ORTHOPEDIC ASSOCIATES
THERAPY CENTER

PATIENT HEALTH QUESTIONNAIRE

DATE: _____ NAME: _____

DOB: _____ Email: _____

DEMOGRAPHIC INFORMATION

WHERE DO YOU LIVE?

□ PRIVATE HOME OR APT. □ ASSISTED LIVING OR GROUP HOME □ LONG-TERM CARE FACILITY
□ OTHER _____

WHO DO YOU LIVE WITH? (CHECK ALL THAT APPLY)

□ ALONE □ SPOUSE/SIGNIFICANT OTHER □ CHILD/CHILDREN □ GROUP SETTING
□ PERSONAL CARE ATTENDANT □ OTHER _____

DOES YOUR OCCUPATION PRIMARILY INVOLVE?

□ SITTING AT A COMPUTER OR PROLONGED COMPUTER USE
□ MANUAL LABOR □ RETIRED
□ HOMEMAKER □ OTHER
□ HOMEMAKER WITH SMALL CHILDREN

EMPLOYMENT/WORK STATUS (CHECK ALL THAT APPLY)

□ FULL-TIME, OUTSIDE HOME □ FULL-TIME, IN HOME
□ PART-TIME, OUTSIDE HOME □ PART-TIME, IN HOME
□ WORKING WITH MODIFICATION BECAUSE OF CURRENT INJURY
□ NOT WORKING BECAUSE OF CURRENT ILLNESS/INJURY
□ UNEMPLOYED □ RETIRED
□ OTHER _____

WHAT ARE YOUR HOBBIES AND ARE YOU ABLE TO CURRENTLY PARTICIPATE AT THE LEVEL AND FREQUENCY YOU WOULD LIKE?

_____

PAST MEDICAL HISTORY

LIST ALL HEALTH PROBLEMS, HOSPITALIZATIONS, SURGERIES AND ALLERGIES OR PROVIDE A LIST TO YOUR THERAPIST:

_____

_____

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING OR PROVIDE A LIST TO YOUR THERAPIST:

_____

ARE YOU A DIABETIC? □ YES □ NO DO YOU HAVE A PACEMAKER? □ YES □ NO
IF YES, FOR HOW LONG? _____

ARE YOU PREGNANT? □ YES □ NO
IF YES, HOW MANY MONTHS? _____

DO YOU USE A? (CHECK ALL THAT APPLY)

□ CANE □ WALKER/ROLLING WALKER/ROLLATOR □ MANUAL WHEELCHAIR □ MOTORIZED WHEELCHAIR
□ OTHER _____

If yes to any of the above, what condition necessitates the use of assistance? _____

PLEASE LIST OTHER PHYSICIANS WHO ARE TREATING YOU AND FOR WHAT CONDITION
(DO NOT INCLUDE THE CONDITION YOU ARE HERE FOR)

_____

HAVE YOU RECEIVED PREVIOUS PHYSICAL OR OCCUPATIONAL THERAPY? □ YES □ NO
If yes, for what condition and what did you like/dislike about the treatment?

_____

DO YOU CURRENTLY HAVE A FAMILY PHYSICAL THERAPIST? □ YES □ NO

IN GENERAL, HOW WOULD YOU SAY YOUR OVERALL HEALTH IS RIGHT NOW?

□ EXCELLENT □ GOOD □ FAIR □ POOR

ORTHOPEDIC ASSOCIATES
THERAPY CENTER

PATIENT HEALTH QUESTIONNAIRE

QUESTIONS 1-12 ARE FOR PATIENTS WHO RECENTLY HAD SURGERY AND ARE HERE FOR POST-SURGICAL REHABILITATION.

1 DATE OF SURGERY: _____ / _____ / _____

2 TYPE OF SURGERY: _____

3 DESCRIBE YOUR SYMPTOMS PRIOR TO SURGERY:

_____

_____

_____

4 HOW DID YOUR SYMPTOMS BEGIN PRIOR TO SURGERY?

_____

_____

5 NATURE OF SYMPTOMS:

SINCE SURGERY

- □ SHARP
- □ BURNING
- □ DULL ACHE
- □ TINGLING
- □ NUMB
- □ SHOOTING

PRIOR TO SURGERY

- □ SHARP
- □ BURNING
- □ DULL ACHE
- □ TINGLING
- □ NUMB
- □ SHOOTING

6 HOW OFTEN ARE SYMPTOMS EXPERIENCED?

SINCE SURGERY

- □ CONSTANTLY (76-100% OF DAY)
- □ FREQUENTLY (51-75% OF DAY)
- □ OCCASIONALLY (26-50% OF DAY)
- □ INTERMITTENTLY (0-25% OF DAY)

PRIOR TO SURGERY

- □ CONSTANTLY (76-100% OF DAY)
- □ FREQUENTLY (51-75% OF DAY)
- □ OCCASIONALLY (26-50% OF DAY)
- □ INTERMITTENTLY (0-25% OF DAY)

7 SINCE YOUR SURGERY WOULD YOU REPORT THAT YOUR SYMPTOMS ARE:

□ BETTER □ WORSE □ SAME □ IMPROVING

8 WHAT IS YOUR AVERAGE PAIN INTENSITY?

LAST 24 HOURS/PAST WEEK/LAST 4 WEEKS (CIRCLE ONE)

None Unbearable

0 1 2 3 4 5 6 7 8 9 10

9 HOW MUCH HAVE YOUR SYMPTOMS INTERFERED WITH YOUR WORK, HOBBIES OR DAILY ACTIVITIES?

SINCE SURGERY □ NOT AT ALL □ A LITTLE BIT □ MODERATELY □ QUITE A BIT □ EXTREMELY

PRIOR TO SURGERY □ NOT AT ALL □ A LITTLE BIT □ MODERATELY □ QUITE A BIT □ EXTREMELY

10 PRIOR TO SURGERY, WHO DID YOU SEE FOR YOUR SYMPTOMS?

□ NO ONE □ CHIROPRACTOR □ MEDICAL DOCTOR □ PHYSICAL THERAPIST

□ OTHER _____

11 WHAT TREATMENT DID YOU RECEIVE PRIOR TO YOUR SURGERY AND WHEN (APPROXIMATELY)?

_____

12 PRIOR TO SURGERY WHAT TESTS DID YOU HAVE?

□ XRAYS □ MRI □ CT SCAN □ OTHER _____

ORTHOPEDIC ASSOCIATES
THERAPY CENTER

CONSENT FOR TREATMENT

HIPAA ACKNOWLEDGEMENT

CONSENT FOR TREATMENT AND ADMISSION:

I agree to be admitted to ORTHOPEDIC ASSOCIATES THERAPY CENTER as an outpatient, and authorize the therapy staff to evaluate and treat within the scope of physical and occupational therapy practice as ordered by the referring physician.
Initials _____

RELEASE OF INFORMATION:

I hereby authorize ORTHOPEDIC ASSOCIATES THERAPY CENTER to furnish medical records, via fax or mail, to my referring physician, insurance carrier and to the physician to whom I am referred concerning my evaluation and treatment.
Initials _____

WORKER'S COMPENSATION PATIENTS RELEASE OF INFORMATION:

I authorize ORTHOPEDIC ASSOCIATES THERAPY CENTER to discuss/forward any relevant vocational information, as related to my rehabilitation, with my worker's compensation/group insurance carrier/external case manager.
Initials if applicable _____

ASSIGNMENT OF BENEFITS:

I hereby assign all of my right, title, and interest to ORTHOPEDIC ASSOCIATES THERAPY CENTER of insurance/health and welfare benefits otherwise payable to me, not to exceed the balance due of ORTHOPEDIC ASSOCIATES THERAPY CENTER customary charges for the services provided. **Initials** _____

FINANCIAL AGREEMENT:

I assume financial responsibility for the payment of all charges at the time of service unless covered under worker's compensation, Medicare, or a specific insurance carrier. As a courtesy to you, ORTHOPEDIC ASSOCIATES THERAPY CENTER will file your claims to the insurance carrier that you have provided to us. By initialing below you agree for your insurance to be filed. All deductibles, co-insurances, and co-pays including non-covered services are your financial responsibility. Any account not paid will be referred to a third party collection agency to include all reasonable collection fees, not limited to attorney fees, investigative fees, and court costs. **Initials** _____

CANCELLATION/NO-SHOW POLICY:

As a courtesy to our staff and other patients we ask that you keep your scheduled appointments. If you are unable to attend a scheduled appointment, please call and cancel at least two(2) hours prior to the appointment. Failure to cancel the appointment within the time frame will result in the assessment of a fee in the amount of $15 per incidence.
Initials _____

HIPAA ACKNOWLEGEMENT:

I have received the Privacy Notice of ORTHOPEDIC ASSOCIATES THERAPY CENTER on today's date. **Initials** _____

The undersigned certifies that he/she has read the foregoing and is the patient, the patient's legal representative, or is duly authorized by the patient and his/her agent to execute the above and accept its terms. If patient's condition prohibits written consent, agent who is present when verbal consent is given should sign patient's name by agent's name. If patient is unable to consent or is a minor, complete the following:

If patient is a minor, how many years of age? _____If patient is unable to give his/her consent,

why?_____

_____ _____
Patient/Relative/Authorized Agent Signature Date

_____
Relationship to Patient (if signature is not the patient's)

_____
Witness Signature

ORTHOPEDIC ASSOCIATES
FLOWER MOUND – DENTON

DISCLOSURE OF PHYSICIAN OWNERSHIP

NOTICE TO PATIENTS

Please carefully review the information contained in this notice.

1. James Heerwagen, MD; Brady Giesler, MD; Jeffery Cantrell, MD; Kent Dickson, MD; David Evanich, MD; Michael Willenborg, MD; Manuj Singhal, MD; Ian Wilkofsky, MD; Aaron Schrayer, MD; and John McElroy, MD are the owners of Orthopedic Associates Therapy Center.

2. You have the right to choose the provider of your physical therapy services. Therefore, you have the option to use a health care facility other than Orthopedic Associates Therapy Center.

3. You will not be treated differently by your physician if you choose to obtain physical therapy services at a facility other than Orthopedic Associates Therapy Center.

If you have any questions concerning this notice, please feel free to ask your physician or any representative of Orthopedic Associates Therapy Center. We welcome you as a patient and value our relationship with you.

By signing this Disclosure of Physician Ownership, you acknowledge that you have read and understand the foregoing notice and hereby understand that your physician has an ownership interest in Orthopedic Associates Therapy Center.

_____ _____

Signature of Patient

Signature of Parent or Guardian
(If applicable)

_____ _____

Type or Print Name of Patient

Type or Print Name of Parent or Guardian
(If applicable)

Dated: _____