# Patient Health Questionnaire

Version 4.27.09

Name: _____ Date: _____

Date of Birth: _____ *Patient Acct#*: _____

Referring Physician: _____ Family Physician: _____

Date of 1st doctor visit for this injury/condition: _____

Are you aware of what your diagnosis is? Yes No

What are your rehabilitation expectations or goals? _____

Have you had Surgery for this injury? Yes No _____

Type of Surgery: _____ Approx date(s) of surgery: _____

Your chief complaint:_____

Date of onset of symptoms or Injury: _____

How often do you experience your symptoms? Constantly (76-100% of the day)
Frequently (51-75% of the day)
□Occasionally (26-50% of the day)
□Intermittently (0-25% of the day)

What describes the nature of your symptoms: *(Choose all that apply)*

Sharp Dull ache □Numb □Shooting □Burning □Tingling

How are symptoms changing: Getting better Not changing □Getting worse

During the past 4 weeks:

a. *Indicate the average intensity of your symptoms:*

None Unbearable

□ □ □ □ □ □ □ □ □ □

b. How much pain interfered with your normal work:
(*including both work outside the home and housework)*?

Not at all A little bit □Moderately □Quite a bit □ Extremely

During the past 4 weeks how much of the time has your condition interfered with your social activities? *(visiting with friends, relatives, etc.)*

All of the time □Some of the time □None of the time
A little of the time □ Most of the time

In general, would you say your overall health right now is:

Excellent Very good □Good □Fair □Poor

Who have you seen for your symptoms? *(Choose all that apply)*

No One Physical Therapist □Chiropractor □Other
□ Medical Doctor □Occupational Therapist □ Orthopedist _____

a. What treatment did you receive and when? _____

b. What tests have you had for your symptoms and when were they performed?

□Other:
Xrays MRI □CT Scan _____

c. What medication are you currently taking for this injury? _____

Have you had similar symptoms in the past? Yes No

*If you have received treatment in the past for the same/similar symptoms, who did you see?*

This Office Medical Doctor □Other □Occupational Therapist
□Chiropractor □Physical Therapist □ Orthopedist _____

What is your occupation? Professional/Executive Laborer □Retired
□White
_____ Collar/Secretarial □Homemaker □Other
□ Tradesperson □ Student

*If you are not retired, a homemaker, or a student, what is your current work status?*

Full-time Part-time □Self-employed □Unemployed □Off work □Other

**Patient/Guardian Signature: _____ Date: _____**

*I have reviewed and discussed this patient medical information with the patient*

**Therapist Signature: _____ _____ Date: _____**

Please circle ***Y (yes)*** or ***N (no)*** if you have, or have had condition. Circle ***M (medications)*** if you are taking medications for the condition.

| | | | |
|---|---|---|---|
| **General** | | | |
| Good general health | Y | N | M |
| Recent weight changes | Y | N | M |
| Fatigue | Y | N | M |
| Night sweats / fevers | Y | N | M |
| **Cardiovascular** | | | |
| Angina / chest pain | Y | N | M |
| Coronary artery disease | Y | N | M |
| Heart surgery | Y | N | M |
| Pacemaker | Y | N | M |
| **Musculoskeletal** | | | |
| Muscle pains or cramps | Y | N | M |
| Stiffness / swelling in joints | Y | N | M |
| Joint pain | Y | N | M |
| Osteoporosis | Y | N | M |
| **Endocrine** | | | |
| Excessive thirst / urination | Y | N | M |
| Thyroid disease | Y | N | M |
| Hormone problem(s) | Y | N | M |
| **Ear / Nose / Throat / Mouth** | | | |
| Hearing loss / ringing in ears | Y | N | M |
| Sinus problems | Y | N | M |
| Nose bleeds | Y | N | M |
| Sore throat | Y | N | M |
| Voice changes | Y | N | M |
| **Respiratory** | | | |
| Shortness of breath | Y | N | M |
| Excessive coughing | Y | N | M |
| Asthma | Y | N | M |
| Bronchitis | Y | N | M |
| Emphysema | Y | N | M |
| **Neurological** | | | |
| Frequent headaches | Y | N | M |
| Seizures / Epilepsy | Y | N | M |
| Numbness / tingling | Y | N | M |
| Dizziness | Y | N | M |
| Weakness | Y | N | M |
| Stroke / TIA | Y | N | M |
| **Hematologic / Lymphatic** | | | |
| Bruise easily | Y | N | M |
| Slow to heal | Y | N | M |
| Enlarged glands | Y | N | M |
| **Eyes** | | | |
| Wear glasses / contacts | Y | N | M |
| Blurred / double vision | Y | N | M |
| Eye disease or injury | Y | N | M |
| Glaucoma | Y | N | M |
| **Allergies** | | | |
| Food | Y | N | M |
| Latex | Y | N | M |
| Medicine | Y | N | M |
| **Gastrointestinal** | | | |
| Nausea / Vomiting | Y | N | M |
| Abdominal pain | Y | N | M |
| Rectal bleeding | Y | N | M |
| Blood in urine | Y | N | M |
| Kidney stones | Y | N | M |
| **Other** | | | |
| Skin infection ie MRSA | Y | N | M |
| Changes in hair or nails | Y | N | M |
| Rashes or itching | Y | N | M |
| Breast lump | Y | N | M |
| Breast pain or discharge | Y | N | M |
| Change in menstrual cycle | Y | N | M |
| Tuberculosis | Y | N | M |
| Cancer | Y | N | M |
| Chemotherapy or radiation | Y | N | M |
| HIV / AIDS | Y | N | M |
| Diabetes | Y | N | M |
| Blood clots | Y | N | M |
| Depression | Y | N | M |
| Insomnia | Y | N | M |
| Confusion or memory loss | Y | N | M |
| Do you smoke? | Y | N | M |
| Use tobacco products? | Y | N | M |
| Are you pregnant? | Y | N | M |

# Given Sports & Physical Therapy, PC

Medicare As Secondary Payor Form (**only to be completed if you have Medicare as a primary or secondary insurance**)

Name: _____ Date: _____

1. Was this injury due to a work related accident/condition? Yes ___ No___
2. Was this injury due to an automobile accident? Yes ___ No___
3. Was this injury related to an accident for which you intend to file a liability claim or in which litigation is forthcoming?
   Yes ___ No___
   If so, please provide Attorney _____
   Address _____
   Phone _____
4. Are you entitled to Medicare based upon: Age 65+? _____
   Disability? _____
   End stage renal disease? _____
   Do you have group health coverage? _____
   Are you within the 30 month coordination period? ____
5. Are you currently employed? Yes___ No___
6. Date of retirement: _____
7. Is spouse currently employed? Yes___ No___
8. His/her date of retirement: _____
9. Do you have a group health plan as primary coverage based on your/spouse's current or former employment?
   Yes ___ No___
10. Does the employer sponsoring the group health plan employ 20 or more employees? Yes___ No___
11. Do you receive Veteran's benefits?
12. Are you receiving benefits under the Black Lung Program? Yes___ No___
13. If yes, date benefits began: _____
14. If yes, are the services you will be receiving related to a non-black lung condition? Yes___ No___

If you answered yes to any of the first three questions above, please complete:
Insurance company: _____
Address: _____
Policy Number: _____
Group name and number: _____

_____ _____
Patient signature Date

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**Consent for Care & Treatment:** I agree and give consent for medical care and treatment to _____ _____ as considered medically necessary in evaluating and treating my/his/her physical condition..

**Patient/Guardian/Responsible Party** _____ **Date** _____

**Benefit Assignment/Release of Information:** I agree to assign all medical benefits to which I am entitled to Given Sports & Physical Therapy, PC for services rendered. I hereby authorize release of all information necessary to secure payment for these services.

**Patient/Guardian/Responsible Party** _____ **Date** _____

## Financial Policy Explanation

- Proper identification is needed at the time of the initial evaluation.
- Accurate insurance and injury information must be presented by the patient.
- If benefits are subsequently denied by an insurance company, the patient is fully responsible for the charge of rendered services.
- Although benefits and coverage are verified prior to therapy, the patient is fully responsible to understand their individual benefits. Pre-verification of benefits/coverage is only an estimate of coverage and not a guarantee of benefits.
- Patients under the age of 18 years old require signed consent from a parent/guardian.
- Patients should be aware that some insurance plans require specific pre-authorization or HMO referral for physical therapy.
- If an insurance carrier does not remit payment within 120 days, the balance shall be considered patient responsibility at that time.
- Pre-collection notices will be sent after the same patient balance is billed on two consecutive occasions. Patients will be responsible for all costs of collecting monies including court costs, additional collection agency fees, and attorney fees incurred
- A $25 charge will be assessed for any dishonored/returned check or any failed payment plan transaction.
- Medical supplies – payment is due in full at the time of receipt as these are not billed to any insurer; payment for medical goods is non-refundable

Commercial Insurance:

- Co-payments: Without exception, insurance companies require that co-payments be paid at the time of service.
- Co-insurances and deductibles: Estimated co-insurance and deductible payments are due at the time of service. After an EOB is received from the insurance company, any remaining balance will be billed to the patient.
- Any refund due to the patient will be credited to the account or a refund check will be issued once all insurance payments are received.

Medicare: Claims will be submitted to Medicare and any supplementary/secondary plan. Clients are urged to speak directly to the therapist about the implications of calendar year caps on Medicare services. Clients need to notify this office if any home health therapy or nursing services have just concluded or continue.

Medicaid: Medicaid limits therapy services to 20 visits/contract year for adults. Clients should notify the therapist of any other therapy services in the contract year.

Workers' Compensation: Case managers/adjusters will be notified of missed appointments.

Auto/Personal Injury: The client may 1) elect to self-pay for services or 2) elect that this office bills their personal health or auto insurance. Personal health insurance shall be considered a secondary payor to auto insurance. No 3rd party billing is allowed.

Self-pay: Payment is due at the time of service at the lesser of billed charges or $125 per treatment session.

**Patient/Guardian/Responsible Party** _____ **Date** _____



407 E. Terra Cotta Avenue, Suite E • Crystal Lake, IL 60014 • (815) 477-8004 • Fax: (815) 477-8005 givensportspt@att.net • www.givensportspt.com

Attendance Policy

You have the right to choose where you attend physical therapy. As a private practice clinic independent of any direct ties to referral sources or hospital networks, we thank you for your decision to attend therapy at **Given Sports & Physical Therapy, P.C.**

Positive clinical outcomes and customer satisfaction are the measures of our success. Compliance with your prescribed frequency of physical therapy and suggested home exercise program is a vital component of your progress with our services. Please realize that your schedule affects not only our staff but also other patients. Our commitment to your progress is reflected in the following attendance policy.

Our policy includes the following steps:

1. We have extended times beyond those typical for a medical facility as a means of accommodating the needs of our patients.
2. We will give you a verbal and/or written schedule of your appointments.
3. If you need to cancel an appointment, please do so one or more days prior to your scheduled visit.
4. If you need to reschedule an appointment, please call our office and we will make every effort to do the same day or later in the week in order to keep your prescribed frequency of therapy.
5. In the event of a missed appointment, you will receive a phone call from our office (usually within 15 minutes of your scheduled appointment time). We will attempt to reschedule the missed appointment to another time during the week.
6. If we are unable to reschedule your missed appointment during the same week of therapy, we reserve the right to charge you a fee of ***$25***. This fee will not be charged to your insurance. Instead, we ask the fee be paid at your next appointment.
7. Your referring physician will be notified of your attendance and compliance with therapy. If you are a patient with workers' compensation insurance, we are obligated to immediately notify your adjuster or case manager of any scheduling issues.

We understand that serious emergencies and last minute changes in your daily schedule can happen. We simply ask for a courtesy call to inform us if such a event occurs. In instances of repeated non-compliance with your scheduled visits, we reserve the right to discontinue care and will notify your physician of this reason.

Again, we sincerely appreciate your decision to begin treatment at **Given Sports & Physical Therapy, P.C**. and wish you well in your rehabilitation!

I have read and understand this policy:_____ Date:_____

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We are committed to providing quality healthcare services to you. An important part of that is facilitating various privacy rights that you have under Federal Law.

This document serves 2 purposes:

1. Acknowledgment by signature that the Notice of Privacy Practices has been made available for review. Signature indicates understanding and agreement with said Notice.
2. Instructions to request any restriction pertaining to the uses and disclosures of your protected health information ("PHI") that we may make for treatment, payment and operational reasons, as well as for other reasons provided for under applicable law.

**Notice of Privacy Practices:**

I understand the Notice of Privacy Practices (posted at www.givensportspt.com and available for review in the clinic itself) and consent to disclosure for permitted uses. I fully understand the terms of consent.

**Patient Name:** _____ **Date of Birth:** _____

**Patient/Legal Representative Signature:** _____ **Date:** _____

**Restriction Request**

Describe the PHI that you would like restricted including any individual(s), provider(s), insurance company(s) and/or other organization(s) that you would like to *prevent* from reviewing the designated PHI.

Detailed Description of restricted information: _____

Persons or Organizations Restricted: _____

*It is our policy to process restriction requests within thirty days (30) of receipt. We will use the contact info that we have on file to: 1) follow-up with you for additional information if necessary; and/or 2) send you our written response to your request.*

**Patient Name:** _____ **Date of Birth:** _____

**Patient/Legal Representative Signature:** _____ **Date:** _____

**Authorization**

*Given Sports & Physical Therapy* may release information regarding my treatment to the following individuals:

NAME: _____ RELATIONSHIP: _____

NAME: _____ RELATIONSHIP: _____

**Patient Name:** _____ **Date of Birth:** _____

**Patient/Legal Representative Signature:** _____ **Date:** _____



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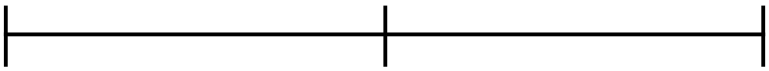
# OPTIMAL INSTRUMENT

## Difficulty–Baseline

| **Instructions:** Please circle the level of difficulty you have for each activity today. | **Able to do without any difficulty** | **Able to do with little difficulty** | **Able to do with moderate difficulty** | **Able to do with much difficulty** | **Unable to do** | **Not applicable** |
|---|---|---|---|---|---|---|
| 1. Lying flat | 1 | 2 | 3 | 4 | 5 | 9 |
| 2. Rolling over | 1 | 2 | 3 | 4 | 5 | 9 |
| 3. Moving–lying to sitting | 1 | 2 | 3 | 4 | 5 | 9 |
| 4. Sitting | 1 | 2 | 3 | 4 | 5 | 9 |
| 5. Squatting | 1 | 2 | 3 | 4 | 5 | 9 |
| 6. Bending/stooping | 1 | 2 | 3 | 4 | 5 | 9 |
| 7. Balancing | 1 | 2 | 3 | 4 | 5 | 9 |
| 8. Kneeling | 1 | 2 | 3 | 4 | 5 | 9 |
| 9. Walking–short distance | 1 | 2 | 3 | 4 | 5 | 9 |
| 10. Walking–long distance | 1 | 2 | 3 | 4 | 5 | 9 |
| 11. Walking–outdoors | 1 | 2 | 3 | 4 | 5 | 9 |
| 12. Climbing stairs | 1 | 2 | 3 | 4 | 5 | 9 |
| 13. Hopping | 1 | 2 | 3 | 4 | 5 | 9 |
| 14. Jumping | 1 | 2 | 3 | 4 | 5 | 9 |
| 15. Running | 1 | 2 | 3 | 4 | 5 | 9 |
| 16. Pushing | 1 | 2 | 3 | 4 | 5 | 9 |
| 17. Pulling | 1 | 2 | 3 | 4 | 5 | 9 |
| 18. Reaching | 1 | 2 | 3 | 4 | 5 | 9 |
| 19. Grasping | 1 | 2 | 3 | 4 | 5 | 9 |
| 20. Lifting | 1 | 2 | 3 | 4 | 5 | 9 |
| 21. Carrying | 1 | 2 | 3 | 4 | 5 | 9 |

22. Thinking about *all* of the activities you would like to do, please mark an "X" at the point on the line that best describes your *overall* level of difficulty with these activities today.



I have *extreme difficulty* doing any of the activities that I would like to do.

I have *no difficulty* doing any of the activities that I would like to do.

23. From the above list, choose the 3 activities you would most like to be able to do without any difficulty (for example, if you would most like to be able to *climb stairs*, *kneel*, and *hop* without any difficulty, you would choose: *1. 12 2. 8 3. 13* ) _____

1.____ 2.____ 3.____



Adapted/revised in July 2005 and August 2006 with permission of APTA from Guccione AA, Mielenz TJ, De Vellis RF, et al. Development and testing of a self-report instrument to measure actions: Outpatient Physical Therapy Improvement in Movement Assessment Log (OPTIMAL). *Phys Ther*. 2005;85:515-530.