PLATINUM
PHYSICAL THERAPY

Consent for Treatment

I, the undersigned, a patient at Platinum Physical Therapy, do hereby consent to treatment as prescribed by my provider, a licensed physical therapist in the state of Massachusetts.

Billing

I understand and agree that health and accident insurance policies are an arrangement between me and an insurance carrier. Furthermore, I understand that as a courtesy Platinum Physical Therapy will prepare insurance forms and bill my insurance company directly. I hereby request assignment of payment of all insurance benefits to Platinum Physical Therapy. I also understand that I am ultimately responsible for payment of all services rendered unless otherwise provided by law.

Deductibles, Coinsurance, and Co-Payments

Co-payments are to be paid at the time of service unless prior arrangements have been made with the Office Manager. Deductible and percentage payment amounts will be billed at the time payment from the insurance company is received. Payment is due within 30 days of the date on the invoice received and it is my responsibility to keep my payments current.

Cancellation/No-Show Policy

Cancellations should be made with a minimum of **24 hours** notice prior to the scheduled appointment time. A **$50.00** fee may be enforced for **no shows** or **late cancellations**.

With my signature I agree to all of the above terms and conditions. Additionally, I confirm that I have received and read a copy of Platinum Physical Therapy's Notice of Privacy Practices.

____

Patient or Legal Guardian's Signature Date

Benefits verified_________________

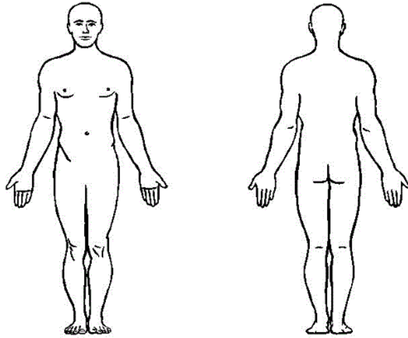
Co-Pay ________________________ After Meeting Deductible of __________________________

Co-Insurance ___________________ After Meeting Deductible of __________________________

PLATINUM
PHYSICAL THERAPY

Medical Questionnaire

Patient Name:____ Date of Injury: _____________________
What problem or diagnosis brings you here today?____
Who referred you to PT?____
Briefly describe your symptoms:____
Describe how your condition or injury occurred:____



Shade your areas of pain or discomfort on the figures to the left:

Please rate your pain on the scale below from 0 to 10:

(0 = no pain; 10 = worst pain imaginable/emergency room pain)

Pain at rest: ○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

Pain with activity: ○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

What is the frequency of your pain? ○ Constant ○ Intermittent

Does the pain wake you at night? ○ Y ○ N How many times?_________

What eases your symptoms? _____________________________What aggravates your symptoms?__________________________

Are your symptoms getting ○Better ○Worse ○Same Is your pain worse in the ○AM ○PM ○Mid-Day ?
What activities at home, work or recreational are you unable to perform?____
Check tests you've had for this condition: ☐X-rays ☐MRI ☐Bone Scan ☐CT Scan ☐Nerve Tests ☐Blood Tests ☐Other_____
Check treatments you've had for this condition: ☐PT ☐Injections ☐Chiropractic ☐Massage ☐Acupuncture
Current level of Physical Activity ○High ○Medium ○Low List: ____
Have you fallen in the past year? ○Yes ○No If yes, how many times? ____ If yes, were you Injured? ○Yes ○No

Medical History (Check any that apply)

☐Angina/Chest Pain
☐Asthma
☐Arthritis
☐Blackouts
☐Blind/Vision Impairment
☐Blood Clot
☐Bowel or Bladder Problem
☐Chest/Abdominal Surgery
☐Coronary Artery Disease
☐Cancer
☐Depression
☐Diabetes
☐Diverticulitis
☐Ear Infections
☐Fibromyalgia
☐Fractures
☐Frequent Falls
☐Hearing Problems
☐Heart Disease
☐Hepatitis
☐High Blood Pressure
☐High Cholesterol
☐Hypoglycemia
☐Migraine Headaches
☐Major Spinal Injury
☐Osteoporosis
☐Pacemaker/Nitroglycerin
☐Poor Circulation/Raynaud's
☐Polio
☐Stroke
☐MVA
☐ Other:

SURGERIES AND/OR PRIOR INJURIES

Year **Problem**

____
____
____
____
____

List any allergies:____
What activities do you believe successful treatment will allow you to do? (e.g. carry groceries, walking in the mall, playing soccer)
____

Medication List

Name of Medication	Dosage	Frequency	Route (Oral, Topical, IV, Other)	Reason

Height: ______________________ Weight: _________________

Signature: ______________________________ Date: _______________

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:______________________________ DATE:______________

Over the last *2 weeks,* how often have you been bothered by any of the following problems? *(use "✓" to indicate your answer)*	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
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
add columns		___ +	___ +	___
(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:				

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?	
	Not difficult at all ______
	Somewhat difficult ______
	Very difficult ______
	Extremely difficult ______

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