Brunswick Physical Therapy
70 Souder Road
Brunswick, MD 21716

Patient Information

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

Billing Preference: How would you like to receive billing statements? ☐ Mail ☐ Email

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?: _____

Patient Initials and Date Completed _____

Patient Initials and Date Updated _____

Patient Initials and Date Updated _____

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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:** _____

****

Patient Initials and Date Updated _____

Patient Initials and Date Updated _____

Patient Initials and Date Updated _____

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Name: _____ **DOB:** _____

List all allergies and your reactions

Allergy	Reaction

List all medications

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

Patient Initials and Date Completed _____

Patient Initials and Date Updated _____

Patient Initials and Date Updated _____

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Patient Health History

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

Patient Initials and Date Completed _____

Patient Initials and Date Updated _____

Patient Initials and Date Updated _____

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Patient Health Questionnaire – PHQ

Name: _____ **DOB:** _____

1) Area to be treated:

_____

2) Left, right, or both sides?

_____

3) Injury/surgery date:

_____

4) How did your symptoms begin?

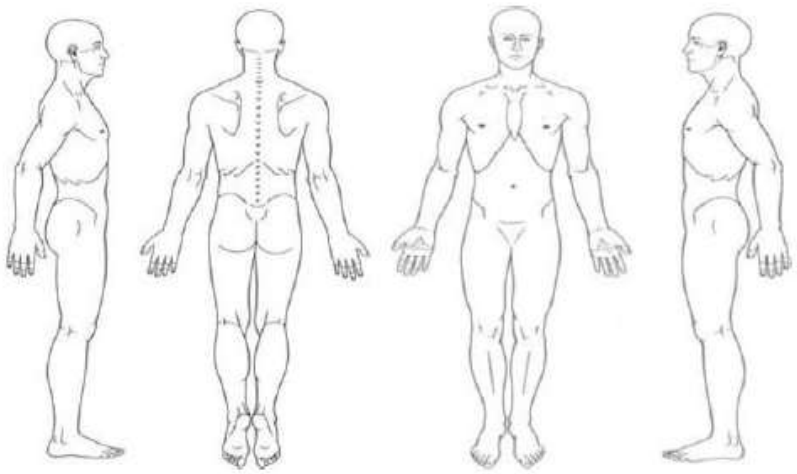
_____

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:** _____

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