



# Patient Information Sheet

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

Home Phone: \_\_\_\_\_  
 Work Phone: \_\_\_\_\_  
 Cell Phone: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

### Emergency Contact:

Contact Name: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_  
 Daytime Phone: \_\_\_\_\_

## 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?

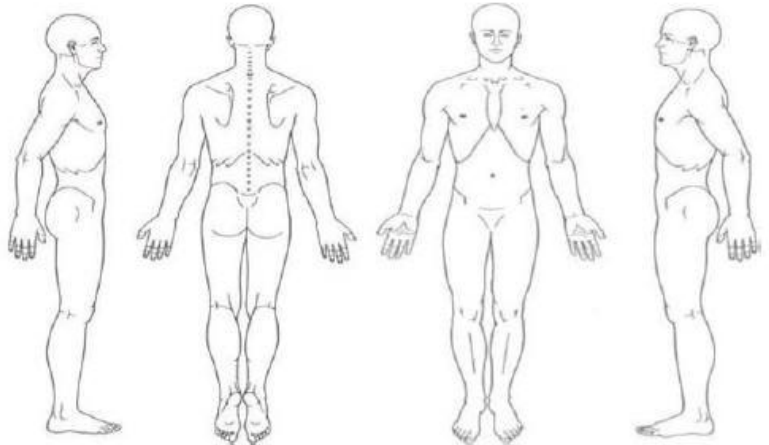
- Constantly  
 Intermittently

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"/> Masseur    | <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?

- Student       Homemaker       Retired  
 Full-time       Part-time       Off work

Occupation (If applicable): \_\_\_\_\_

## The Neck Disability Index

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

Please read instructions:

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage everyday life. Please answer each section and mark in each section only ONE box that applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please just mark the box the most closely describes your problem.

### Section 1 – Pain Intensity

- I have no pain at the moment. (0 points)
- The pain is very mild at the moment. (1 point)
- The pain is moderate at the moment. (2 points)
- The pain is fairly severe at the moment. (3 points)
- The pain is very severe at the moment. (4 points)
- The pain is the worst imaginable at the moment. (5 points)

### Section 2 – Personal Care (Washing, Dressing, etc.)

- I can look after myself normally, without causing extra pain. (0 points)
- I can look after myself normally, but it causes extra pain. (1 point)
- It is painful to look after myself and I am slow and careful. (2 points)
- I need some help, but manage most of my personal care. (3 points)
- I need help every day in most aspects of my self care. (4 points)
- I do not get dressed; I wash with difficulty and stay in bed. (5 points)

### Section 3 – Lifting

- I can lift heavy weights without extra pain. (0 points)
- I can lift heavy weights, but it gives me extra pain. (1 point)
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table. (2 points)
- Pain prevents me from lifting heavy weights, but I can manage lifting light to medium weights if they are conveniently positioned. (3 points)
- I can lift very light weights. (4 points)
- I can not lift anything at all. (5 points)

### Section 4 – Reading

- I can read as much as I want with no pain in my neck. (0 points)
- I can read as much as I want with slight pain in my neck. (1 point)
- I can read as much as I want with moderate pain in my neck. (2 points)
- I can not read as much as I want because of moderate pain in my neck. (3 points)
- I can not read as much as I want because of severe pain. (4 points)
- I can not read at all. (5 points)

### Section 5 – Headaches

- I have no headaches at all. (0 points)
- I have slight headaches the come infrequently. (1 point)
- I have moderate headaches that come infrequently. (2 points)
- I have moderate headaches that come frequently. (3 points)
- I have severe headaches that come on frequently. (4 points)
- I have headaches almost all the time. (5 points)

## The Neck Disability Index

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

### Section 6 – Concentration

- I can concentrate fully when I want to, with no difficulty. (0 points)
- I can concentrate fully when I want to, with slight difficulty. (1 point)
- I have a fair degree of difficulty in concentrating when I want to. (2 points)
- I have a lot of difficulty in concentrating when I want to. (3 points)
- I have a great deal of difficulty in concentrating when I want to. (4 points)
- I cannot concentrate at all. (5 points)

### Section 7 – Work

- I can do as much work as I want to. (0 points)
- I can do my usual work, but no more. (1 point)
- I can do most of my usual work, but no more. (2 points)
- I cannot do my usual work. (3 points)
- I can hardly do any work at all. (4 points)
- I cannot do any work at all. (5 points)

### Section 8 – Driving

- I can drive my car without any neck pain. (0 points)
- I can drive my car as long as I want, with slight pain in my neck. (1 point)
- I can drive my car as long as I want, with moderate pain in my neck. (2 points)
- I cannot drive my car as long as I want, because of moderate pain in my neck. (3 points)
- I can hardly drive at all, because of severe pain in my neck. (4 points)
- I cannot drive my car at all. (5 points)

### Section 9 – Sleeping

- I have no trouble sleeping. (0 points)
- My sleep is slightly disturbed (less than 1 hr sleepless). (1 point)
- My sleep is mildly disturbed (1-2 hours sleepless). (2 points)
- My sleep is moderately disturbed (2-3 hours sleepless). (3 points)
- My sleep is greatly disturbed (3-5 hours sleepless). (4 points)
- My sleep is completely disturbed (5-7 hours sleepless). (5 points)

### Section 10 – Recreation

- I am able to engage in all my recreation activities, with no neck pain at all. (0 points)
- I am able to engage in all my recreation activities, with some neck pain. (1 point)
- I am able to engage in most, but not all, of my usual recreation activities, because of pain in my neck. (2 points)
- I am able to engage in few of my recreation activities, because of pain in my neck. (3 points)
- I can hardly do any recreation activities, because of pain in my neck. (4 points)
- I cannot do any recreation activities at all. (5 points)