Patient Health Questionnaire

How did you hear about us?

☐ Yelp ☐ Dr. Referral ☐ Friend ☐ Social Media ☐ Other_______________________________________

1. Name ____
2. Email address*: ____

   *For private use only. We will never use your email for spam or external marketing purposes.

3. Height _________________ Weight ________________ Preferred Gender: Male Female Other

   a. Would you like a referral to a dietician/nutritionist? ☐ Yes ☐ No

4. What is your age? ___________ Date of Birth: ______________ Hand Dominance: ☐ R ☐ L
5. Please list all current prescriptions (OTC, herbals, vitamins/minerals/dietary with name/dosage/frequency and route of administration):

   ____

   ____

6. What is your occupation? ____
7. Do you currently have a diagnosis? If yes, what is it? ____

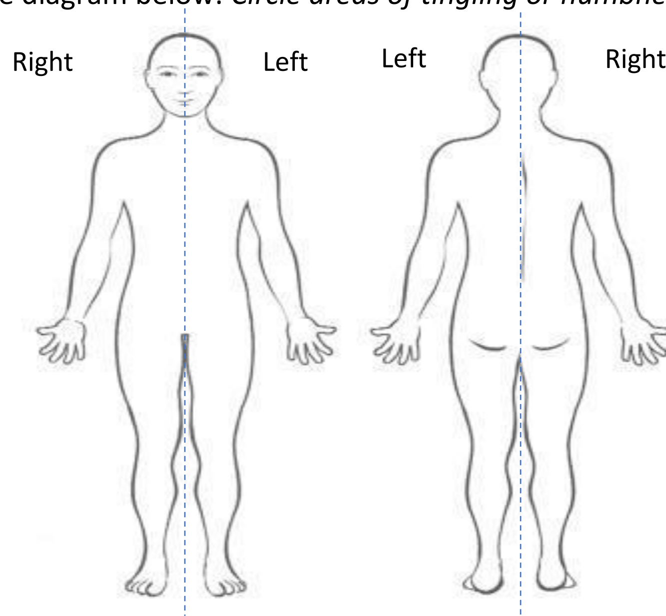
   ____

8. Have you ever received physical therapy for current diagnosis? _________________________________
9. How confident are you physical therapy will help your current problem?

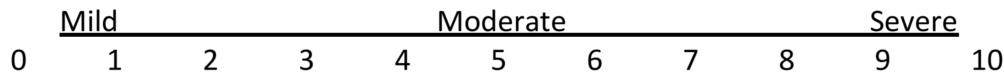
   Very confident *Most Likely* *Not sure it will* *Not sure why I am here*

10. Where is your pain/problem? ____
11. What caused your pain/problem? ____
12. Approximately when did it start? ____
13. Have you ever had this pain/problem before? ☐ Yes ☐ No

14. Draw your pain in the diagram below. *Circle areas of tingling or numbness*.



15. On the scale below circle your average pain level in the past couple of days:



0 1 2 3 4 5 6 7 8 9 10

16. Please indicate when your pain is the greatest (AM, PM, Middle of night)? ________________________

____

17. Have you recently taken steroids or ANTICOAGULANTS?____

18. What aggravates your symptoms (movements, positions, etc.)? Be specific. ______________________

____

19. What eases your symptoms (movements, positions, meds, etc.)? ________________________________

____

20. What activities are you limited in or unable to perform due to your condition? ____________________

____

21. Do you exercise? ☐ Yes ☐ No

Type____Frequency__________________

22. List recent diagnostic studies (X-Rays, MRIs, etc.): ____

____

23. Do you have METAL (pins, plates) anywhere in your body? __________________________________

24. Do you have a pacemaker? ☐ Yes ☐ No

25. *If applicable*: are you pregnant? ☐ Yes ☐ No Months of pregnancy____________

26. Have you noticed a recent unexplained weight loss or gain? ☐ Yes ☐ No

a. Would you like a referral? ☐ Yes ☐ No

27. During the past month, have you often been bothered by feeling down, depressed, or hopeless?
☐ Yes ☐ No

b. Would you like help? ☐ Yes ☐ No

28. Have you ever had or been diagnosed with (check box by all that apply and list others)?:

Asthma		Diabetes		Bone or Joint Disease		Other (list)	
Allergies		Heart Disease		Auto-immune disease			
Stroke		Lung Disease		Depression			
Seizures		Kidney Disease		Cancer (type)			
Heart Attack/ Angina		Liver Disease		Blood clot			
High Blood Pressure		Thyroid Disease		Lymphedema			

29. Please list any past surgeries and injuries and indicate whether or not the symptoms continue to persist:

____

____

____

30. For **MEDICARE PATIENTS ONLY**: Have you received home health care in the past month?
☐ Yes ☐ No

MEDICARE PATIENTS ONLY

By signing below I hereby state that I have NOT received any in home health visits, and/or that no health care provider has visited my house in the past month.

⇒____ _____________________________

Signature of Medicare Patient/Guardian **Date**

Have you been discharged from your home health care? Y N

CONSENT FOR CARE AND TREATMENT

I, the undersigned, do herby agree and give consent for Forward Motion Physical Therapy, Inc to furnish medical care and treatment necessary in treating his/her physical condition.

⇒____ _____________________________

Signature of Patient/Guardian **Date**

BENEFIT ASSIGNMENT / RELEASE OF INFORMATION

I, hereby assign medical benefits to which I am entitled, including Medicare, private insurance and third party payers to Forward Motion Physical Therapy, Inc. A photo copy of this assignment is information necessary including Medical records, to secure payment.

⇒____ _____________________________

Signature of Patient/Guardian **Date**

AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL RECORDS FROM MEDICAL PROVIDERS

I hereby authorize Forward Motion Physical Therapy, Inc to obtain any and all medical records concerning my case from any physician, hospital or health care professional that has provided medical care to me in the past.

I also authorize Forward Motion Physical Therapy, Inc to release any and all medical records concerning my care to any physician, hospital or other health care professional providing care to myself / and or child at any time.

⇒____ _____________________________

Signature of Patient/Guardian **Date**

PAYMENT POLICY

You are financially responsible for all services not covered by your insurance company. At each visit you will be expected to pay the amount verbally quoted to us by your insurance company, including any outstanding deductibles. We accept cash, check, and most credit cards. Accounts with a past due balance over 30 days will be charged a monthly interest rate of 1.5% plus a monthly $20.00 late administration fee. There is a $25.00 fee for returned checks.

⇒____ _____________________________

Signature of Patient/Guardian **Date**

MEDI-CAL POLICY

I, the undersigned,understand that Forward Motion Physical Therapy is NOT a Medi-Cal provider. If you have Medi-Cal or become Medi-Cal eligible while undergoing treatment at our facility you will be financially responsible for the patient responsibility as determined by your primary insurance carrier.

⇒____ _____________________________

Signature of Patient/Guardian **Date**

CANCELLATION POLICY

Cancellations must be made at least 24 hours prior to your appointment time. Late cancellations and "NO SHOW" appointments will be charged a $50.00 fee which is not billable to your insurance company.

⇒____ _____________________________

Signature of Patient/Guardian **Date**

FORWARD MOTION PHYSICAL THERAPY

WAIVER, RELEASE OF LIABILITY, AND CONSENT TO MEDICAL ATTENTION

In consideration of my being allowed to use the fitness facilities, the pool and all associated facilities on the premises of Forward Motion Physical Therapy at 23101 Sherman Pl. Suite 515, 23622 Calabasas Rd. Suite 100 ,and at the de Toledo High School, and 22622 Vanowen St, hereto thus referred to as the "Facilities", I agree to be bound by each of the following:

1. **Voluntary Participation**: I understand and confirm that my use of the Facilities is voluntary.
2. **Obligation to Inspect the Facilities and Equipment**: I agree that prior to use, I shall inspect the Facilities and equipment to be used. If I believe anything is unsafe, I will immediately advise Forward Motion Physical Therapy of such unsafe condition(s) and shall not use the Facilities or any such equipment.
3. **Identification of Risks**: I understand that my use of the Facilities and the equipment in the Facilities involves risk of property damage, significant injury, disability and death. In addition to the risks of new injury described in this section, I further understand that physical exertion associated with the use of the Facilities can activate or aggravate pre-existing physical injuries, conditions, symptoms or congenital defects. I further understand that the Facilities is unsupervised.
4. **Assumption of Risk**: I have sought the advice of a physician, or have indicated that I am a non-referral patient prior to using the Facilities. I am physically and psychologically ready to use the Facilities and assume all risks, known or unknown, foreseeable and unforeseeable, connected with my use of the Facilities. I accept personal responsibility for any liability, injury, loss, or damage in any way connected with my use of the Facilities and any of the equipment in the Facilities.
5. **Waiver and Release**: I release and discharge Forward Motion Physical Therapy, and any affiliated organizations and any employees, agents, successors, and assigns thereof, from all claims for any liability, injury, loss, or damage in any way connected with my use of the Facilities, whether or not caused in whole or part by the negligence of any organizations or individuals mentioned above. I intend for this waiver and release also to apply to my relatives, personal representatives, heirs, beneficiaries, next of kin, or assigns who might pursue any legal action or claim for such liability, injury, loss or damage.
6. **Medical Treatment**: I understand that my use of the Facilities is related in to the provision of Physical Therapy or other services offered by Forward Motion Physical Therapy, and that my use of the Facilities is a component of my Physical Therapy treatment. I agree that Forward Motion Physical Therapy, or any representative thereof, may, but has no duty to, provide to me, through medical personnel of its choice, customary medical or training assistance, transportation, and emergency medical services. This consent does not impost a duty upon [Facilities] or its affiliated organization or their employees, agents, or successors to provide such assistance, transportation or services. I understand that it is my obligation to obtain health and any other insurance appropriate in connection with my use of the Facilities. I agree to otherwise be responsible for all medical expenses incurred in connection with my use of the Facilities.
7. **Applicable Law/Venue Selection**: I understand and agree that this Waiver, Release of Liability and Consent to Medical Attention shall be governed by and construed in accordance with the laws of the State of California, that any action arising hereunder may be brought only in a court of competent jurisdiction located in Los Angeles County, California, and I hereby consent to such exclusive jurisdiction.
8. **Severability**: I understand that this Waiver, Release of Liability and Consent to Medical Attention is intended to be as broad and inclusive as permitted by law and that if any portion hereof is held invalid, I agree that the balance shall continue in full legal force and effect. I further agree that if this waiver and release in not valid as such in California, it shall be construed as a covenant not to sue.

I HAVE READ THIS WAIVER, RELEASE, AND CONSENT AND UNDERSTAND THAT I HAVE GIVEN UP SUBSTANTIAL RIGHTS BY SIGNING IT. I AM SIGNING THIS WAIVER, RELEASE, AND CONSENT VOLUNTARILY.

____________________ ____________________ __________

Signature Printed Name Date

SIGNATURE OF PARENT(S) OR LEGAL GUARDIAN(S) ARE ALSO REQUIRED FOR ANY PERSON SIGNING THIS FORM WHO IS UNDER EIGHTEEN (18).

____________________ ____________________ __________

Signature Printed Name Date