

Brunswick Physical Therapy
70 Souder Road
Brunswick, MD 21716

Patient Information (Please print in BLACK ink**)**

Last Name: _____ First Name: _____ MI: _____

Nickname: _____

DOB: _____ Age: _____ SSN: _____ - _____ - _____ Gender: Male Female

Home Phone: _____ Work: _____ Cell: _____

Can we leave appointment/billing information on your voicemail? Yes No

Email: _____

Would you like to receive appointment reminders via email? Yes No

Physical Address: _____

City/State: _____ Zip: _____

Mailing Address: SAME AS ABOVE

Address: _____

City/State: _____ Zip: _____

Marital Status: Married Single Widow Divorced Separated

Are you a student? Yes No

Employer Name: _____

Occupation: _____

Emergency Contact Name: _____

Relation to you: _____ Phone: _____

Responsible Party (*minors only*): _____

Attorney name & phone (*if applicable*): _____

Primary Care Physician: _____

Referring Dr.: _____

How did you hear about us?: _____

Initial and Date Completed _____

Initial and Date Reviewed _____

Initial and Date Reviewed _____

Name: _____

DOB: _____

INSURANCE FILING AND TREATMENT RELEASE

Assignment of insurance, benefits, release of information and authorization to treat; and the responsibility for payment, assignment of benefits authorization and medical release: I, the undersigned, do hereby expressly guarantee payment in full of any and all claims and charges in consideration for medical services rendered to, or to be rendered to me by Brunswick Physical Therapy. I hereby authorize and demand the assignment of my basic medical, major medical, auto medical, third party medical, or any other medical benefits that may apply, herein specified and otherwise payable to me, directly to Brunswick Physical Therapy, LLC. I authorize Brunswick Physical Therapy to release medical information acquired in the course of my treatment and examination to my insurance company. If for any reason the account should become delinquent, I agree to pay all rebilling charges, interest charges, collection of costs and reasonable legal fees. I understand and agree to the Brunswick Physical Therapy payment policies.

Signature: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You may refuse to sign this acknowledgment****

I understand a copy of this office’s Notice of Privacy Practices is available to me upon request.

Extended Authorization Option:

Please list any person you would like to authorize to have access to your billing, make/change or access to your appointment or health information (with the exclusion of information that is protected under State or Federal law) **such as your spouse, caretaker, parent, or other family member**. If their name is not listed below no information will be given or changed, including appointments

If you wish not to list anyone, write “N/A”.

Name:

Relationship:

Signature

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgment
- An emergency situation prevented us from obtaining acknowledgement
- Other (please specify)

Initial and Date Reviewed _____

Initial and Date Reviewed _____

Initial and Date Reviewed _____

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Patient Medications

Patient Name _____

DOB _____

List all allergies and your reactions

Allergy	Reaction

List all medications

Medication	Strength (ex: mg, mcg...)	How is it taken (ex: mouth, cream, shot)	Frequency (ex: once daily, as needed)	Why are you taking this medication?

Initial and Date Completed _____

Initial and Date Reviewed _____

Initial and Date Reviewed _____

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Patient Health History

Patient Name _____

DOB _____

1) Have you completed an advance directive/ Do Not Resuscitate Order (DNR)? A DNR is a request not to have cardiopulmonary resuscitation (CPR) if your heart stops or if you stop breathing.

Yes No

2) Please check if you have / ever had:

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Broken bones/fractures | <input type="checkbox"/> Muscular Dystrophy |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Osteoporosis/Osteopenia | <input type="checkbox"/> Seizures/epilepsy |
| <input type="checkbox"/> Blood disorders | <input type="checkbox"/> Allergies | <input type="checkbox"/> Circulation/vascular | <input type="checkbox"/> Heart problems |
| <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Cancer | <input type="checkbox"/> Skin diseases |
| <input type="checkbox"/> Lung problems | <input type="checkbox"/> Stroke | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Head injury |
| <input type="checkbox"/> Repeated infections | <input type="checkbox"/> Ulcers/stomach problems | <input type="checkbox"/> Depression | <input type="checkbox"/> Prostate disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Metal implant | <input type="checkbox"/> Low blood sugar/
hypoglycemia | <input type="checkbox"/> Infectious disease (e.g.
tuberculosis, hepatitis) |
| <input type="checkbox"/> Developmental or
growth problems | <input type="checkbox"/> Other: _____ | | |

3) List all surgeries

Surgery	Approx Month & Year

Initial and Date Completed _____

Initial and Date Reviewed _____

Initial and Date Reviewed _____

Patient Health Questionnaire – PHQ

Patient Name _____

DOB _____

1) Area to be treated:

Indicate where you have pain or other symptoms

2) Left, right, or both sides?

3) Injury/surgery date:

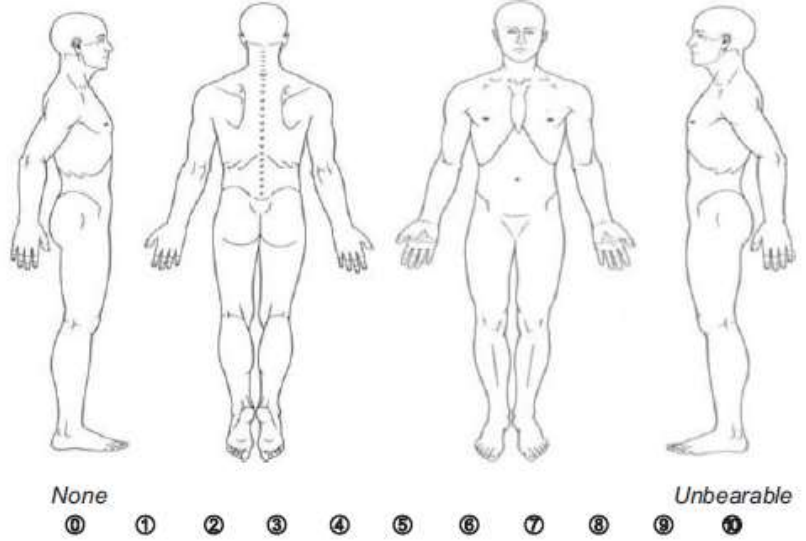
4) How did your symptoms begin?

5) Is this injury from a:

- Work injury: Yes No

- Auto accident: Yes No

(If yes, in what state? _____)



6) Describe your symptoms _____

7) Who have you seen for your symptoms? When? _____

8) What tests have you had (Xrays/MRI/CT Scan) and when? _____

9) Have you had similar symptoms in the past? If so, when? Who did you see? _____

10) **For women only** a) Are you pregnant, or think you might be pregnant? Yes No

b) Vaginal or C-section delivery? Yes No If yes, what months/years? _____

11) Have you had any of these symptoms in the last 6 months? (Check all that apply)

- | | | |
|---|---|--|
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Loss or changes in sensation | <input type="checkbox"/> Unexplained weight loss or gain |
| <input type="checkbox"/> Dizziness or blackouts | <input type="checkbox"/> Changes with bowel/bladder | <input type="checkbox"/> Fever/chills/night sweats |
| <input type="checkbox"/> Calf pain or swelling | <input type="checkbox"/> Pain at night | <input type="checkbox"/> Other: _____ |

12) Do you exercise beyond normal daily activities and chores? If yes, describe the exercise and how often

13) What are your functional goals for physical therapy (be able to do that you are not doing now)?

Patient Signature _____

Date _____

MFES - Initial Visit

Today's Date: ____ / ____ / ____

Date of Birth: ____ / ____ / ____

Name: _____

Please rate your pain level with activity:

0	1	2	3	4	5	6	7	8	9	10
NO PAIN					VERY SEVERE PAIN					

INSTRUCTIONS: On a scale of 0 to 10, how confident are you that you can do each of these activities without falling, with 0 meaning "not confident/not sure at all", 5 being "fairly confident/fairly sure", and 10 being "completely confident/completely sure"?

If you have stopped doing the activity at least partly because of being afraid of falling, score a 0;

If you have stopped an activity purely because of a physical problem, leave that item blank

If you do not currently do the activity for other reasons, please rate that item based on how you perceive you would rate if you had to do the activity today.

	NOT CONFIDENT AT ALL					FAIRLY CONFIDENT					COMPLETELY CONFIDENT				
1. Get dressed and undressed	0	1	2	3	4	5	6	7	8	9	10				
2. Prepare a simple meal	0	1	2	3	4	5	6	7	8	9	10				
3. Take a bath or a shower	0	1	2	3	4	5	6	7	8	9	10				
4. Get in/out of a chair	0	1	2	3	4	5	6	7	8	9	10				
5. Get in/out of bed	0	1	2	3	4	5	6	7	8	9	10				
6. Answer the door or telephone	0	1	2	3	4	5	6	7	8	9	10				
7. Walk around the inside of your house	0	1	2	3	4	5	6	7	8	9	10				
8. Reach into cabinets or closet	0	1	2	3	4	5	6	7	8	9	10				

	NOT CONFIDENT AT ALL				FAIRLY CONFIDENT				COMPLETELY CONFIDENT			
9. Light housekeeping	0	1	2	3	4	5	6	7	8	9	10	
10. Simple shopping	0	1	2	3	4	5	6	7	8	9	10	
11. Using public transport	0	1	2	3	4	5	6	7	8	9	10	
12. Crossing roads	0	1	2	3	4	5	6	7	8	9	10	
13. Light gardening or hanging out the washing*	0	1	2	3	4	5	6	7	8	9	10	
14. Using front or rear steps at home	0	1	2	3	4	5	6	7	8	9	10	

* RATE MOST COMMONLY PERFORMED OF THESE ACTIVITIES