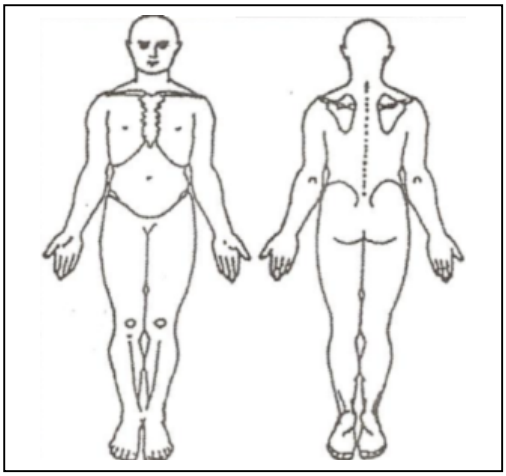
SCHRAMM PHYSICAL THERAPY, INC.
PATIENT HEALTH QUESTIONNAIRE

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.
   ☐ Constantly (76-100% of the day)
   ☐ Frequently (51-75% of the day)
   ☐ Occasionally (26-50% of the day)
   ☐ Intermittently (0-25% of the day)



3. What describes the nature of your symptoms?
   ☐ Sharp ☐ Shooting
   ☐ Dull Ache ☐ Burning
   ☐ Numb ☐ Tingling

4. How are your symptoms changing?
   ☐ Getting Better
   ☐ Not Changing
   ☐ Getting Worse

5. During the past 4 weeks: None Unbearable
   a. Indicate the average intensity of your symptoms (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)
   b. How much has pain interfered with your normal work (including both work outside the home and housework)?
   ☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

6. During the past 4 weeks how much of the time has your condition interfered with your social activities? (e.g., visiting with friends, relatives, etc.)
   ☐ All of the time ☐ Most of the time ☐ Some of the time ☐ A little of the time ☐ None of the time

7. In general would you say your overall health right now is …
   ☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

8. Who have you seen for your symptoms? ☐ No One ☐ Medical Doctor
   ☐ Chiropractor ☐ Physical Therapist
   Other _____

   a. What treatment did you receive and when? _____
   b. What tests have you had for your symptoms and when were they performed? ☐ X-rays date: _____ ☐ CT Scan date: _____ ☐ MRI date: _____ ☐ Other date: _____

9. Have you had similar symptoms in the past? ☐ Yes ☐ No

   a. If you have received treatment in the past for the same or similar symptoms, who did you see? ☐ This office ☐ Physical Therapist ☐ Chiropractor ☐ Medical Doctor
   Other _____

10. What is your occupation? ☐ Professional/Executive ☐ White Collar/Secretarial
    ☐ Tradesperson ☐ Laborer ☐ Homemaker
    ☐ FT Student ☐ Retired ☐ Other _____

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

Patient Signature _____ Date: _____

PATIENT MEDICAL HISTORY

Patient: _____ Home Phone: (____)_____

Birth date:_____ Work Phone:(____)_____ Cell Phone: (____)_____

Address: _____City:_____ State:_____ Zip:_____

Social Security Number: _____Email Address:_____

Employer:_____
Address State Zip

Emergency Contact: Name_____ Phone #:_____

Address:

Your goals for physical therapy:_____

Athletic goals: _____How did you hear about us?_____

Were you referred to a particular practitioner? If so, who?_____-_____

Referring Physician:_____ Phone: {____)_____

Address:_____

When do you see your physician again?_____

Primary Care Physician:_____ Phone: (____)_____

Type of Injury/Condition: _____Onset/Injury Date:_____

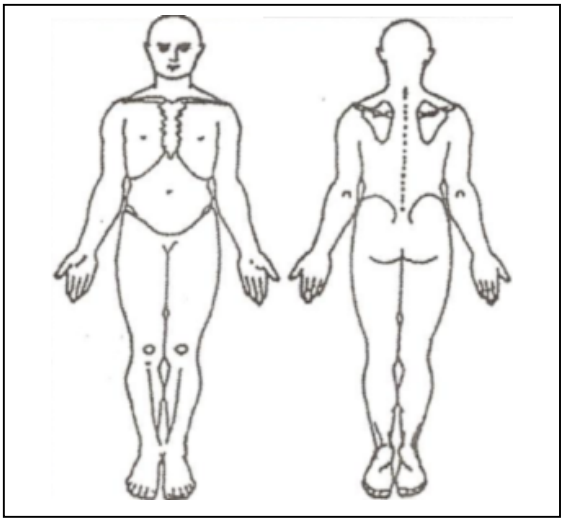
Physical limitations due to injury:_____

What activities aggravate your symptoms? _____

_____

Type of Surgery & Date: _____

Describe any previous treatment for this condition:



Have you had any diagnostic tests for this condition?

☐X-ray ☐CT scan ☐MRI ☐Doppler ☐Ultrasound

Please describe your pain: ☐ Sharp ☐Burning ☐Aching

Tingling / Numbness / Other: _____

Please rate your pain (0 = none, l = minimal, l0 = severe):

At present: 0 1 2 3 4 5 6 7 8 9 10
At its worst: 0 1 2 3 4 5 6 7 8 9 10
At its best: 0 1 2 3 4 5 6 7 8 9 10

Are you currently taking medications: Yes / No

Please list meds:_____

Have you recently noted any of the following?

☐Breathing Difficulty
☐ Change in Vision
☐ Fatigue
☐Fever/Chills/Sweats
☐Headaches
☐ Insomnia
☐ Nausea/Vomiting
☐ Pain at Night
☐ Pregnancy
☐ Weakness
☐ Weight Loss

Do you have now or have you ever had any of the following?

☐ Allergies/Skin Sensitivity
☐ Asthma!Breathing Problems
☐ Autoimmune Deficiency
☐ Cancer
☐Circulation Problems
☐ Diabetes
☐ Easy Bruising/Bleeding
☐ Fainting
☐ Fractures
☐Heart Problems
☐Hepatitis
☐ High Blood Pressure
☐ Indigestion/Heartbum
☐ Kidney Disease
☐ Leg/Ankle Swelling
☐Loss of Consciousness
☐ Lung Disease
☐ Metal Implant
☐ Motor Vehicle Accident
☐ Multiple Sclerosis
☐ Osteoporosis/Osteopenia
☐ Sprains/Strains
☐ Stroke
☐ Surgeries
☐ Thyroid Problems
☐ Urinary Problems/Infections

Any previous injury that may affect current care? Please describe:_____

Please explain & give approximate dates for any conditions marked above. _____

_____

_____

INSURANCE INFORMATION

Insurance Carrier:_____Phone: (____)_____

Address:_____

Claim Number:_____ Group Number:_____

Date of Injury: _____ Adjustor or Contact Person: _____

Name of Insure: _____Relationship to Patient: _____

Birth Date of Name of Insured: _____

Additional Insurance Coverage: _____ Claim Number:_____

Address: _____ Phone Number: (____)_____

Did this accident occur at work'? ☐ YES ☐ NO

Were you involved in an automobile accident? ☐ YES ☐ NO

Financial Class:
Insurance ☐In Network ☐Out of Network
☐ Workers' Comp
☐ Wellness/Cash
Other (select one): ☐ Auto ☐ Medicare

Dx: _____
Physical Therapist: Craig W. Schramm MSPT

SCHRAMM PHYSICAL THERAPY, INC.

HIPAA REGULATIONS

Privacy Practices

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information. .

Our Legal Duty

The law requires us to: l) Keep your medical information private. 2) Give you notice describing our legal duties and privacy practices. 3) Notify you of any changes in our privacy practices.

Use and Disclosure

To follow are different ways that we are permitted to use and disclose medical information. We will not use or disclose any medical information not listed without specific written authorization from you.

Treatment: We may use medical information about you to provide you with medical treatment or other services related to your care. We may disclose medical information about you to doctors, nurses, technicians or other people involved in your care. We may also share medical information about you to your other health care providers to assist them in treating you.

Payment: We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third party payer (i.e., insurance company, attorney, consulting physician). We may also disclose information to your health plan about treatment or possible treatment to help determine if your health plan will pay for certain services.

lf you have any question about any of our policies or your rights, please feel free to speak with your physical therapist or any of our staff.

Your signature below indicates your understanding and compliance of the above privacy practices.

_____ _____

Printed Name Date

_____

Signature