PATIENT HEALTH QUESTIONNAIRE

DATE: _____ NAME: _____

CURRENT SYMPTOM HISTORY

DESCRIBE YOUR SYMPTOMS: _____

HOW DID SYMPTOMS BEGIN? _____

DATE SYMPTOMS BEGAN: _____/ _____/ _____

NATURE OF SYMPTOMS:

- ☐ SHARP
- ☐ BURNING
- ☐ DULL ACHE
- ☐ TINGLING
- ☐ NUMB
- ☐ SHOOTING

HOW OFTEN ARE SYMPTOMS EXPERIENCED?

- ☐ CONSTANTLY (76-100% OF DAY)
- ☐ FREQUENTLY (51-75% OF DAY)
- ☐ OCCASIONALLY (26-50% OF DAY)
- ☐ INTERMITTENTLY (0-25% OF DAY)

HOW ARE YOUR SYMPTOMS CHANGING?

- ☐ GETTING BETTER
- ☐ NOT CHANGING
- ☐ GETTING WORSE

DURING PAST 4 WEEKS, INDICATE INTENSITY OF SYMPTOMS:

None Unbearable

0 1 2 3 4 5 6 7 8 9 10

DURING PAST 4 WEEKS, HOW MUCH HAS PAIN INTERFERED WITH YOUR NORMAL WORK?

☐ NOT AT ALL ☐ A LITTLE BIT ☐ MODERATELY ☐ QUITE A BIT ☐ EXTREMELY

DURING PAST 4 WEEKS, HOW MUCH HAS YOUR CONDITION INTERFERED WITH SOCIAL ACTIVITIES?

☐ NOT AT ALL ☐ A LITTLE BIT ☐ MODERATELY ☐ QUITE A BIT ☐ EXTREMELY

IN GENERAL, HOW WOULD YOU SAY YOUR OVERALL HEALTH IS RIGHT NOW?

☐ EXCELLENT ☐ VERY GOOD ☐ GOOD ☐ FAIR ☐ POOR

DO YOU USE A? (CHECK ALL THAT APPLY)

☐ CANE ☐ WALKER/ROLLING WALKER/ROLLATOR ☐ MANUAL WHEELCHAIR ☐ MOTORIZED WHEELCHAIR
☐ OTHER _____

WHO HAVE YOU SEEN FOR YOUR SYMPTOMS?

☐ NO ONE ☐ CHIROPRACTOR ☐ MEDICAL DOCTOR ☐ PHYSICAL THERAPIST ☐ OTHER _____

What treatment did you receive and when? _____

What tests did you have and when?

☐ XRAYS date: _____ ☐ MRI date: _____ ☐ CT SCAN date: _____

☐ Other date: _____

HAVE YOU HAD SIMILAR SYMPTOMS IN THE PAST? ☐ YES ☐ NO

If yes, who did you see?

☐ THIS OFFICE ☐ CHIROPRACTOR ☐ MEDICAL DOCTOR ☐ PHYSICAL THERAPIST ☐ OTHER _____

PAST MEDICAL HISTORY

LIST ALL HEALTH PROBLEMS, HOSPITALIZATIONS, SURGERIES AND ALLERGIES:

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING OR PROVIDE A LIST TO YOUR THERAPIST:

ARE YOU A DIABETIC? ☐ YES ☐ NO
IF YES, FOR HOW LONG? _____

DO YOU HAVE A PACEMAKER? ☐ YES ☐ NO

ARE YOU PREGNANT? ☐ YES ☐ NO
IF YES, HOW MANY MONTHS? _____

PLEASE LIST OTHER PHYSICIANS WHO ARE TREATING YOU AND FOR WHAT CONDITIONS?

DEMOGRAPHIC INFORMATION

WHERE DO YOU LIVE?

☐ PRIVATE HOME ☐ PRIVATE APT. ☐ RENTED ROOM ☐ BOARD AND CARE/ASSISTED LIVING/GROUP HOME
☐ HOMELESS(WITH OR WITHOUT SHELTER) ☐ LONG-TERM CARE FACILITY ☐ HOSPICE ☐ OTHER _____

WITH HOME DO YOU LIVE? (CHECK ALL THAT APPLY)

☐ ALONE ☐ SPOUSE/SIGNIFICANT OTHER ☐ CHILD/CHILDREN ☐ OTHER RELATIVE(S)
☐ GROUP SETTING ☐ PERSONAL CARE ATTENDANT ☐ OTHER _____

WHAT IS YOUR OCCUPATION?

☐ PROFESSIONAL/EXECUTIVE
☐ WHITE COLLAR/SECRETARIAL
☐ TRADESPERSON
☐ LABORER
☐ HOMEMAKER
☐ FT STUDENT
☐ RETIRED
☐ OTHER
☐ UNEMPLOYED

EMPLOYMENT/WORK STATUS (CHECK ALL THE APPLY)

☐ FULL-TIME, OUTSIDE HOME ☐ FULL-TIME, IN HOME
☐ PART-TIME, OUTSIDE HOME ☐ PART-TIME, IN HOME
☐ SELF-EMPLOYED ☐ OTHER
☐ WORKING WITH MODIFICATION BECAUSE OF CURRENT ILLNESS/INJURY
☐ NOT WORKING BECAUSE OF CURRENT ILLNESS/INJURY

TO THE BEST OF MY KNOWLEDGE THE ABOVE INFORMATION IS CORRECT AND ACCURATE

SIGNATURE: _____

DATE: _____

CONSENT FOR TREATMENT
HIPAA ACKNOWLEDGEMENT

CONSENT FOR TREATMENT AND ADMISSION:
I agree to be admitted to **OASIS PHYSICAL THERAPY** as an outpatient, and authorize the therapy staff to evaluate and treat within the scope of physical and occupational therapy practice as ordered by the referring physician. Initials _____

RELEASE OF INFORMATION:
I hereby authorize **OASIS PHYSICAL THERAPY** to furnish medical records, via fax or mail, to my referring physician, insurance carrier and to the physician to whom I am referred concerning my evaluation and treatment. Initials _____

WORKER'S COMPENSATION PATIENTS RELEASE OF INFORMATION:
I authorize **OASIS PHYSICAL THERAPY** to discuss/forward any relevant vocational information, as related to my rehabilitation, with my worker's compensation/group insurance carrier/external case manager. Initials if applicable _____

ASSIGNMENT OF BENEFITS:
I hereby assign all of my right, title, and interest to **OASIS PHYSICAL THERAPY** of insurance/health and welfare benefits otherwise payable to me, not to exceed the balance due of **OASIS PHYSICAL THERAPY'S** customary charges for the services provided. Initials _____

FINANCIAL AGREEMENT:
I, the undersigned, assume financial responsibility for the payment of all charges at the time of service unless covered under worker's compensation, Medicare, or a specific insurance carrier. Insurance carriers will be billed directly by **OASIS PHYSICAL THERAPY.** All deductibles, co-insurance portions, including non-covered services are my financial responsibility. Any account not paid will be referred to a third party collection agency to include all reasonable collection fees, not limited to attorney fees, investigative fees, and court costs.

I understand the physician charges are billed separately. Inquiries regarding physician charges should be directed to my physician. Initials _____

Cancellation/No-show Fee Policy:
I acknowledge that I have read and received a copy of the Cancellation/No-show fee policy of **OASIS PHYSICAL THERAPY** and agree to its terms. Initials _____

HIPAA ACKNOWLEGEMENT:
I_____, have received the Privacy Notice of **OASIS PHYSICAL THERAPY'S** on today's date.

The undersigned certifies that he/she has read the foregoing and is the patient, the patient's legal representative, or is duly authorized by the patient and his/her agent to execute the above and accept its terms. If patient's condition prohibits written consent, agent who is present when verbal consent is given should sign patient's name by agent's name. If patient is unable to consent or is a minor, complete the following:

If patient is a minor, how many years of age? _____

If patient is unable to give his/her consent, why?_____

_____ _____
Patient/Relative/Authorized Agent Signature Date

_____
Relationship to Patient (if signature is not the patient's)

_____
Witness Signature