



# 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?

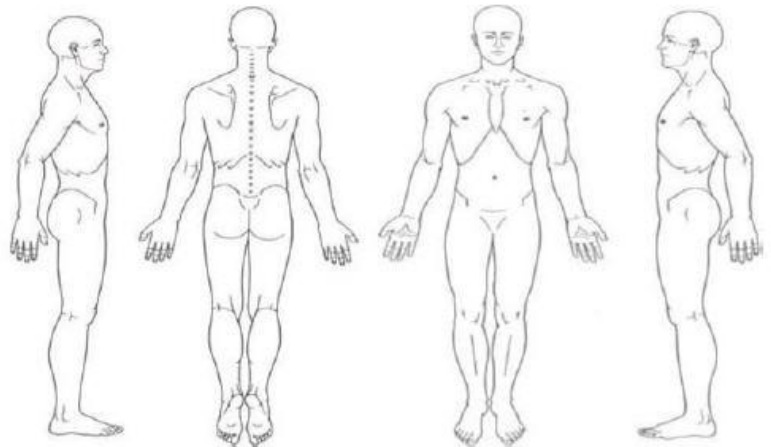
- Constantly  
 Intermittently

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"/> 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): \_\_\_\_\_

## Shoulder Pain and Disability Index (SPADI)

**Instructions:**

Please answer the following questions by circling the number that best describes your pain.

If you feel a question does not pertain to you please put NA (not applicable) beside the question.

We will ask you to repeat this index in order to help the therapist track the progress of your treatment.

Thank you.

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

**Pain Scale:**

How severe is your Pain; 0 = No Pain -----10 = the worst pain imaginable

1. At its worst?	0	1	2	3	4	5	6	7	8	9	10
2. When lying on the involved side?	0	1	2	3	4	5	6	7	8	9	10
3. Reaching for something on a high shelf?	0	1	2	3	4	5	6	7	8	9	10
4. Touching the back of your neck?	0	1	2	3	4	5	6	7	8	9	10
5. Pushing with your involved arm?	0	1	2	3	4	5	6	7	8	9	10

**Disability Scale:**

How much difficulty do you have; 0 = no difficulty -----10 = so difficult it requires help

6. Washing your hair?	0	1	2	3	4	5	6	7	8	9	10
7. Washing your back?	0	1	2	3	4	5	6	7	8	9	10
8. Putting on a undershirt or pullover sweater?	0	1	2	3	4	5	6	7	8	9	10
9. Putting on a shirt with buttons down the front?	0	1	2	3	4	5	6	7	8	9	10
10. Putting on your pants?	0	1	2	3	4	5	6	7	8	9	10
11. Placing an object on a high shelf?	0	1	2	3	4	5	6	7	8	9	10
12. Carrying a heavy object of 10 pounds?	0	1	2	3	4	5	6	7	8	9	10
13. Removing something from your back pocket?	0	1	2	3	4	5	6	7	8	9	10

**To be completed by staff:**

**Total Score:**