑ F
			Home Phone No. ( )
Email Address			Cell Phone No. ( )

Would you like to receive a reminder of your appointments via text? ❑ Yes **OR** ❑ No

Please Provide Cell Phone Carrier (Circle One): Verizon / AT&T / T-Mobile / Boost Mobile / Sprint PCS / Other: _____

Occupation	Employer

Employer Address	City	State	Zip Code	Employer Phone No. ( )

Chose Clinic Because/Referred to Clinic by (Please check one box) ❑ Dr. _____ ❑ Insurance Plan ❑ Hospital

❑ Family ❑ Friend ❑ Close to Home/Work ❑ Yellow Pages ❑ Other _____

Other Family Members Seen Here _____

Is your injury work related? ❑ Yes ❑ No If yes, Date of injury: _____/_____/_____

IN CASE OF EMERGENCY

Name of Local Friend or Relative	Relationship to Patient	Home Phone No. ( )	Work Phone No. ( )

Patient Information Consent Form

I have read and fully understand **Physical Therapy Care, Inc.'s** Notice of Information Practices. I understand that **Physical Therapy Care Inc.** may use or disclose my personal health information for the purposes 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 operations if I notify the practice. I also understand that **Physical Therapy Care Inc.** will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions. **Initial** _____

I hereby consent to the use and disclosure of my personal health information for purposes as noted in **Physical Therapy Care Inc.'s** Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time. **Initial** _____

I authorize Physical Therapy Care or my insurance company to release any information required to process my claims. **Initial** _____

I authorize my insurance benefits be paid directly **Physical Therapy Care**. I understand that I am financially responsible for any unpaid balance. **Initial** _____

I have read, understand and have received a copy of **Physical Therapy Care Inc.** Policies and Procedures**. Initial** _____

The above information is true to the best of my knowledge.

X _____

PATIENT/GUARDIAN SIGNATURE DATE

OVER →

Patient Health Questionnaire - PHQ

Form PHQ-202

rev 7/18/05

Patient Name _____ ***Date*** _____

1. Describe your symptoms _____

_____

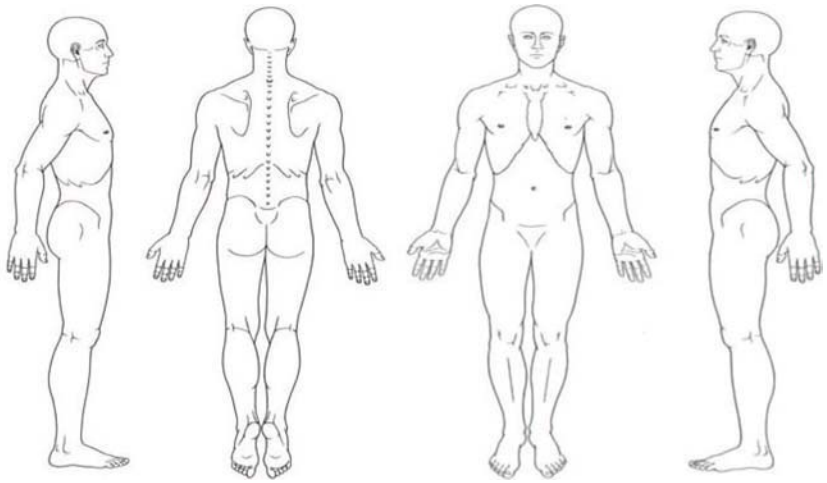
a. When did your symptoms start? _____

b. How did your symptoms begin? _____

2. How often do you experience your symptoms?

① Constantly (76-100% of the day)
② Frequently (51-75% of the day)
③ Occasionally (26-50% of the day)
④ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?

① Sharp ④ Shooting
② Dull ache ⑤ Burning
③ Numb ⑥ Tingling

4. How are your symptoms changing?

① Getting Better
② Not Changing
③ Getting Worse

5. During the past 4 weeks:

None *Unbearable*

a. Indicate the average intensity of your symptoms ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

b. How much has pain interfered with your normal work (including both work outside the home, and housework)

① Not at all ② A little bit ③ Moderately ④ Quite a bit ⑤ Extremely

6. During the past 4 weeks how much of the time has your condition interfered with your social activities?
(like visiting with friends, relatives, etc)

① All of the time ② Most of the time ③ Some of the time ④ A little of the time ⑤ None of the time

7. In general would you say your overall health right now is...

① Excellent ② Very Good ③ Good ④ Fair ⑤ Poor

8. Who have you seen for your symptoms?

① No One
② Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

a. What treatment did you receive and when? _____

b. What tests have you had for your symptoms and when were they performed?

① Xrays *date:* _____ ③ CT Scan *date:* _____
② MRI *date:* _____ ④ Other *date:* _____

9. Have you had similar symptoms in the past? ① Yes ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

① This Office
② Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

10. What is your occupation?

_____

① Professional/Executive
② White Collar/Secretarial
③ Tradesperson
④ Laborer
⑤ Homemaker
⑥ FT Student
⑦ Retired
⑧ Other

a. If you are not retired, a homemaker, or a student, what is your current work status?

① Full-time
② Part-time
③ Self-employed
④ Unemployed
⑤ Off work
⑥ Other

Patient Signature _____ ***Date*** _____

Please complete all requested information:

Have you ever had: If yes, please explain

High Blood Pressure	No ❑ Yes ❑	_____
Heart or Circulation Disorders	No ❑ Yes ❑	_____
Seizures	No ❑ Yes ❑	_____
Dizzy Spells	No ❑ Yes ❑	_____
Diabetes	No ❑ Yes ❑	_____
Cancer	No ❑ Yes ❑	_____
Arthritis/Osteoarthritis	No ❑ Yes ❑	_____
Osteoporosis	No ❑ Yes ❑	_____
Immune Deficiency Disease	No ❑ Yes ❑	_____
Other	No ❑ Yes ❑	_____

Do you have any METAL anywhere in your body: pins/plates post fracture, or pacemaker (other than teeth)?

No ❑ Yes ❑ Describe: _____

***(For women only)* Are you now pregnant?** No ❑ Yes ❑

Do you have any abnormal trouble with vision? No ❑ Yes ❑ ***Hearing?*** No ❑ Yes ❑

List any allergies you have _____

List any medications you are now taking _____

_____

Have you ever had Physical Therapy treatments before? No ❑ Yes ❑

If yes, please indicate where, when, and for what problem _____

_____

Date of last doctor appointment: ____/____/____ **Date of next appointment** ____/____/____

For office use ONLY: