# Eberhardt

Physical Therapy ✦ Nutrition ✦ Wellness

# NEW PATIENT INFORMATION

Patient Name: _____ Social Security#_____

Address: _____City: _____State: _____Zip: _____
(Physical Address Required)

Home#_____ Cell#_____ *OK to receive text messages ? Y / N / Appts only

Date of Birth: ___/___/_____ Email: _____ Email Appts/contact OK? Y / N

Circle how you heard about us:

| | | | |
|---|---|---|---|
| Word of Mouth | Advertisement | Community Event | Friend/Family |
| Local Business | Internet Search | Mailed Invite | Food Demo |
| Facebook | Physician | Church Member | Other:_____ |

*If you circled one, please explain:_____

**EMPLOYMENT INFO:**

What is your Occupation: _____Employer Name: _____Wk#_____

Address of Employment: _____

Insurance Company:_____ Secondary Insurance: Y / N _____

**REFFERING PHYSICAN:**

Referring Physician: _____Phone#_____

Date of next appointment: _____Date of Surgery, if applicable: _____

**PRIMARY CARE PHYSICAN:**

Primary Care Physician: _____Phone#_____

**Health Insurance Portability & Accountability Act (HIPAA)**
I acknowledge that I have been provided with the "Notice of Privacy Practices" for review. I understand that I may ask questions about the "Notice of Privacy Practices" at any time. I may revoke this authorization by five (5) days written notice to Eberhardt Physical Therapy, Nutrition and Wellness Clinic, Inc.

Please list individuals in which you allow us to contact regarding your health information or in case of an emergency:

Emergency Contact Outside of Home: _____Phone#_____

Spouse Name: _____ Phone#_____

Other: _____Phone#_____

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## PATIENT MEDICAL HISTORY

**PLEASE CHECK ALL THAT APPLY TO YOUR CURRENT INJURY**

* If any apply, please ask front desk for appropriate forms to avoid incurring 100% of billed charges directly to you personally. _____ (Initials)

_____**Auto Accident** _____**Employment Related** _____**Legal Representation**

**PLEASE MARK THE FOLLOWING IF YOU HAVE HAD:**

____ Alcohol abuse problems
____ Asthma/Bronchitis
____ Allergies
____ Angina
____ Arthritis
____ Back Injuries
____ Bowel/Bladder Problems
____ Cancer
____ Circulatory Problems
____ Diabetes
____ Dislocation of Joints
____ Emotional problems
____ Epilepsy/Seizures
____ Fractures (broken bones)
____ Gastrointestinal problems
____ Gout
____ Headaches of any type
____ Heart Attacks
____ Heart Disease
____ Heart Surgery
____ High blood pressure
____ Joint strains
____ Kidney Disease
____ Lung Disease
____ Muscle strains
____ Neck Injuries
____ Nervous Problems
____ Osteoporosis
____ Pacemaker Placement
____ Stroke/TIA
____ TMJ / Jaw injuries
____ Tumors
____ Whiplash

**CHECK THE FOLLOWING BOXES IF YOU HAVE RECENTLY EXPERIENCED**

____ Headaches
____ Muscle pain with activity
____ Muscle pain at rest
____ Tremors
____ Falls or Nearly Falling
____ Difficulty sleeping
____ Constant Pain unrelieved by rest or movement
____ Shortness of breath
____ Hoarseness
____ Dizziness
____ Balance problems
____ Unusual fatigue
____ Unusual weakness
____ Blurred or double vision
____ Unusual skin coloration
____ Unexplained weight loss
____ Tingling, numbness or loss of feeling
____ Pain with coughing or sneezing
____ Change in bowel and/or bladder habits
____ Jaw pain and/or clicking
____ Foot pain (heel or ball of foot) persistent / recurring

**PLEASE LIST ANY MAJOR SURGERIES AND HOSPITALIZATIONS**

_____ DATE: _____
_____ DATE: _____

**DO YOU SMOKE?** YES / NO. If yes, how many per day? ____ **ARE YOU PREGNANT?** YES / NO

**ARE YOU ALLERGIC TO ANY MEDICATION?** YES / NO. IF YES, PLEASE LIST MEDICATIONS.

**PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:**

_____
_____
_____

**Are you currently getting Home Health services ? Y / N**
**Have you had PT this YEAR for any condition? Y / N if YES, Where ?** _____

***I, THE UNDERSIGNED, STATE THAT I HAVE ANSWERED THIS QUESTIONAIRE TO THE BEST OF MY KNOWLEDGE.***

**Signature:** _____ Date:_____

*Treating Therapist's Signature* _____Date:_____

Eberhardt Physical Therapy, Nutrition and Wellness Clinic, Inc 820 Jordan St. Ste 150. Shreveport, LA 71101
Phone 318-222-7442 Fax 318-424-4751

# 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** _____

_____

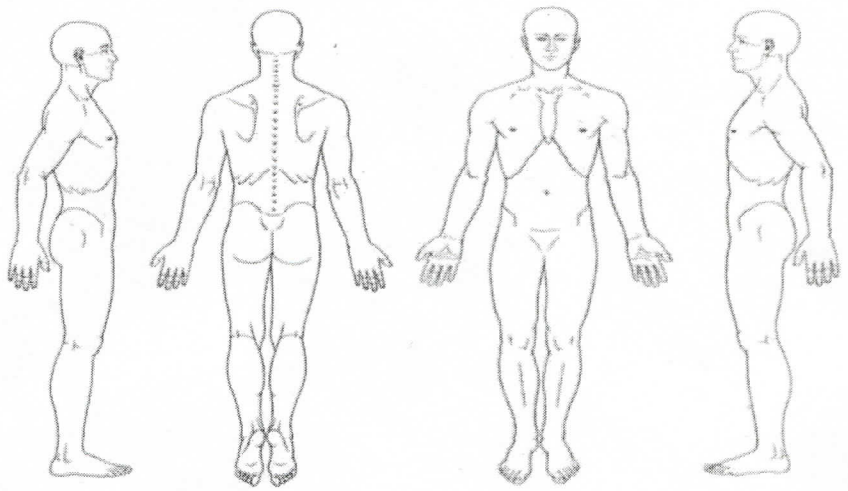
*a. When did your symptoms start?* _____

*b. How did your symptoms begin?* _____

**2. How often do you experience your symptoms?**

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)

**Indicate where you have pain or other symptoms**



**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:**

*a. Indicate the average intensity of your symptoms*

None ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Unbearable

*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
② Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

*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
② Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

**10. What is your occupation?**

_____

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

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

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

**Patient Signature** _____ **Date** _____

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# NEW PATIENT INFORMATION

## Consent to Therapy

I have presented myself to this facility for therapy treatments and consent to diagnostic procedures by my attending therapist.

I realize I have the right to refuse any drugs, treatments or procedures to the extent permitted by law. I acknowledge that medicine is not an exact science, no guarantees or warranties can be made to me regarding the results of any treatments at this facility. I understand that information from any medical record(s) kept by this facility may be used for educational, administrative, and/or facility approved purposes and my personal identity will not be revealed.

Authorization for Release of Information I, _____give Eberhardt Physical Therapy, Nutrition and Wellness Clinic, Inc consent for the release of my records to any authorized representative(s) of Medicare, Medicare Intermediary, Worker's Compensation, Private Insurance Company and/or Consulting Physician(s) for review in determining benefits to which I am entitled. I further authorize the facility to review my records and/or make photocopies of said records. I fully understand that I can, by legal right, refuse the release of said records. Therefore, I hereby authorize the facility access to my records.

I consent to maintain the confidentiality of other patients of the facility, to not disclose to anyone the identity of anyone or anything discussed at the facility by anyone other than myself.

This facility takes photographs of patients while performing therapy to be displayed in your chart. Do you consent to have your photograph taken? ____YES ____NO

I HAVE READ AND FULLY UNDERSTAND THE ABOVE GENERAL CONSENT FORM AND ANY QUESTION(S) I MAY HAVE HAD, HAVE BEEN ANSWERED TO MY SATISFACTION.

**Signature of Patient**
(or Guardian if Patient is a Minor – Under 18)

_____Date:_____

**Witness**
(Authorized Signature of Eberhardt Physical Therapy)

_____Date:_____

## Appointment Policy

Thank you for choosing **Eberhardt Physical Therapy, Nutrition and Wellness Clinic**. We consider it a privilege that you have chosen to see an Eberhardt Physical Therapist or Dietitian. From the moment you walk in the door until the time we have to say our goodbyes, we are committed to providing you with exceptional service. Eberhardt Physical Therapy, Nutrition and Wellness is committed to respecting your valuable time by treating promptly based on appointment time. We ask for your cooperation/understanding with the following:

- Patients are seen according to their appointment time and not the time they arrive, if you are late, you will be worked in on a space available basis only.
- If you are running more than 10 minutes late we ask that you call us to reschedule your appointment for either a later time the same day or another day.
- Exceptions may be made to this policy based on unforeseen circumstances.

In today's hectic world, unplanned issues come up for all of us. At Eberhardt Physical Therapy, Nutrition and Wellness Clinic we have instituted an appointment cancellation and "no show" policy for all physical therapy appointments. We will gladly reschedule your appointment up until 24 hours before your appointment. In other words, you must cancel your scheduled appointment by calling us a minimum of 24 hours in advance. That way, the open slot can be filled with someone needing of an appointment. We take our appointment policy seriously because when a patient misses an appointment, three people are adversely affected:

- You, the patient – for not receiving the treatment you need
- Another patient – who could have had your appointment time
- Your therapist – as now he or she has a gap in their schedule

### 24 Hour Advance Notice $25 fee:

If you wish to cancel an appointment we require a minimum of 24 Hours advance notice. Failure to cancel according to policy may result in a $25 fee that will be due prior to your next visit. The $25 charge is intended to act as a deterrent from making last minute changes thereby making our schedule more predictable. Additionally, by giving advance notice we are better able to accommodate other patients that are looking to get back to what they want to do through getting proper treatment.

*I understand a $25.00 fee may be assessed if I violate the appointment policy.* _____ *(Initial)*