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:

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

3) List all surgeries

Surgery	Approx Month & Year

Initial and Date Completed _____

Initial and Date Reviewed _____

Initial and Date Reviewed _____

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Patient Health Questionnaire – PHQ

Patient Name _____ **DOB** _____

1) Area to be treated:

_____

2) Left, right, or both sides?

_____

3) Injury/surgery date:

_____

4) How did your symptoms begin?

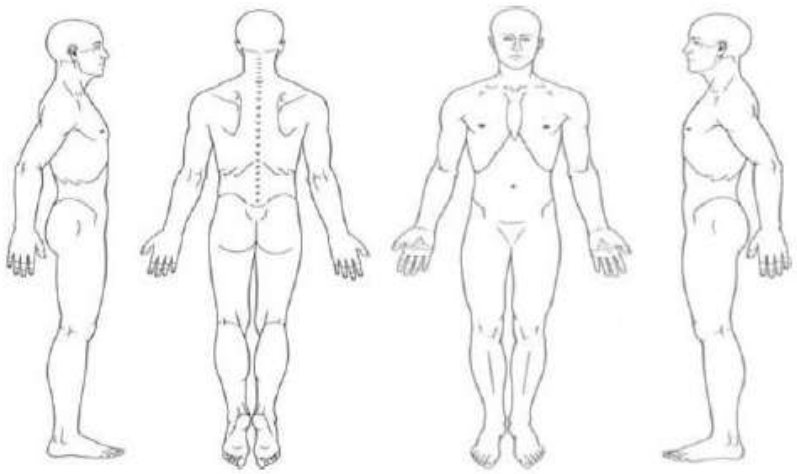
_____

5) Is this injury from a:

- Work injury: ☐ Yes ☐ No
- Auto accident: ☐ Yes ☐ No

(If yes, in what state? _____)

Indicate where you have pain or other symptoms



None ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Unbearable

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)

☐ Chest pain	☐ Loss or changes in sensation	☐ Unexplained weight loss or gain
☐ Dizziness or blackouts	☐ Changes with bowel/bladder	☐ Fever/chills/night sweats
☐ Calf pain or swelling	☐ Pain at night	☐ 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** _____

QuickDASH - Initial Patient name:_____ Date:_____

INSTRUCTIONS

This questionnaire asks about your symptoms as well as your ability to perform certain activities.
Please answer every question, based on your condition in the last week, by circling the appropriate number.
If you did not have the opportunity to perform an activity in the past week, please make your best estimate of which response would be the most accurate.
It doesn't matter which hand or arm you use to perform the activity; please answer based on your ability regardless of how you perform the task.

1. Please rate your pain level with activity: NO PAIN = 0 1 2 3 4 5 6 7 8 9 10 = VERY SEVERE PAIN

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. Open a tight or new jar	1	2	3	4	5
2. Do heavy household chores (e.g., wash walls, floors).	1	2	3	4	5
3. Carry a shopping bag or briefcase.	1	2	3	4	5
4. Wash your back	1	2	3	4	5
5. Use a knife to cut food.	1	2	3	4	5
6. Recreational activities in which you take some force or impact through your arm, shoulder or hand(e.g., golf, hammering, tennis, etc.).	1	2	3	4	5
	NOT AT ALL	SLIGHTLY	MODERATELY	QUITE A BIT	EXTREMELY
7. During the past week, to what extent has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbors or groups?	1	2	3	4	5
	NOT LIMITED AT ALL	SLIGHTLY LIMITED	MODERATELY LIMITED	VERY LIMITED	UNABLE
8. During the past week, were you limited in your work or other regular daily activities as a result of your arm, shoulder or hand problem?	1	2	3	4	5
Please rate the severity of the following symptoms in the last week. (circle number)	NONE	MILD	MODERATE	SEVERE	EXTREME
9. Arm, shoulder or hand pain.	1	2	3	4	5
10. Tingling (pins and needles) in your arm, shoulder or hand.	1	2	3	4	5
	NONE	MILD	MODERATE	SEVERE DIFFICULTY	SO MUCH DIFFFICULTY THAT I CAN'T SLEEP
11. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand? (circle number)	1	2	3	4	5

Therapist Use Only

Comorbidities:
- ☐Cancer
- ☐Diabetes
- ☐Heart Condition
- ☐High Blood Pressure
- ☐Multiple Treatment Areas
- ☐Neurological Disorders (e.g., Parkinson's, Muscular Dystrophy, Huntington's, CVA, Alzheimer's, TBI)
- ☐Obesity
- ☐Surgery for this Problem
- ☐Systemic Disorders (e.g., Lupus, Rheumatoid Arthritis, Fibromyalgia)

ICD Code: _____