Patient Information

First Name_____ Last Name _____MI _____Suffix_____
Social Security #_____ Gender _____Birth Date_____
Marital Status_____ Student Status_____
Address_____
City _____State _____Zip Code _____Country_____
Email_____Fax_____
Phone Numbers: Home_____Cell_____Work_____
Which is the primary number? ☐ Home ☐ Cell ☐ Work
Notify by Email? ☐ Yes ☐ No Notify by text? ☐ Yes ☐ No
Emergency Contact Name_____ Phone #:_____

Insured information same as patient? ☐ Yes ☐ No If no, name of policy holder_____
Patient relationship to insured:_____ Policy holder date of birth: _____

Referred by doctor: _____Primary Care doctor: _____

Date of onset of injury _____Is this a work related injury/condition? ☐ Yes ☐ No
If yes, date of injury: _____ Where: _____How: _____
Did you report injury to your employer or supervisor? ☐ Yes ☐ No
Is this related to an auto accident? ☐ Yes ☐ No If yes, date of injury:_____
Insurance claim information:_____

Occupation:_____ Employer _____
Employer address: _____Phone #_____

Have you had previous therapy for your present condition? ☐ Yes ☐ No
If yes, where: _____ When: _____

How did you hear about us? _____

The above information is correct to the best of my knowledge.

Patient Signature_____ Date_____

Comments:_____
_____
_____
_____
_____
_____
_____

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

MEDICAL HISTORY

Allergies	☐ Yes ☐ No	Depression	☐ Yes ☐ No	Multiple Sclerosis	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No
Anxiety	☐ Yes ☐ No	Dizzy Spells	☐ Yes ☐ No	Parkinson's	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Emphysema/Bronchitis	☐ Yes ☐ No	Rheumatoid Arthritis	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Fractures	☐ Yes ☐ No	Seizures	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Gallbladder Problems	☐ Yes ☐ No	Strokes	☐ Yes ☐ No
Cardiac Conditions	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Thyroid Disease	☐ Yes ☐ No
Cardiac Pacemaker	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Chemical Dependency	☐ Yes ☐ No	Incontinence	☐ Yes ☐ No	Vision Problems	☐ Yes ☐ No
Circulation Problems	☐ Yes ☐ No	Kidney Problems	☐ Yes ☐ No		
Currently Pregnant	☐ Yes ☐ No	Metal Implants	☐ Yes ☐ No		

Describe any other conditions or precautions:

Fall History:

Injury as a result of a fall in the past year? ☐ Yes ☐ No Date of fall: _____

Two or more falls in the last year? ☐ Yes ☐ No Date of fall: _____

Surgical History:

Body Region: _____ Surgery Type: _____ Date of Surgery: _____

Body Region: _____ Surgery Type: _____ Date of Surgery: _____

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Body Region: _____ Surgery Type: _____ Date of Surgery: _____

Body Region: _____ Surgery Type: _____ Date of Surgery: _____

Body Region: _____ Surgery Type: _____ Date of Surgery: _____

Current Medications:

Drug: _____ Dosage: _____ Route of administration: _____ Reason for taking: _____

Drug: _____ Dosage: _____ Route of administration: _____ Reason for taking: _____

Drug: _____ Dosage: _____ Route of administration: _____ Reason for taking: _____

Drug: _____ Dosage: _____ Route of administration: _____ Reason for taking: _____

Drug: _____ Dosage: _____ Route of administration: _____ Reason for taking: _____

Drug: _____ Dosage: _____ Route of administration: _____ Reason for taking: _____

Patient Health Questionnaire - PHQ

ACN Group, Inc. - Form PHQ-202

Patient Name: _____ ***Date:*** _____

1. Describe your symptoms: _____

_____

_____

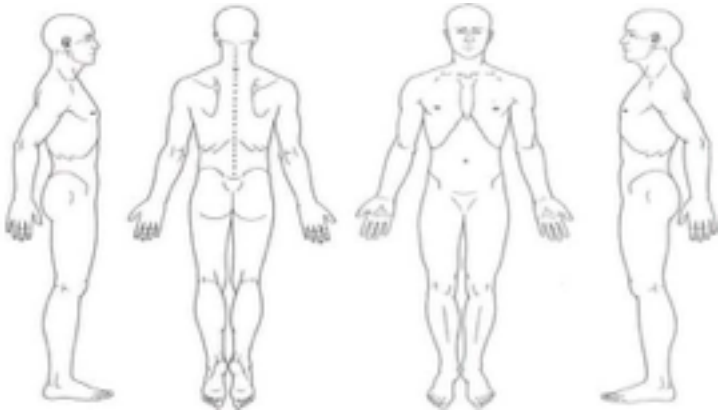
a. When did your symptoms start? _____

b. How did your symptoms begin? _____

2. How often do you experience your symptoms?

A. Constantly (76-100% of the day)
B. Frequently (51-75% of the day)
C. Occasionally (26-50% of the day)
D. Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms:



3. What describes the nature of your symptoms?

A. Sharp D. Shooting
B. Dull ache E. Burning
C. Numb F. Tingling

4. How are your symptoms changing?

A. Getting Better
B. Not Changing
C. Getting Worse

5. During the past 4 weeks:

None *Unbearable*

a. Indicate the average intensity of your symptoms: 0 1 2 3 4 5 6 7 8 9 10

b. How much has pain interfered with your normal work (including both work outside the home, and housework)

A. Not at all B. A little bit C. Moderately D. Quite a bit E. Extremely

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

A. Not at all B. A little bit C. Moderately D. Quite a bit E. Extremely

7. In general would you say your overall health right now is...

A. Excellent B. Very Good C. Good D. Fair E. Poor

8. Who have you seen for your symptoms?

A. No One
B. Chiropractor
C. Medical Doctor
D. Physical Therapist
E. Other

a. What treatment did you receive and when? _____

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

A. XRAYs date: _____
B. MRI date: _____
C. CT Scan date: _____
D. Other date: _____

9. Have you had similar symptoms in the past? A. Yes B. No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

A. This Office
B. Chiropractor
C. Medical Doctor
D. Physical Therapist
E. Other

10. What is your occupation?

A. Professional/Executive
B. White Collar/Secretarial
C. Tradesperson
D. Laborer
E. Homemaker
F. FT Student
G. Retired
H. Other

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

A. Full-time
B. Part-time
C. Self-employed
D. Unemployed
E. Off work
F. Other

Patient Signature _____ ***Date*** _____

CONSENT TO TREAT/FINANCIAL POLICY FORM

Consent To Treat

I, _____, hereby consent to physical therapy treatment.
(please print)

_____

Patient Signature (or Guardian if minor) Date

Financial Policy

I authorize the assignment of benefits for my insurance to pay Advanced Physical Therapy of Laguna-Viejo directly. I understand that I am ultimately responsible for the charges incurred for my treatment by Advanced Physical Therapy. I understand that the staff of Advanced Physical Therapy will help in billing my insurance company for payment. It is my responsibility to follow-up on any daim submitted if payment is not received in a reasonable amount of time.

I authorize the release of any and all medical information necessary to determine liability for payment and to obtain reimbursement including medical records to any person or corporation, which is or may be liable for all or any portion of charges.

I understand there is a $25.00 fee for any cancellation and/or No Show of appointments without 24 hour notification.

I have read and understand all of the information above, and I have completed the information to the best of my knowledge.

_____

Patient Signature (or Guardian if minor) Date

Medicare Patients

Have you had any home health care in the last 6 months? ☐ Yes ☐ No

Are you receiving any Hospice care? ☐ Yes ☐ No