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?

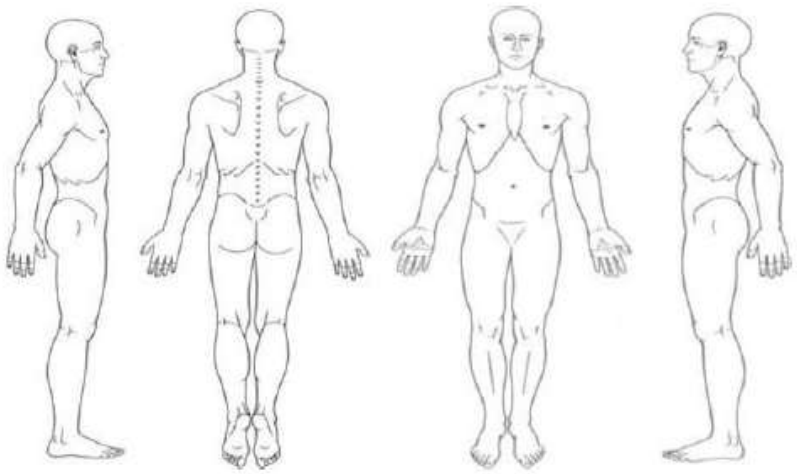
_____

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:** _____

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

NECK DISABILITY INDEX – INITIAL VISIT

1. Pain Intensity
(0) I have no pain at the moment.
(1) The pain is very mild at the moment.
(2) The pain is moderate at the moment.
(3) The pain is fairly severe at the moment.
(4) The pain is very severe at the moment.
(5) The pain is the worse imaginable at the moment.

2. Personal Care (washing, dressing, etc)
(0) I can look after myself normally without extra pain.
(1) I can look after myself normally but it causes extra pain.
(2) It is painful to look after myself and I am slow and careful.
(3) I need some help but manage most of my personal care.
(4) I need help every day in most aspects of self care.
(5) I cannot get dressed, wash with difficulty and stay in bed

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

4. Headache
(0) I have no headaches at all.
(1) I have slight headaches which come infrequently.
(2) I have moderate headaches which come infrequently.
(3) I have moderate headaches which come frequently.
(4) I have severe headaches which come infrequently.
(5) I have headaches almost all the time.

5. Recreation
(0) I am able engage in all my recreational activities without pain.
(1) I am able to engage in my recreational activities with some pain.
(2) I am able to engage in most but not all of my usual recreational activities because of my neck pain.
(3) I am able to engage in a few of my usual recreational activities with some neck pain.
(4) I can hardly do any recreational activities because of neck pain.
(5) I can't do any recreational activities at all.

6. Reading
(0) I can read as much as I want with no pain in my neck.
(1) I can read as much as I want with slight neck pain.
(2) I can read as much as I want with moderate neck pain.
(3) I can't read as much as I want because of moderate neck pain.
(4) I can hardly read at all because of severe neck pain.
(5) I cannot read at all because of neck pain.

7. Work
(0) I can do as much as I want to.
(1) I can only do my usual work but no more.
(2) I can do most of my usual work but no more.
(3) I cannot do my usual work.
(4) I can hardly do any usual work at all.
(5) I can't do any work at all.

8. Sleeping
(0) Pain does not prevent me from sleeping well.
(1) My sleep is slightly disturbed (<1 hr sleep loss).
(2) My sleep is mildly disturbed (1-2 hr sleep loss).
(3) My sleep is moderately disturbed (2-3 hr sleep loss).
(4) My sleep is greatly disturbed (3-4 hr sleep loss).
(5) My sleep is completely disturbed (5-7 hr sleep loss).

9. Concentration
(0) I can concentrate fully when I want with no difficulty.
(1) I can concentrate fully when I want with slight difficulty.
(2) I have a fair degree of difficulty concentrating when I want.
(3) I have a lot of difficulty concentrating when I want.
(4) I have great difficulty concentrating when I want.
(5) I cannot concentrate at all.

10. Driving
(0) I can drive my car without neck pain.
(1) I can drive my car as long as I want with slight neck pain.
(2) I can drive my car as long as I want with moderate neck pain.
(3) I can't drive my car as long as I want because of moderate pain.
(4) I can hardly drive my car at all because of severe neck pain.
(5) I can't drive my car at all.

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: _____