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? |
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**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 |
|---|---|
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**Initial and Date Completed** _____

**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?

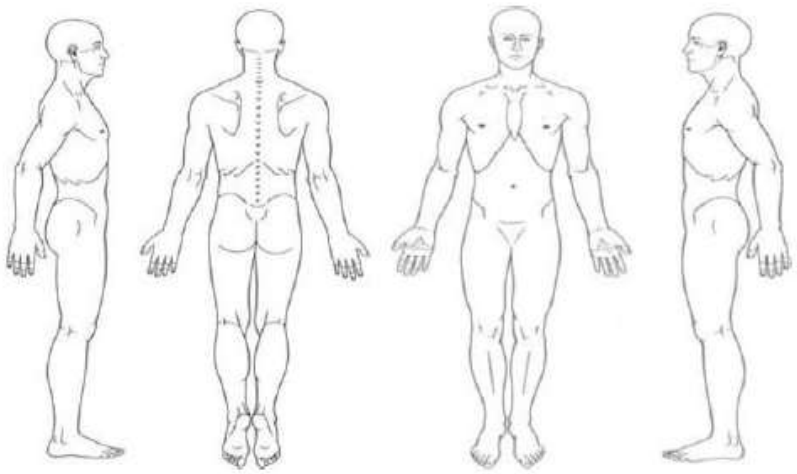
_____

**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** _____

**PATIENT NAME:** _____ **ID#:** _____ **DATE:** _____

**Description**: This survey is meant to help us obtain information from our patients regarding their current levels of discomfort and capability. **Please circle the answers below that best apply.**

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

## MODIFIED OSWESTRY DISABILITY SCALE – INITIAL VISIT

**1. Pain Intensity**
(0) I can tolerate the pain I have without having to use pain medication.
(1) The pain is bad, but I can manage without having to take pain medication.
(2) Pain medication provides me with complete relief from pain.
(3) Pain medication provides me with moderate relief from pain.
(4) Pain medication provides me with little relief from pain.
(5) Pain medication has no effect on my pain.

**2. Personal Care (washing, dressing, etc.)**
(0) I can take care of myself normally without causing increased pain.
(1) I can take care of myself normally, but it increases my pain.
(2) It is painful to take care of myself, and I am slow and careful.
(3) I need help, but I am able to manage most of my personal care.
(4) I need help every day in most aspects of my care.
(5) I do not get dressed, wash with difficulty, and stay in bed.

**3. Lifting**
(0) I can lift heavy weights without increased pain.
(1) I can lift heavy weights, but it causes increased pain.
(2) Pain prevents me from lifting heavy weights off the floor, but I can manage if the weights are conveniently positioned (eg, on a table).
(3) Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
(4) I can lift only very light weights.
(5) I cannot lift or carry anything at all.

**4. Walking**
(0) Pain does not prevent me from walking any distance.
(1) Pain prevents me from walking more than 1 mile.
(2) Pain prevents me from walking more than ½ mile.
(3) Pain prevents me from walking more than ¼ mile.
(4) I can only walk with crutches or a cane.
(5) I am in bed most of the time and have to crawl to the toilet.

**5. Sitting**
(0) I can sit in any chair as long as I like.
(1) I can only sit in my favorite chair as long as I like.
(2) Pain prevents me from sitting more than 1 hour.
(3) Pain prevents me from sitting more than ½ hour.
(4) Pain prevents me from sitting more than 10 minutes.
(5) Pain prevents me from sitting at all.

**6. Standing**
(0) I can stand as long as I want without increased pain.
(1) I can stand as long as I want but, it increases my pain.
(2) Pain prevents me from standing more than 1 hour.
(3) Pain prevents me from standing more than 1/2 hour.
(4) Pain prevents me from standing more than 10 minutes.
(5) Pain prevents me from standing at all.

**7. Sleeping**
(0) Pain does not prevent me from sleeping well.
(1) I can sleep well only by using pain medication.
(2) Even when I take pain medication, I sleep less than 6 hours.
(3) Even when I take pain medication, I sleep less than 4 hours.
(4) Even when I take pain medication, I sleep less than 2 hour
(5) Pain prevents me from sleeping at all.

**8. Social Life**
(0) My social life is normal and does not increase my pain.
(1) My social life is normal, but it increases my level of pain.
(2) Pain prevents me from participating in more energetic activities (eg. sports, dancing).
(3) Pain prevents me from going out very often.
(4) Pain has restricted my social life to my home.
(5) I have hardly any social life because of my pain.

**9. Traveling**
(0) I can travel anywhere without increased pain.
(1) I can travel anywhere, but it increases my pain.
(2) My pain restricts my travel over 2 hours.
(3) My pain restricts my travel over 1 hour.
(4) My pain restricts my travel to short necessary journeys journeys under 1/2 hour.
(5) My pain prevents all travel except for visits to the physician/therapist or hospital.

**10. Employment / Homemaking**
(0) My normal homemaking/job activities do not cause pain.
(1) My normal homemaking/job activities increase my pain, but I can still perform all that is required of me.
(2) I can perform most of my homemaking/job duties, but pain prevents me from performing more physically stressful activities (eg, lifting, vacuuming).
(3) Pain prevents me from doing anything but light duties.
(4) Pain prevents me from doing even light duties.
(5) Pain prevents me from performing any job or homemaking chores.



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