Patient Health Questionnaire – PHQ

Patient Name_____ **Date**_____

1. Describe your symptoms _____

_____

a. When did your symptoms start? _____

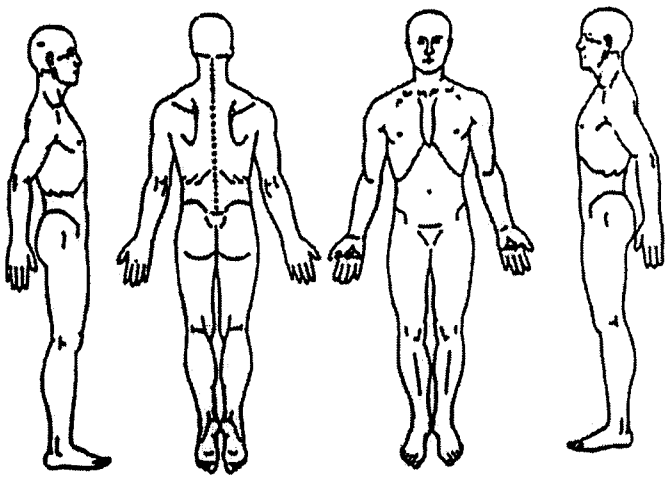
b. How did your symptoms begin? _____

_____

2. How often do you experience your symptoms? Please indicate where you have pain or other symptoms

Check one:

O Constantly (76-100% of the day)
O Frequently (51-75% of the day)
O Occasionally (26-50% of the day)
O Intermittently (0-25% of the day)



3. What describes the nature of your symptoms

Mark all that apply:

O Sharp O Shooting
O Dull Ache O Burning
O Numbness O Tingling

4. How are your symptoms changing?

Check one:

O Getting Better
O Not Changing
O Getting Worse

5. Indicate the average intensity of your symptoms (0 being no pain, 10 being unbearable)

1 2 3 4 5 6 7 8 9 10

6. Who have you seen for your symptoms? O No One O Medical Doctor O Other
Mark all that apply: O Chiropractor O Physical Therapist

a. What treatment did you receive and when?

_____

b. What tests have you had for your symptoms and when? O X-rays (date:_____) O CT (date:_____) O MRI (date:_____) O Other (date:_____)

7. What is your occupation?_____

8. How did you hear about us? O Newspaper O Previous Patient O Physician O Work Comp O Internet Search O Facebook O Friend/Family

Patient Signature_____ **Date**_____

Medical History

Medical Conditions:

Allergies	**O Yes O No**	**Headaches**	**O Yes O No**
Anxiety	**O Yes O No**	**Hearing Impairment**	**O Yes O No**
Asthma	**O Yes O No**	**High/Low Blood Pressure**	**O Yes O No**
Cancer	**O Yes O No**	**HIV/AIDS**	**O Yes O No**
Cardiac Conditions	**O Yes O No**	**Metal Implants**	**O Yes O No**
Cardiac Pacemaker	**O Yes O No**	**MRSA**	**O Yes O No**
Currently Pregnant	**O Yes O No**	**Multiple Sclerosis**	**O Yes O No**
Diabetes	**O Yes O No**	**Parkinson's Disease**	**O Yes O No**
Dizzy Spells	**O Yes O No**	**Rheumatoid Arthritis**	**O Yes O No**
Emphysema/Bronchitis	**O Yes O No**	**Seizures**	**O Yes O No**
Fibromyalgia	**O Yes O No**	**Strokes**	**O Yes O No**
Fractures	**O Yes O No**		

Fall History: Have you been injured because of a fall in the past year? O Yes O No
Have you had two or more falls in the past year? O Yes O No

Surgical history:

Body Region:	Surgery Type:	Date:
Body Region:	Surgery Type:	Date:
Body Region:	Surgery Type:	Date:
Body Region:	Surgery Type:	Date:

Current Medications:

Drug:	Dosage:	Frequency:	Reason:
Drug:	Dosage:	Frequency:	Reason:
Drug:	Dosage:	Frequency:	Reason:
Drug:	Dosage:	Frequency:	Reason:
Drug:	Dosage:	Frequency:	Reason:
Drug:	Dosage:	Frequency:	Reason:

Height: _____ **Weight:** _____

Professional Rehabilitation Services, LLC—Patient Information

Patient Name_____Phone_____
Street/City/State/Zip_____
SS#_____Date of Birth_____Age_____
E-Mail Address_____
Marital Status (circle one): S M D W Spouse's Name_____

Date of first symptom_____Date of next MD appt_____

Employer Information:
Company Name_____ Phone #_____
Work Related Injury? (circle one) Yes No If yes, date of injury? _____

Insurance Information:
Primary Insurance _____ID# _____
Subscriber Name _____DOB_____SS#_____
Secondary Insurance_____ID#_____
Subscriber Name_____DOB_____SS#_____

Person responsible for account payments *REQUIRED IF PATIENT IS A MINOR*
Name_____Relationship to Patient_____
Address_____Employer_____
Phone_____Date of Birth_____ SS#_____

Name of nearest relative NOT living with you
Name_____Relationship_____Phone_____

Consent for Treatment—I authorize services and treatment to be provided by Professional Rehabilitation Services, LLC. If patient is under the age of 18, a parent/guardian must be the one to sign for them.

_____ _____
Signature Date

We must have a copy of your insurance cards so that we may submit your claims

I hereby assign medical benefits to include major medical benefits to which I am entitled, including private insurances and other health plans to Professional Rehabilitation Services, LLC. I authorize payment directly to Professional Rehabilitation Services, LLC. I authorize release of my medical records in order for PRS to obtain payment. We do not accept third party claims.

I hereby acknowledge receipt of Professional Rehabilitation Services, LLC notice of privacy practices.

_____ _____
Signature Date

Workers Compensation

I hereby authorize Professional Rehabilitation Services, LLC to release my medical records whether related to prior or subsequent medical treatment provided to me, to the employees or agents of my employer, my insurance company, or the insurance company of my employer. If my work comp claim is denied at any time, I may be held responsible for payment. In the event my claim is denied, I must furnish Professional Rehabilitation Services, LLC with a group health insurance if I would like them to file the claim as a courtesy. However, due to timely filing limitations imposed by many insurance carriers, my private insurance company may deny the claim. Any residual balances will be my responsibility.

I understand that I may revoke this authorization anytime in writing to Professional Rehabilitation Services, LLC. A photocopy of this authorization shall be considered as valid as an original.

_____ _____

Signature Date

Medicare Patients

Medicare has a $2,010.00 cap for physical therapy for 2018. You must notify PRS of all providers who treated you during the calendar year. You may be financially liable for all charges incurred after your cap of $2,010.00 has been reached.

Medicare pays 80% of their allowable fee schedule. If you do not have a supplemental insurance you will be responsible for the remaining 20%.

Medicare requires you to see your doctor for new physical therapy orders 60 days after the first order and 30 days after each additional order.

Insurance Benefits

Our office has contacted your insurance company regarding your physical therapy benefits. Your insurance company has advised us that you have a $_____ deductible per year, with a coverage of _____% and/or a co-pay of $_____ per office visit. You will receive a statement for an outstanding deductible, co-insurance, or any non-covered services. The information provided by your insurance company does not guarantee payment and/or benefits. Your insurance pays for _____ visits per calendar year.

I understand and agree that if I fail to make any of the payments for which I am responsible, all cost of collecting money owed including 1.5% interest monthly on any balances over 90 days, court costs, collection agency fees (20%), and attorney fees shall be my responsibility.

_____ _____

Signature Date

Professional Rehabilitation Services, LLC

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT RECEIPT

I have received the Notice of Privacy Practices on this visit or a previous one. I understand I can request another copy at any time.

First Name MI Last Name Date of Birth

Signature of Patient / Parent or Legal Guardian Date

PATIENT RECORD OF DISCLOSURES

IN GENERAL, THE HIPAA PRIVACY RULE GIVES INDIVIDUALS THE RIGHT TO REQUEST RESTRICTION ON DISCLOSURES OF THEIR PROTECTED HEALTH INFORMATION (PHI). THE INDIVIDUAL IS ALSO PROVIDED THE RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS OR THAT A COMMUNICATION OF PHI MAY BE MADE BY ALTERNATIVE MEANS SUCH AS: SENDING CORRESPONDENCE TO THE INDIVIDUAL'S OFFICE OR CELL PHONE, INSTEAD OF THE INDIVIDUAL'S HOME PHONE.

PLEASE CHECK ALL THAT APPLY

	HOME TELEPHONE:			**WRITTEN COMMUNICATION:**
	LEAVE MESSAGE WITH DETAILED INFORMATION			O.K. TO MAIL TO:
	LEAVE MESSAGE WITH CALL BACK NUMBER ONLY			O.K. TO FAX TO:
	WORK TELEPHONE:			**CELL PHONE:**
	LEAVE MESSAGE WITH DETAILED INFORMATION			LEAVE MESSAGE WITH DETAILED INFORMATION
	LEAVE MESSAGE WITH CALL BACK NUMBER ONLY			LEAVE MESSAGE WITH CALL BACK NUMBER ONLY
				TEXT REMINDERS FOR APPOINTMENTS ONLY

I GIVE CONSENT TO THIS OFFICE TO RELEASE ANY AND ALL RESULTS TO THE PERSONS LISTED BELOW:

NAME	RELATIONSHIP	PHONE NUMBER

THIS DOCUMENT WILL BE A PART OF YOUR MEDICAL RECORD