LEADING EDGE
PHYSICAL THERAPY

Patient Information

Name ______________________________ Soc. Sec. # ____/____/______ Date of Birth ____/____/______

Preferred Name/Nickname ______________ Age ________ Sex: M F

Address ________________________________ City_____________ State ________ Zip ____________

Phones: Home ______________________ Cell ______________________

Email Address (we use this to send you home exercises) __________________________________

How would you like us to contact you? Text ____ Phone Call ____ Email ____

How did you hear about Leading Edge Physical Therapy? Self Friends/Family Doctor Event Website Google Other: ____________

Accident Related: Y N Auto Related: Y N Employment Related: Y N

Date of Accident/Injury: ____/____/______

Emergency Contact:

Name ______________________________ Relationship ______________________________

Phones: Home ______________________ Cell ______________________

Are you taking any medications? Y N If yes, what kind and why?

____

____

Have you had surgery in the past two years? Y N If yes, please explain.

____

____

Please check any of the following conditions that apply:

____ AIDS ____ Chest Pain ____ Edema ____ Pregnant ____ Other
____ Asthma ____ Diabetes ____ Heart Condition/Pacemaker ____ Seizure Disorder
____ Cancer ____ Dizziness, fainting ____ Stroke

Who is your referring doctor? ________________________________

What treatment did you receive and when? ________________________________ Date: ____/____/______

What tests have you had for your symptoms and when were they performed? X rays Date: ____/____/______ CT Scan Date: ____/____/______ MRI Date: ____/____/______ Other Date: ____/____/______

Have you had similar symptoms in the past? Y N If Y, please explain: ______________________________

If you have received treatment in the past for the same or similar symptoms, who did you see? ____ This Clinic ____ Medical Doctor ____ Other ____ Chiropractor ____ Physical Therapist

What is your occupation? ____ Professional/Exec ____ Tradespersons ____ Homemaker ____ Retired ____ White collar/Sec'y ____ Laborer ____ FT Student ____ Other

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Leading Edge – Patient Health Questionnaire

ACN Group, Inc. Form PHQ-202

ACN Group, Inc. Use Only rev 8/14/14

Patient Name ______________________ Date ___/___/___

Date symptoms began: ___/___/___

Describe your symptoms ______________________

____

How did your symptoms begin? ______________________

____

How often do you experience your symptoms?

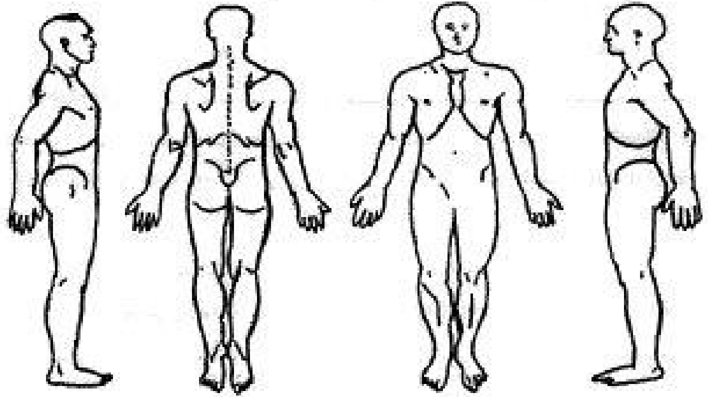
① Constantly (76-100% of the day)
② Frequently (51-75% of the day)
③ Occasionally (26-50% of the
④ day) Intermittently (0-25% of the day)

What describes the nature of your symptoms?

① Sharp
② Dull Ache
③ Numb
④ Shooting
⑤ Burning
⑥ Tingling

How is your condition changing, since care began at this facility?

⓪ N/A - This is my first visit
① Much worse
② Worse
③ A little worse
④ No change
⑤ A little better
⑥ Better
⑦ Much better



Average pain intensity:

Last 24 hours: No pain ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Worst pain
Past week: No pain ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Worst pain

How much have your symptoms interfered with your usual daily activities?

Both work outside the home and housework
① Not at all ② A little bit ③ Moderately ④ Quite a bit ⑤ Extremely

Visiting with friends, relatives, etc.
① Not at all ② A little bit ③ Moderately ④ Quite a bit ⑤ Extremely

In general would you say your overall health right now is...

① Excellent ② Very Good ③ Good ④ Fair ⑤ Poor

Because a therapist must be aware of any existing physical conditions that I have, I have listed all my known medical conditions and physical limitations, and I will inform my therapist of any changes in my physical health. I understand that a therapist neither diagnoses illness, disease, or any other medical, physical, or mental disorder. I am responsible for consulting a qualified physician for any physical ailment that I have.

I hereby give permission to the therapists and staff to administer treatment and perform such general procedures, as they may deem necessary in the diagnosis and/or treatment of my condition.

Patient Signature: ______________________ **Date:** ___/___/___

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