



Redbud Patient Intake Form

Medical History

Please fill this form and bring it with you when you come in for your appointment at Redbud

Name: _____

Date of Birth: _____

Date Completed: _____

Please check any of the following conditions that you have **CURRENTLY** been diagnosed as having:

- | | |
|---|--|
| <input type="checkbox"/> Diabetes Mellitus | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Encephalitis (Current diagnosis) | <input type="checkbox"/> Vertiginous/ Vestibular Syndromes |
| <input type="checkbox"/> Hypertensive Heart Disease | <input type="checkbox"/> Chronic Ischemic Heart Disease |
| <input type="checkbox"/> Acute Pulmonary Heart Disease | <input type="checkbox"/> Chronic Pulmonary Heart Disease |
| <input type="checkbox"/> Cardiac Dysrhythmias | <input type="checkbox"/> Congestive Heart Failure |
| <input type="checkbox"/> Peripheral Vascular Disease | <input type="checkbox"/> Venous Embolism/Thrombosis |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Chronic Obstructive Pulmonary Disease |
| <input type="checkbox"/> Chronic Ulcer of Skin | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Difficulty Walking | <input type="checkbox"/> Sciatica (Current diagnosis) |
| <input type="checkbox"/> Abnormal Posture | <input type="checkbox"/> LumboSacral, Neuritis or Radiculitis |

Comments: _____

Please check any of the following conditions that you have **EVER** been diagnosed as having:

- | | | |
|---|---|---|
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Chest pain, Angina, Heart Attack | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Circulation Problems | <input type="checkbox"/> Bleeding/ Bruising | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Blood Disorders | <input type="checkbox"/> Other Arthritic Conditions | <input type="checkbox"/> Emphysema/Bronchitis |
| <input type="checkbox"/> Osteoporosis/Osteopenia | <input type="checkbox"/> Chemical Dependency/Alcoholism | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Anxiety/ Panic Attacks | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Fainting Disorders |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Concussion |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Light-Headedness |
| <input type="checkbox"/> HIV/ AIDS | <input type="checkbox"/> Multiple Sclerosis/Parkinson's | <input type="checkbox"/> Cancer, |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Traumatic Brain Injury | if so what kind/type |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Swelling of Extremities | |
| <input type="checkbox"/> Spinal Cord Injury | | |

Comments: _____

Please check any of the following conditions that an immediate family member (parent, brother, sister) has ever been treated for:

- | | | | |
|--|-----------------------------------|---|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Mental Illness |

Comments: _____

Please check any of the following symptoms you have recently experienced:

- | | | | |
|---|--|------------------------------------|--|
| <input type="checkbox"/> Unexplained Weight Loss | <input type="checkbox"/> Nausea/Vomiting | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Weakness |
| <input type="checkbox"/> Fever/Chills/ Night Sweats | <input type="checkbox"/> Night Pain | <input type="checkbox"/> Accidents | <input type="checkbox"/> Do you cough or choke |
| <input type="checkbox"/> Numbness/Tingling | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Burning | when you eat or drink? |

Comments: _____

Please list any surgeries or other conditions for which you have been hospitalized, including, the approximate date and reason for the surgery or hospitalization.

Date	Reason for surgery/hospitalization

Please list **Prescribed** Medications you are currently taking (including pills, injections, etc.)

Please any of the following **Over-The-Counter** medications you are currently using.

- Aspirin Laxatives Antacids Tylenol Decongestants
 Antihistamines Advil/Motrin/Ibuprofen Vitamins/Supplements

Other:

Comments:

Do you have allergies to Medications?

Do you have allergies to Other substances?

How many ounces of caffeinated beverages do you drink per day?

Do you use tobacco products? Yes No

If so, what kind and how much per day? Cigarettes, /day, Cigars, /day, Smokeless, /day

How many days per week do you drink alcohol?

If one beer or glass of wine equals one drink, how much do you drink at an average sitting?

WOMEN: Are you pregnant or think you might be pregnant? Yes No Due?

Fall Risk Assessment:

- Have you fallen in the past 6 months? Yes No
 Do you experience dizziness or Vertigo? Yes No
 Are you afraid of falling? Yes No
 Do you have memory / cognitive difficulties? Yes No
 Do you use sedatives that affect your arousal during the day? Yes No
 Do you have a lower extremity disability that affects walking? Yes No
 Do you have vision problems that are not corrected by glasses? Yes No
 Have recently felt unsteady on your feet, or in your wheelchair? Yes No

NOTES:

Patient signature:

Date:

Relationship if other than patient / parent / guardian if minor:

OFFICE USE ONLY:

Patient has been identified as a fall risk: Yes No

(Yes if patient answered yes to 3 or more fall risks questions above)

If yes, fall prevention program has been implemented: Yes No

Patient Information Report

Location:

Apt Date:

Apt Time:

Patient Information			
Patient ID		Patient Phone #	
Patient Name		Patient Cell #	
Patient Address		Patient DOB	
Patient City		Patient SSN	
Patient State		Patient Sex	
Patient ZIP		Marital Status	
Spouse Information			
Spouse Name		Spouse State	
Spouse Employer		Spouse Phone	
Spouse Address		Spouse Occupation	
Spouse Zip		Spouse Date of Birth	
Spouse City			
Guarantor Information			
Guarantor Name		Guarantor State	
Guarantor Address		Guarantor Zip	
Guarantor City		Guarantor Phone	
Employer Information			
Employer Name		Employer ZIP	
Employer Address		Employer Phone #	
Employer City		Occupation	
Employer State			
Emergency Contact Information			
Contact Name		Contact ZIP	
Contact Address		Contact Phone #	
Contact City		Contact Relationship	
Contact State			
Injury Information			
Injury Date		Other Accident	
Employ Related		W/C Claim	
Auto Related		Post-Operative	
Accident State		Surgery Date	
Physical Therapy Insurance Information			
Insurance ID		Prior Auth #	
Insurance Name		Authorized From	
Insurance Address		Authorized To	
Insurance City		Auth \$ Amount	
Insurance State		Insured Name	
Insurance Zip		Relationship	
Policy #		Group #	
% Coverage		Deductible	
Copay Yes/No		Authorized Visits	
Effective From		Insurance Contact Person	
Effective To		Comment	
Physical Therapy Secondary Insurance Information			
Insurance ID		Prior Auth #	
Insurance Name		Authorized From	
Insurance Address		Authorized To	
Insurance City		Auth \$ Amount	
Insurance State		Insured Name	
Insurance Zip		Relationship	
Policy #		Group #	
% Coverage		Deductible	
Copay Yes/No		Authorized Visits	
Effective From		Insurance Contact Person	
Effective To		Comment	
Attorney Information			
Attorney Name		Attorney State	
Attorney Address		Attorney Zip	
Attorney City		Attorney Phone #	

Patient Information Report

Comments		
ID #	Primary M.D.	
ID #	Referring M.D.	
ID #	Referring Organization	
Diagnosis ID	Description	Onset Date
Please circle Yes or No to the following questions :		
How did you hear about us? Friend/Relative Radio TV Newspaper Phone Book Other: (List)		
Are you presently under the care of Home Health? Yes No		
Are you under the age of 65, covered by Medicare and disabled? Yes No		
Is this a Worker's Compensation claim? Yes No		
If this condition a result of a motor vehicle accident? Yes No If yes, do you have Med Pay coverage? Yes No		
Have you had physical therapy prior to this? Yes No If yes, list dates:		
When is your next doctor's visit?		
Consent for treatment:		
I hereby consent to such treatment procedures and patient care which, in the judgment of my therapist and/or physician, may be considered necessary or advisable while a patient of Redbud Physical Therapy.		
Authorization of release of information/assignment benefits:		
I hereby authorize Redbud Physical Therapy and its agents to furnish information it may have regarding my condition (treatment, diagnosis, prognosis, recommendation) to the insurance company or its representatives, my employer, my physician or my attorney upon their request during treatment and progress conferences. This authorization shall remain valid until revoked by me in writing.		
Guaranty of account:		
I hereby authorize payment of medical benefits to Redbud Physical Therapy for services rendered and accept total responsibility for all services not paid in full by my insurance company or payer source. I understand that I am responsible for paying co-pays, deductible, and coinsurance at <i>each</i> service as applicable.		
Disclaimer:		
While Redbud Physical Therapy makes every effort to obtain correct information regarding co-pay, coinsurance and deductible, we cannot guarantee the information we receive from your insurance company to be completely accurate. I understand that Redbud Physical Therapy cannot be held responsible for information provided to them incorrectly to my insurance company.		
Attendance policy:		
I understand that attendance at all scheduled physical therapy appointments is vital to my rehabilitation. It is Redbud Physical Therapy's policy that my physician, case manager, insurance adjustor and employer, if applicable, may be notified regarding any no shows or unjustified cancellations. In addition, I also understand that a total of any combination of cancellations or no shows greater than three will serve as reason for discharge from physical therapy services, unless otherwise indicated by my physician.		
Patient Signature:		Date:
Parent or Legal Guardian (If minor):		Date:

Patient Health Questionnaire - PHQ

ACN Group, Inc. - Form PHQ-202

ACN Group, Inc. Use Only rev 7/18/05

Patient Name _____ Date _____

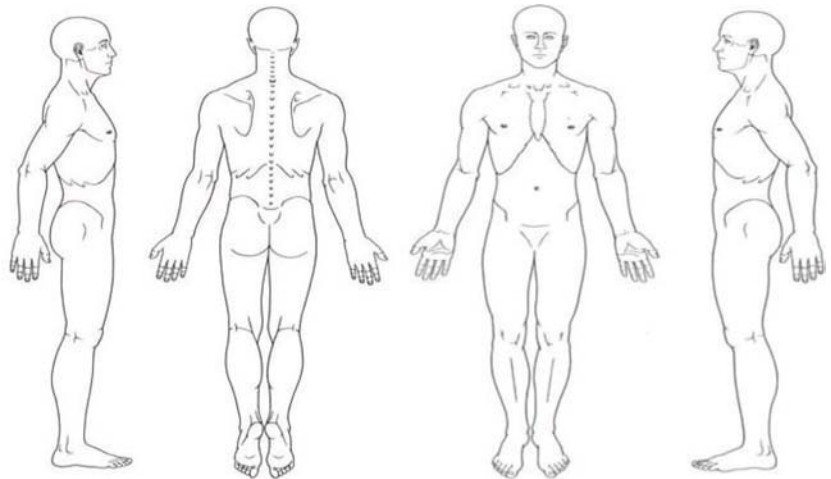
1. Describe your symptoms

a. When did your symptoms start?

b. How did your symptoms begin?

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

- ① Constantly (76-100% of the day)
- ② Frequently (51-75% of the day)
- ③ Occasionally (26-50% of the day)
- ④ Intermittently (0-25% of the day)



3. What describes the nature of your symptoms?

- ① Sharp
- ② Dull ache
- ③ Numb
- ④ Shooting
- ⑤ Burning
- ⑥ Tingling

4. How are your symptoms changing?

- ① Getting Better
- ② Not Changing
- ③ Getting Worse

5. During the past 4 weeks:

a. Indicate the average intensity of your symptoms

None ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Unbearable

b. How much has pain interfered with your normal work (including both work outside the home, and housework)

- ① Not at all
- ② A little bit
- ③ Moderately
- ④ Quite a bit
- ⑤ Extremely

6. During the past 4 weeks how much of the time has your condition interfered with your social activities?

(like visiting with friends, relatives, etc)

- ① All of the time
- ② Most of the time
- ③ Some of the time
- ④ A little of the time
- ⑤ None of the time

7. In general would you say your overall health right now is...

- ① Excellent
- ② Very Good
- ③ Good
- ④ Fair
- ⑤ Poor

8. Who have you seen for your symptoms?

- ① No One
- ② Chiropractor
- ③ Medical Doctor
- ④ Physical Therapist
- ⑤ Other

a. What treatment did you receive and when?

b. What tests have you had for your symptoms and when were they performed?

- ① Xrays date: _____
- ② MRI date: _____
- ③ CT Scan date: _____
- ④ Other date: _____

9. Have you had similar symptoms in the past?

- ① Yes
- ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

- ① This Office
- ② Chiropractor
- ③ Medical Doctor
- ④ Physical Therapist
- ⑤ Other

10. What is your occupation?

- ① Professional/Executive
- ② White Collar/Secretarial
- ③ Tradesperson
- ④ Laborer
- ⑤ Homemaker
- ⑥ FT Student
- ⑦ Retired
- ⑧ Other

a. If you are not retired, a homemaker, or a student, what is your current work status?

- ① Full-time
- ② Part-time
- ③ Self-employed
- ④ Unemployed
- ⑤ Off work
- ⑥ Other

Patient Signature _____ Date _____

11. What activities, positions, or movements make your symptoms worse?

12. What activities, positions, or movements help decrease your symptoms?

13. Please indicate any other past or current medical problems or injuries:



MEDICARE SECONDARY PAYOR QUESTIONNAIRE

1. Are you receiving Black Lung (BL) benefits or has the Department of Veterans Affairs (DVA) authorized and agreed to pay for care at this facility?

Yes. Date Benefits began: ___/___/___ **STOP.**
BL or DVA is primary for these services.

No. Go to Question 2.

Is this illness /injury due to a work related accident/condition (WC)?

Yes. Date of illness/injury: ___/___/___ **STOP.** Complete Part IV & VI and Stop.
Workers Compensation Primary for this claim.

No. Go to Question 3.

Is this illness /injury due to an auto accident?

Yes. Date of accident: ___/___/___ Complete Part V and **STOP.**
No-Fault/Liability Insurer Primary for claim to this accident.

No. Go to Question 4.

Do you feel that another party is responsible for this illness/injury?

Yes. Complete Part V and **STOP.**
No-fault /Liability Insurer Primary for claim to this accident.

No. Go to Question 5.

Are you entitled to Medicare based on

Age (over 65). Go to Part I.
Disability. Go to Part I and answer A & B, then go to Part II.
End Stage Renal Disease (ESRD). Go to Part III.

PART I

A. Are you, or your spouse, currently employed?

Yes. Complete Part VI and go to B.

No. **STOP.** Medicare Primary.
Date of your retirement ___/___/___.
Date of spouse's retirement ___/___/___.

B. Do you have Group Health Plan (GHP) coverage based on your own, or a spouse's current employment?

Yes. Go to C.

No. **STOP.** Medicare Primary.

C. Does the employer that sponsors your (or spouse) GHP employ 20 or more employees?

Yes. Complete Part VII and **STOP.**

No. **STOP.** Medicare Primary.

PART II

A. Does the employer that sponsors your (or spouse) GHP employ 100 or more employees?

Yes. Complete Part VII **STOP.**

No. **STOP.** Medicare Primary.

PART III

A. Do you have Group Health Plan (GHP) coverage?

Yes. Complete Part VI & VII, and go to B.

No. **STOP.** Medicare Primary.

B. Are you within the 30-month coordination period?

Yes. Go to C.

No. **STOP.** Medicare Primary.

C. Are you entitled to Medicare on the basis of either ESRD and age OR ESRD and disability? (End State Renal Disease)

Yes. Go to D.

No. **STOP.** Medicare Primary.

D. Was your initial entitlement to Medicare (including simultaneous entitlement) based on ESRD?

Yes. **STOP.** GHP Primary during 30 Month Coordination Period.

No. Go to E.

E. Did you have Group Health Plan (GHP) coverage secondary to Medicare at the time you were diagnosed with ESRD?

Yes. **STOP.** GHP Primary during 30 Month Coordination Period.

No. **STOP.** Medicare Primary.

Part IV, V, VI and VII on Back of Page

PART IV

Name of Workers compensation Plan: _____

Address of WC Plan: _____

Policy or Identification Number: _____

PART V

Name of No-Fault/Liability Insurer: _____

Address of No-Fault/Liability Insurer: _____

Insurance Claim Number: _____

PART VI

Patient

Spouse

Name & Address of Employer: _____

PART VII

Patient

Spouse

Name of Group Health Plan: _____

Address of Group Health Plan: _____

Policy ID Number: _____

Group ID Number: _____

Name of Policy Holder: _____

Relationship to Patient: _____

Representative Date

Witness Date

Redbud Physical Therapy

Acknowledgement of Receipt of Notice of Privacy Practices

Redbud Physical Therapy reserves the right to modify the privacy practices outlines in the notice.

Signature

I have received a copy of the Notice of Privacy Practices for Redbud Physical Rehabilitation.

Name of Patient (Print or Type)

Signature of Patient

Signature of Patient Representative
(Required if the patient is a minor or an adult who is unable to sign this form)

Relationship of Patient Representative to Patient