DIRECT
PHYSICAL THERAPY

Patient Health Questionnaire

Patient Name:______________________________ Date:______________

1. Describe your symptoms:______________________________

   When did they start?______________________________

   What caused your symptoms?______________________________

   Did you have surgery? if yes, date of surgery:______________type of surgery:______________

   ____

2. What symptoms are you having? (check all that apply)

   ☐ Swelling ☐ Loss of Motion ☐ Weakness ☐ Pain ☐ Stiffness ☐ Loss of Balance

   ☐ Numbness ☐ Tingling ☐ Other:______________

3. Describe your pain (check all that apply)

   ☐ Sharp ☐ Dull Ache ☐ Radiating ☐ Burning ☐ Stabbing ☐ Pins & Needles

4. Please indicate your pain level on a scale from 0 (no pain) to 10 (extreme pain):

   Pain level at the moment: 0 1 2 3 4 5 6 7 8 9 10

   Pain level at best moment: 0 1 2 3 4 5 6 7 8 9 10

   Pain level at worst moment: 0 1 2 3 4 5 6 7 8 9 10

5. What activities are you currently involved in?(specifiy activity/frequency per week):______________

   ____

6. What activities increase your symptoms? (i.e. sitting, walking, driving...):______________

   ____

7. What eases your symptoms? (i.e. ice, heat, sitting...):______________

   ____

8. What diagnostic tests have you had and when?:

☐ X-rays Date:______________ ☐ MRI Date:______________ ☐ CT Scan Date:______________

☐ EMG Date:______________ ☐ Other Kind Date:______________

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9. Do you have any of the following conditions? (check all that apply):

☐ High Blood Pressure/Heart Disease ☐ Diabetes ☐ Cancer ☐ Stroke/CVA ☐ Osteoarthritis

☐ Angina/chest pain ☐ Osteoporosis ☐ Rheumatoid Arthritis ☐ Gout ☐ None of the above

10. Do you have a history of any of the following? (please check all that apply):

☐ Pacemaker ☐ Seizures ☐ Headaches ☐ Metal Implants ☐ Pulmonary Disease ☐ Liver Disease

☐ Kidney Disorders ☐ Thyroid Disease ☐ History of Falls ☐ Balance Problems ☐ Vision Problems

☐ Sexually Transmitted Disease ☐ Autoimmune Disorders ☐ Sensitivity to Heat ☐ Sensitivity to Cold

☐ Stomach Ulcers ☐ Swollen Legs/Feet ☐ Anxiety/Panic Attacks ☐ Recent Weight Loss/Gain

☐ Allergies/Skin Sensitivity (indicate type):______________________________

☐ Other:______________________________ ☐ None of the above

11. In the last 3 months, have you had or do you experience (check all that apply):

☐ Muscle Cramps ☐ Muscle Weakness ☐ Dizziness ☐ Shortness of Breath ☐ Bruise Easily

☐ Nausea/Vomiting ☐ Pregnant ☐ Night Sweats ☐ General Fatigue ☐ Depression

☐ Recent Fever ☐ Bowel/Bladder Incontinence ☐ Positive for Covid ☐ None of the Above

12. Past surgeries for anything else (date/what for):______________________________

____

13. What medications are you currently taking?

Name	Dosage	Frequency

14. What goals or activities do you want to achieve with Physical Therapy?:______________________________

____

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PATIENT INFORMATION

NAME: (First, MI, Last)______________________________ DATE OF BIRTH: ________________ AGE:______

ADDRESS ______________________________CITY: ________________ST:_____ ZIP:________

CELL #: ________________HOME #:________________EMAIL:______________________________

EMERGENCY CONTACT #: ________________ NAME/RELATIONSHIP:______________________________

EMPLOYER:______________________________OCCUPATION:______________________________

HOW DID YOU HEAR ABOUT DIRECT PHYSICAL THERAPY?______________________________

PAYMENT AUTHORIZATION & CONSENT

I authorize payment to Direct Physical Therapy, PLLC for all physical therapy services rendered. I also understand I am responsible for knowing my co-payment amount, my deductible amount and for the balance on my account for any professional services rendered. I consent that if my insurance company for any reason denies payment of services, I will be billed $150 for an evaluation and $75 per visit for services that have been rendered.

Initial to acknowledge ________

I consent to the release of information and/or disclosure to Direct Physical Therapy, PLLC of all or any part of my record to other health care providers involved in my care or a third-party payer as is necessary for processing claims. I agree that I am responsible for forwarding to Direct Physical Therapy, PLLC any insurance payment check(s) that are mailed to my home for services received at Direct Physical Therapy, PLLC. I agree to do so within 14 days of receipt of check(s).

Initial to acknowledge ________

As a courtesy to our other patients, as well as our staff members, Direct Physical Therapy, PLLC asks for a 24 hour notification of cancellation prior to your scheduled appointment. Please note without notification a fee of $25 will be billed to you or will be collected upon your next visit.

Initial to acknowledge ________

I consent to be assessed by and to receive treatment from Direct Physical Therapy, PLLC consistent with a plan of care. I confirm that I have been informed and I have participated in planning the care and procedure(s) to be carried out by Direct Physical Therapy, PLLC and sign this consent willingly and voluntarily.

Initial to acknowledge ________

I consent for our staff to speak with your significant other, close family member and/or another designated individual ***only if listed below****. Please understand this is waiving your right to confidentiality if consent is given.*

Consent given to: ______________________________ Relationship: ________________________

Patient / Guardian Signature: ______________________________ Date: ________________

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****INTERNAL USE ONLY****

Dr. Referral / Rx ____
Copy of Ins Card(s) ____
Patient Signature ____