



Patient Information Sheet

Patient Name: _____
 Address: _____
 City/State/Zip: _____
 E-Mail : _____
 Date Of Birth: _____

Home Phone: _____
 Work Phone: _____
 Cell Phone: _____

Emergency Contact:

Contact Name: _____
 Home Phone: _____
 Daytime Phone: _____

Referring Physician: _____ Primary Care Physician: _____

Medical History:

Please circle Y or N for each of the following:

- Y/N Heart disease Explain: _____
- Y/N Lung / breathing problems Explain: _____
- Y/N Cancer Explain: _____
- Y/N Neurological problems Explain: _____
- Y/N Bone / Joint problems Explain: _____
- Y/N Diabetes Explain: _____
- Y/N Surgeries Explain: _____
- Y/N Pacemaker / Defibrillator Explain: _____
- Y/N Currently Pregnant Number of weeks: _____
- Y/N Other Medical Conditions Explain: _____
- Y/N **Have you had Physical Therapy, for any reason, at any clinic, this calendar year?**

Please list your
current medications

- The injury you are treating for is not related to work or auto accident
- You have shown our HIPPA "Notice of Information Practices" , available on our website and on display in each office and understand that a copy is available upon request.
- You have reviewed and understand our cancellation policy. _____ Patient Initials

We require a copy of your health insurance card(s) and photo ID .

We consider it appropriate to contact you on any phone # that you make available to us. Please have our front desk staff remove any phone numbers from our files that you do not wish to be contacted on.

Authorization For Treatment: I hereby authorize the medical staff of North Shore Physical Therapy Associates, Inc. to render such services as may be deemed necessary to me/ my child/ or my dependent as listed above.

Authorization To Release Information: I hereby authorize North Shore Physical Therapy Associates, Inc. to release or obtain any information requested with respect to the above referenced account to the extent necessary to manage care, process claim, or determine liability for payment and to obtain reimbursement.

Assignment Of Benefits: I hereby authorize and direct any payment of medical benefits to which I am entitled under medicare, and/or private insurance, and/or other health plan(s), be made directly to North Shore Physical Therapy Associates, Inc.

Information Practices: I hereby attest that I have seen North Shore Physical therapy's Notice Of Information Practices. I understand that a copy of this form is available to me should I request one.

A photocopy of this authorization/assignment is to be considered as valid as an original. This authorization/assignment will remain in effect until revoked by me in writing to the assignee.

I understand that I am financially responsible for any charges not covered by my insurance company's payments.

Authorized Signature: _____

Date: _____

Patient Health Questionnaire – PHQ

Patient Name: _____

Date: _____

1. Injury Date / Onset of symptoms: _____

Surgery Date : _____
(If applicable)

2. Describe your symptoms: _____

3. How did your symptoms start or most recently flare-up: _____

4. Please identify up to three important activities that you are unable to do or are having difficulty doing as a result of your current injury or problem. Circle the number on the line that best describes your current ability to perform that activity.

	0	1	2	3	4	5	6	7	8	9	10
1. _____	0	1	2	3	4	5	6	7	8	9	10
2. _____	0	1	2	3	4	5	6	7	8	9	10
3. _____	0	1	2	3	4	5	6	7	8	9	10

Able to perform activity at same level as before your injury

Unable to perform activity

5. During the past week

a. Indicate the average intensity of your symptoms No Pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable

b. how much has pain interfered with your normal work (include both work outside the home and housework)

- Not at all
 A little bit
 Moderate
 Quite a bit
 Extremely

Indicate where you have pain or other symptoms

6. How often do you experience your symptoms?

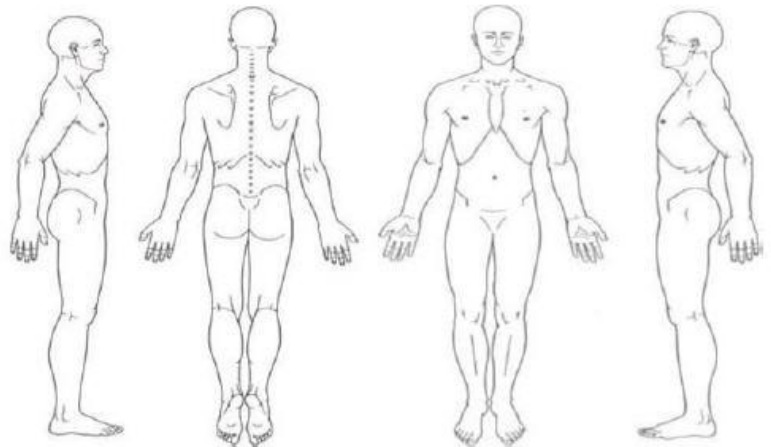
- Constantly
 Intermittently

7. What describes the nature of your symptoms?

- | | | |
|------------------------------------|-----------------------------------|--------------------------------------|
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Shooting | <input type="checkbox"/> Stiffness |
| <input type="checkbox"/> Dull Ache | <input type="checkbox"/> Burning | <input type="checkbox"/> Weakness |
| <input type="checkbox"/> Numb | <input type="checkbox"/> Tingling | <input type="checkbox"/> Off Balance |

8. How are you symptoms changing?

- Getting better
 Not changing
 Getting worse



9. Who have you seen for your symptoms?

- | | | | |
|---|-------------------------------------|--|--------------------------------------|
| <input type="checkbox"/> Primary Care Dr | <input type="checkbox"/> Specialist | <input type="checkbox"/> Acupuncturist | <input type="checkbox"/> No One |
| <input type="checkbox"/> Physical Therapist | <input type="checkbox"/> Masseuse | <input type="checkbox"/> Chiropractor | <input type="checkbox"/> Other _____ |

10. What test have you recently had for your symptoms, and when were they performed?

- | | |
|---|---|
| <input type="checkbox"/> X-ray Body part: _____ Date: _____ | <input type="checkbox"/> CT Scan Body part: _____ Date: _____ |
| <input type="checkbox"/> MRI Body part: _____ Date: _____ | <input type="checkbox"/> Other Body part: _____ Date: _____ |

11. Have you had similar symptoms in the past? Yes / No

12. What is your current work status?

- | | | |
|------------------------------------|------------------------------------|-----------------------------------|
| <input type="checkbox"/> Student | <input type="checkbox"/> Homemaker | <input type="checkbox"/> Retired |
| <input type="checkbox"/> Full-time | <input type="checkbox"/> Part-time | <input type="checkbox"/> Off work |

Occupation (If applicable): _____

LEFS(lower extremety functional scale)

Patient Name: _____

Date: _____

Instructions

We are interested in knowing whether you are having any difficulty at all with the activities listed **below because of your lower limb problem** for which you are currently seeking attention. Please provide an answer to **each** activity

Today, do you or would you have any difficulty at all with:

Activities	Extreme difficulty or unable to perform activity	Quite a bit of difficulty	Moderate difficulty	A little bit of difficulty	No difficulty
1. Any of your usual work, housework, or school activities.	0	1	2	3	4
2. Your usual hobbies, recreational, or sporting activities.	0	1	2	3	4
3. Getting into or out of the bath.	0	1	2	3	4
4. Walking between rooms.	0	1	2	3	4
5. putting on your shoes or socks.	0	1	2	3	4
6. Squatting.	0	1	2	3	4
7. Lifting an object, like a bag of groceries from the floor.	0	1	2	3	4
8. Performing light activities around your home.	0	1	2	3	4
9. Performing heavy activities around your home.	0	1	2	3	4
10. getting into or out of a car.	0	1	2	3	4
11. Walking two blocks	0	1	2	3	4
12. Walking a mile	0	1	2	3	4
13. Going up or down 10 stairs (about 1 flight of stars).	0	1	2	3	4
14. Standing for 1 hour.	0	1	2	3	4
15. Sitting for 1 jour.	0	1	2	3	4
16. Running on even ground	0	1	2	3	4
17. Running on uneven ground	0	1	2	3	4
18 Making sharp turns while running fast	0	1	2	3	4
19. Hopping	0	1	2	3	4
20. Rolling over in bed.	0	1	2	3	4
Column totals					

Score (for staff only): _____