DAMON ANDERSON & ASSOCIATES PHYSICAL THERAPY

☐ 980 Cass Street Suite A
Monterey, CA 93940
(831) 375-2466

☐ 2511 Garden Road, Suite A-120
Monterey, CA 93940
(831) 375-1562

PERSONAL INFORMATION

DATE	E-MAIL	DATE OF BIRTH	MALE FEMALE
NAME		CELL	PHONE #
ADDRESS			SOCIAL SECURITY #
CITY		STATE	ZIP
PERSON TO CALL IN CASE OF EMERGENCY/RELATIONSHIP			PHONE #
REFERRING DOCTOR			PHONE #
HOW DID YOU HEAR ABOUT US?			MARITAL STATUS

EMPLOYMENT INFORMATION

OCCUPATION		EMPLOYED HOW LONG?	
EMPLOYER		EMPLOYER PHONE #	
EMPLOYER'S ADDRESS		CITY	STATE ZIP
SPOUSE'S NAME		SPOUSE'S EMPLOYER	

INSURANCE INFORMATION

DATE OF INJURY	TYPE OF ACCIDENT: AUTO_____ WORK _____ OTHER _____		
IF AN ACCIDENT, PLEASE EXPLAIN:			
NAME OF ATTORNEY:		PHONE #	
NAME OF PRIMARY INSURANCE			
INSURED'S NAME		INSURED'S DATE OF BIRTH	
IDENTIFICATION #		GROUP #	
NAME OF SECONDARY INSURANCE			
INSURED'S NAME		INSURED'S DATE OF BIRTH	
IDENTIFICATION #		GROUP #	

I authorize any holder of medical or other information about me to release to the insurance company any information needed for this or a related claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical benefits to DAMON ANDERSON & ASSOCIATES PHYSICAL THERAPY.

WE WILL BILL YOUR INSURANCE AS A COURTESY; HOWEVER, WE DO REQUIRE PAYMENT TOWARDS YOUR DEDUCTIBLE AND/OR COINSURANCE AT EACH VISIT.

I have read the above and understand that I am ultimately responsible for payment.

X_____ _____

SIGNATURE OF PATIENT (OR PARENT 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 _____

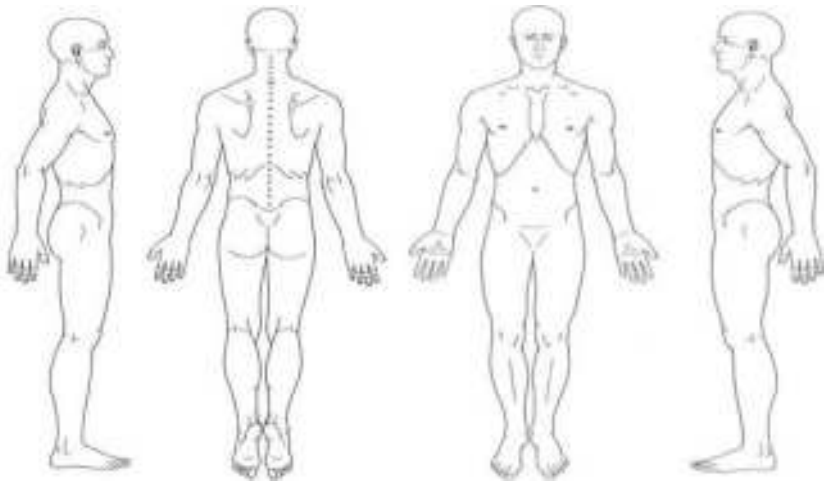
_____

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 ④ Shooting
② Dull ache ⑤ Burning
③ Numb ⑥ Tingling

4. How are your symptoms changing?

① Getting Better
② Not Changing
③ Getting Worse

5. During the past 4 weeks:

None *Unbearable*

⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

a. Indicate the average intensity of your symptoms

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 ③ Medical Doctor ⑤ Other
② Chiropractor ④ Physical Therapist

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:* _____ ③ CT Scan *date:* _____
② MRI *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 ③ Medical Doctor ⑤ Other
② Chiropractor ④ Physical Therapist

10. What is your occupation?

_____

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

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

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

Patient Signature _____ ***Date*** _____

DAMON ANDERSON & ASSOCIATES
PHYSICAL THERAPY, INC.
Cardiovascular Questionnaire

Name_____ Resting BP_____
Age_____ Sex_____ Resting HR_____

1. Do you experience angina (chest pain)? YES or NO. If YES:
   A. Where is it?_____
   B. How long does it last?_____
   C. What gives relief?_____

2. Do you experience sweating with angina (chest pain) YES or NO. If YES:
   A. Do you ever sweat without exercise? YES OR NO. If YES:
   B. When?_____

3. Do you experience palpitations or irregular heart beats? YES or NO. If YES:
   A. How often do they affect you?_____
   B. How do you get rid of them?_____

4. Do you experience breathlessness unrelated to exercise? YES or NO. If YES:
   A. What brings on breathlessness? (Activity, sleep, stress, certain positions, other_____)

5. Do you experience being light headed/loss of consciousness? YES or No. If YES:
   A. Have you ever felt dizzy or black out? YES or NO. If YES:
   B. How Often? _____What brings it on? _____
   C. How do you get relief?_____

6. Do you get easily fatigues? YES or NO.
   A. How is your energy level in general?_____
   B. How well do you sleep at night?_____

7. Have you ever been told that you have high blood pressure? YES or NO. If YES:
   A. Is it currently within normal limits? YES or NO.
   B. What is it?_____/_____

8. Have you ever smoked? YES or NO. If YES:
   A. Do you smoke now? YES or NO.
   B. How much and how often do you (or did you) smoke?_____ cigarettes/packs(please circle) daily

9. Have you ever had your blood cholesterol checked? YES or NO. If YES:
   A. Please write the level here if you know it_____

10. Do you have diabetes? YES or NO. If so, do you take insulin? YES or NO.

11. What activities do you do regularly?_____

12. Has anyone in your immediate family (parents, siblings) ever had a heart attack? YES or NO.

13. Have you ever had a heart attack, angina (chest pain), or cardiac surgery? YES or No. If YES:
    A. Please elaborate:_____

14. Are you currently taking any medications? YES or NO. If YES:
    A. Please list_____

15. Are you under the care of a physician for any heart or lung problems? YES or NO. If YES:
    A. Please elaborate_____

DAMON ANDERSON & ASSOCIATES PHYSICAL THERAPY
FINANCIAL POLICY

PRIVATE INSURANCE: You are responsible for your deductible and co-payment. A $100.00 payment will be collected per visit until deductible and co-payment have been verified, at which time any outstanding co-pay or deductible will be due. Once your insurance company has paid their portion, any remaining balance will be your responsibility for immediate payment.

WORKER'S COMPENSATION INSURANCE: We will verify your worker's compensation claim and obtain authorization for treatment with your employer's insurance company. We require a signed worker's compensation lien form, if your Worker's Compensation claim is in dispute. We will require information regarding your attorney and private insurance does not apply.

OTHER:

1.) If you wish to bill your own insurance, we require **payment in full** at the time of service.

2.) Any supplies your therapist recommends to you that you wish to purchase will also be due and payable at the time of your visit. We do not bill insurance for equipment.

NOTE: As a courtesy, Damon Anderson & Associates will bill your primary insurance company for you. If you have no insurance coverage, a large deductible, or a financial hardship, please speak to the front office personnel regarding a payment plan.

If during the course of treatment, I must cancel a scheduled appointment, I will notify DAPT, Inc. no less than **24-hours** before the time of the appointment. If I fail to give notice of cancellations, I understand that a **$40 fee** will be charged and due prior to receiving my next treatment. Your insurance will not pay this fee.

I hereby acknowledge that I have read the aforementioned financial policy and hereby assign medical benefits pertaining to the physical therapy benefits to which I am entitled, including Medicare, private insurance and other health care plans, to Damon Anderson and Associates Physical Therapy.

Printed Name: _____

SIGNATURE: _____ **DATE:** _____

DAMON ANDERSON & ASSOCIATES
PHYSICAL THERAPY, INC.

Patient: _____

I hereby authorize _____ MD to release copies of doctor's notes, radiology/imaging reports & operative reports to Damon Anderson and Associates Physical Therapy.

_____ _____

Signature of Patient (or parent, if a minor) Date

980 CASS STREET • MONTEREY, CALIFORNIA 93940 • (831) 375-2466

Medication List for (Patient Name): ____ Date: ______________

Please list all medications, including all prescriptions, over the counter medications, herbals, vitamins, minerals, and dietary supplements. Include the dosage, frequency and administration method for each medication.

Medication	Dosage	Frequency	Method of Administration
		❑ As Needed ❑ Once daily ❑ Twice daily ❑ Three times daily ❑ Other:	❑ Oral ❑ Sublingual ❑ Topical ❑ Subcutaneous injection ❑ Other:
		❑ As Needed ❑ Once daily ❑ Twice daily ❑ Three times daily ❑ Other:	❑ Oral ❑ Sublingual ❑ Topical ❑ Subcutaneous injection ❑ Other:
		❑ As Needed ❑ Once daily ❑ Twice daily ❑ Three times daily ❑ Other:	❑ Oral ❑ Sublingual ❑ Topical ❑ Subcutaneous injection ❑ Other:
		❑ As Needed ❑ Once daily ❑ Twice daily ❑ Three times daily ❑ Other:	❑ Oral ❑ Sublingual ❑ Topical ❑ Subcutaneous injection ❑ Other:
		❑ As Needed ❑ Once daily ❑ Twice daily ❑ Three times daily ❑ Other:	❑ Oral ❑ Sublingual ❑ Topical ❑ Subcutaneous injection ❑ Other:
		❑ As Needed ❑ Once daily ❑ Twice daily ❑ Three times daily ❑ Other:	❑ Oral ❑ Sublingual ❑ Topical ❑ Subcutaneous injection ❑ Other:
		❑ As Needed ❑ Once daily ❑ Twice daily ❑ Three times daily ❑ Other:	❑ Oral ❑ Sublingual ❑ Topical ❑ Subcutaneous injection ❑ Other:
		❑ As Needed ❑ Once daily ❑ Twice daily ❑ Three times daily ❑ Other:	❑ Oral ❑ Sublingual ❑ Topical ❑ Subcutaneous injection ❑ Other:
		❑ As Needed ❑ Once daily ❑ Twice daily ❑ Three times daily	❑ Oral ❑ Sublingual ❑ Topical ❑ Subcutaneous injection

Patient Signature: ____ Date: ____________

Reviewed By: ____ Date: ____________