MOORE
PHYSICAL THERAPY

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____ Sex: Male / Female

Email: _____ Cell Number: _____ Home Number: _____

Address: _____Unit #: _____ City: _____ State: ____ Zip Code: _____

Referring Physician: _____ Marital Status: _____ Date of Injury: _____

Emergency Contact: _____ Relationship: _____ Phone Number_____

Employer: _____ Work Phone Number: _____ SS#_____

How did you hear about us?: _____ Claim # (If Workers Comp): _____++++_____

Have you had physical therapy in this calendar year? Y / N If yes, how many visits? _____

Have you lived in a Healthcare facility and/or had Home Healthcare. Y / N If yes, when did you last? _____

Have you provided us your most current insurance card(s) to be copied? Y / N

RESPONSIBLE PARTY or SECOND HOME ADDRESS
Fill in applicable information below if the patient is not the responsible party or has a second home address

Name: _____ Date of Birth: _____ Relationship: _____

Address: _____Unit #: _____ City: _____ State: ____ Zip Code: _____

Home Phone Number: _____ Cell Phone: _____

Employer: _____ Work Phone: _____

Address: _____Unit #: _____ City: _____ State: ____ Zip Code: _____

HIPAA Privacy Authorization
Authorization for Use or Disclosure of Protected Health Information

I authorize Moore Physical Therapy to disclose medical information to _____, and to

_____. This information may be used by this (these) authorized person(s) in order to receive information regarding medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

This authorization covers the period from: A. _____ To _____. OR B. All past, present, and future periods. ☐

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Patient/ Legal Guardian Signature: _____ Date: _____

HIPAA Acknowledgement

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Patient/ Legal Guardian Signature: _____ Date: _____

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Patient Name_____ Date_____

Health problems may affect your treatment. Please check (x) any of the following that apply to you:

- ☐ Arthritis (Rheumatoid / Osteoarthritis)
- ☐ Osteoporosis
- ☐ Asthma
- ☐ Chronic Obstructive
- ☐ Pulmonary Disease (COPD), Acquired Respiratory Distress Syndrome (ARDS), or Emphysema
- ☐ Angina
- ☐ Congestive Heart Failure (or Heart Disease)
- ☐ Heart Attack (Myocardial Infarction)
- ☐ High Blood Pressure
- ☐ Neurological Disease (Such as Multiple Sclerosis or Parkinson's)
- ☐ Stroke or TIA
- ☐ Peripheral Vascular Disease
- ☐ Headaches
- ☐ Diabetes Types I And II
- ☐ Gastrointestinal Disease (Ulcer, Hernia, Reflux, Bowel, Liver, Gall Bladder)
- ☐ Pacemaker
- ☐ Seizures
- ☐ Visual Impairment
- ☐ Hearing Impairment (Very Hard of Hearing, Even with Hearing Aids)
- ☐ Back Pain (Neck Pain, Low Back Pain, Degenerative Disc Disease, Spinal Stenosis)
- ☐ Kidney, Bladder, Prostate, or Urination Problems
- ☐ Previous Accidents
- ☐ Allergies
- ☐ Incontinence
- ☐ Anxiety or Panic Disorders
- ☐ Depression
- ☐ Hepatitis, Tuberculosis, HIV, AIDS, or Other Bloodborne Condition
- ☐ Prior Surgery
- ☐ Prosthesis / Implants
- ☐ Sleep Dysfunction
- ☐ Cancer
- ☐ None of the Above

Height (Required): _____ ft. _____ in. Weight (Required): _____

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List of Current Medications

Patient Name:_____

Please provide any current medications that you are taking including vitamins and supplements.

❑ **I am not currently taking any medications, vitamins or supplements.**

Medication Name	Dosage (mg or ml...)	Frequency (How often?)	Route of Administration (such as oral, IV, injection...)

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Patient Name_____ Date_____

Patient Health Questionnaire-2 (PHQ-2)

Over the last *2 weeks*, how often have you been bothered by any of the following problems?	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3

For office coding: _____*0*_____*+*_____*+*_____*+*_____

= Total Score _____

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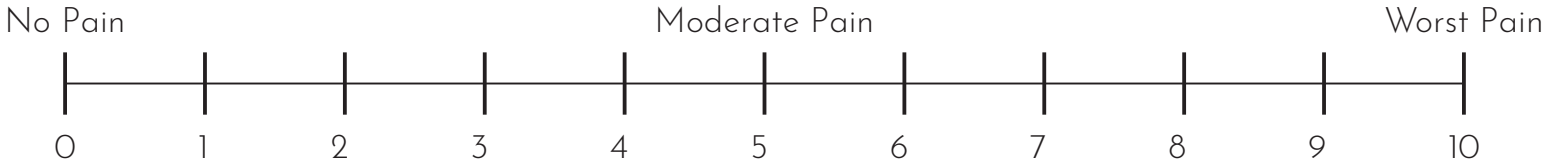
Patient Name_____Date_____

Within the last 12 months:		
1) Have you relied on people for any of the following: bathing, dressing, shopping, banking, or meals?	YES	NO
2) Has anyone prevented you from getting food, clothes, medication, glasses, hearing aides or medical care, or from being with people you wanted to be with?	YES	NO
3) Have you been upset because someone talked to you in a way that made you feel shamed or threatened?	YES	NO
4) Has anyone tried to force you to sign papers or to use your money against your will?	YES	NO
5) Has anyone made you afraid, touched you in ways that you did not want, or hurt you physically?	YES	NO

Visual Analogue Scale (VAS-24)

Circle the number that represents the worst your pain has been in the last 24 hours.



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NAME_____

Wellness Questionnaire

1. In the past 2 months, did you or others you live with eat smaller meals or skip meals because you didn't have money for food?
   _____ Yes _____ No

2. Are you homeless or worried that you might be in the future?
   _____ Yes _____ No

3. Do you have trouble paying for your utilities (gas, electricity, phone)?
   _____ Yes _____ No

4. Do you have trouble finding or paying for a ride?
   _____ Yes _____ No

5. Do you need daycare, or better daycare, for your kids?
   _____ Yes _____ No

6. Are you unemployed or without regular income?
   _____ Yes _____ No

7. Do you need help finding a better job?
   _____ Yes _____ No

8. Do you need help getting more education?
   _____ Yes _____ No

9. Are you concerned about someone in your home using drugs or alcohol?
   _____ Yes _____ No

10. Do you feel unsafe in your daily life?
    _____ Yes _____ No

11. Is anyone in your home threatening or abusing you?
    _____ Yes _____ No

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Missed Visit Policy

Our scheduling method sets aside time for each patient to receive the care they need.

We have established this policy in order to avoid conflicts in caring for all of our patients. Our aim is to prevent cancellations with less than a day's notice, missed scheduled appointments, or late arrivals.

Our policy is as follows:

1. We require that you provide us with **at least a day's notice during business hours** when canceling an appointment. We know the unexpected happens and appreciate you letting us know the circumstances. With repeated violations of this policy you may be placed on a "call same day" status which will require you to call in on the day you wish to be seen and choose from the currently available appointments.

2. A **"No-Show"** is missing your appointment without notifying us. If this occurs you may be placed on a "call same day" status requiring you to call on the day you wish to be seen and choose between the currently available appointments.

3. Please arrive **five minutes early** for your appointment. If you are **late to your scheduled appointment time** your visit may need to be rescheduled and the appointment may be considered as a violation of item 1 above. If you are running late for an appointment, please call to help us prepare for your late arrival.

4. Note: If you are placed on a "call same day" status, you can be restored to the normal scheduling method after one successful "call same day" appointment.

Thank you for helping us set aside time for each patient in need.

I have read this Missed Visit Policy and by signing below I am indicating that I understand this policy.

_____ _____

Signature **Date**

_____

Printed Name