

# Patient Health Questionnaire

Version 4.27.09

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Patient Acct#: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Family Physician: \_\_\_\_\_

Date of 1<sup>st</sup> 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 <b>Y (yes)</b> or <b>N (no)</b> if you have, or have had condition. Circle <b>M (medications)</b> if you are taking medications for the condition.			
<b>General</b>			
Good general health	Y	N	M
Recent weight changes	Y	N	M
Fatigue	Y	N	M
Night sweats / fevers	Y	N	M
<b>Cardiovascular</b>			
Angina / chest pain	Y	N	M
Coronary artery disease	Y	N	M
Heart surgery	Y	N	M
Pacemaker	Y	N	M
<b>Musculoskeletal</b>			
Muscle pains or cramps	Y	N	M
Stiffness / swelling in joints	Y	N	M
Joint pain	Y	N	M
Osteoporosis	Y	N	M
<b>Endocrine</b>			
Excessive thirst / urination	Y	N	M
Thyroid disease	Y	N	M
Hormone problem(s)	Y	N	M
<b>Ear / Nose / Throat / Mouth</b>			
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
<b>Respiratory</b>			
Shortness of breath	Y	N	M
Excessive coughing	Y	N	M
Asthma	Y	N	M
Bronchitis	Y	N	M
Emphysema	Y	N	M
<b>Neurological</b>			
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
<b>Hematologic / Lymphatic</b>			
Bruise easily	Y	N	M
Slow to heal	Y	N	M
Enlarged glands	Y	N	M
<b>Eyes</b>			
Wear glasses / contacts	Y	N	M
Blurred / double vision	Y	N	M
Eye disease or injury	Y	N	M
Glaucoma	Y	N	M
<b>Allergies</b>			
Food	Y	N	M
Latex	Y	N	M
Medicine	Y	N	M
<b>Gastrointestinal</b>			
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
<b>Other</b>			
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

## 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: \_\_\_\_\_

**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 and plan details. 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 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 may 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 of 35%, 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 an active 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 occur during the course of therapy.

Workers' Compensation: It is our obligation to notify case managers/adjusters of missed or cancelled 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 3<sup>rd</sup> party billing is allowed.

Sports Medicine • Orthopedics • Spine Rehab • Balance Training • Functional Capacity Evaluations • Work Conditioning

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givensportspt@att.net • www.givensportspt.com

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**

Version 1.1.201

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](http://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: \_\_\_\_\_

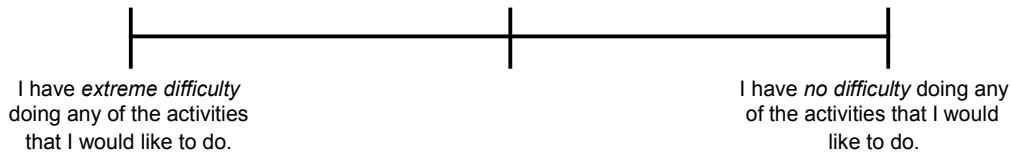
Date: \_\_\_\_\_

# 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.



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. \_\_\_\_\_

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