

**PATIENT INFORMATION**

PATIENT NAME \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ SEX **M F** MARITAL STATUS \_\_\_\_\_  
ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
HOME PHONE # (\_\_\_\_)\_\_\_\_-\_\_\_\_ CELL PHONE # (\_\_\_\_)\_\_\_\_-\_\_\_\_-\_\_\_\_  
SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ EMAIL ADDRESS \_\_\_\_\_  
EMPLOYER \_\_\_\_\_ OCCUPATION \_\_\_\_\_  
EMPLOYER ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
WORK PHONE # (\_\_\_\_)\_\_\_\_-\_\_\_\_-\_\_\_\_ HOW DID YOU HEAR ABOUT US? \_\_\_\_\_

SPOUSE'S NAME \_\_\_\_\_  
EMERGENCY CONTACT (OTHER THAN ABOVE) \_\_\_\_\_ PHONE # (\_\_\_\_)\_\_\_\_-\_\_\_\_

**INSURANCE INFORMATION (Please provide insurance card/information for primary and secondary insurances)**

**INSURED INFORMATION**

**INSURED NAME** (if different than patient) \_\_\_\_\_ **RELATIONSHIP TO PATIENT** \_\_\_\_\_  
ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
**INSURED SS#** \_\_\_\_\_ **INSURED DOB** \_\_\_\_/\_\_\_\_/\_\_\_\_ **INSURED HOME PHONE** \_\_\_\_\_  
EMPLOYER \_\_\_\_\_ WORK PHONE # (\_\_\_\_)\_\_\_\_-\_\_\_\_

**INSURANCE INFORMATION**

PRIMARY INSURANCE NAME \_\_\_\_\_ PHONE: (\_\_\_\_)\_\_\_\_-\_\_\_\_  
GROUP NAME AND # \_\_\_\_\_ ID# \_\_\_\_\_

**SUPPLEMENTAL INSURANCE SUPPLEMENTAL POLICY #**

**FOR MEDICARE PATIENTS ONLY**

DID YOU RECEIVE HOME HEALTH CARE? **YES NO** DATE LAST SEEN BY HOME HEALTH AGENCY \_\_\_\_/\_\_\_\_/\_\_\_\_  
NAME OF HOME HEALTH AGENCY \_\_\_\_\_

DATE OF INJURY \_\_\_\_/\_\_\_\_/\_\_\_\_ REFERRING PHYSICIAN \_\_\_\_\_ MD

IS THIS INJURY THE RESULT OF AN (AUTO, PERSONAL INJURY) ACCIDENT? **YES NO**  
IS THIS A WORK RELATED INJURY? **YES NO**  
WILL MEDICAL COST BE COVERED BY WORKERS COMPENSATION? **YES NO**

ATTORNEY'S NAME (IF APPLICABLE): \_\_\_\_\_ PHONE: (\_\_\_\_)\_\_\_\_-\_\_\_\_  
ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

From this date forward I authorize the release of any information, concerning me or my child, necessary to process a claim, and authorize payment of MEDICARE or other insurance benefits, otherwise payable to me, to **COLLETTI PHYSICAL THERAPY**. I understand that I am responsible for any charges not covered by insurance including but not limited to deductible, co-insurance, co-pays, medical supplies, benefit limits, etc. Please note that the payment information provided by your insurance company is not a guarantee of payment. Co-payments are due at each visit. If your deductible has not been met, the portion of your deductible due will be billed to you and payable upon notification by your insurance company. I acknowledge that failure to keep this account in good standing may result in the use of a collection agency. I agree to pay all collection cost and attorney fees incurred in attempting to collect on this account or future outstanding balances. Please contact your insurance company directly with any questions to help avoid any unexpected additional financial responsibility on your part.

DATE \_\_\_\_/\_\_\_\_/\_\_\_\_ SIGNATURE \_\_\_\_\_

**PAST MEDICAL HISTORY**

Heart Condition	Yes	No	Seizures	Yes	No
Stroke	Yes	No	Pregnant	Yes	No
High Blood Pressure	Yes	No	Pacemaker	Yes	No
Diabetes	Yes	No	Other	Yes	No

Have you been hospitalized or had surgery in the past 5 years?    Yes    No  
 If YES, what was the condition or treatment. \_\_\_\_\_  
 Where were you admitted? \_\_\_\_\_ Surgical Date \_\_\_\_\_

**Mechanism of Symptoms? (What happened?)**

WORK    AUTOMOBILE    ACCIDENT    FALL    SPORTS    OTHER  
 Please Explain

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**What makes symptoms feel better? (positions, activities, etc)**

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**What makes symptoms feel worse? (positions, activities, etc)**

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**Functional Limitations: (How has your present condition limited your ability to perform work activities, recreational activities, or any other activities?)**

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**Present Medications:** \_\_\_\_\_  
 \_\_\_\_\_

**Name of Physician:** \_\_\_\_\_  
 \_\_\_\_\_

# 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?

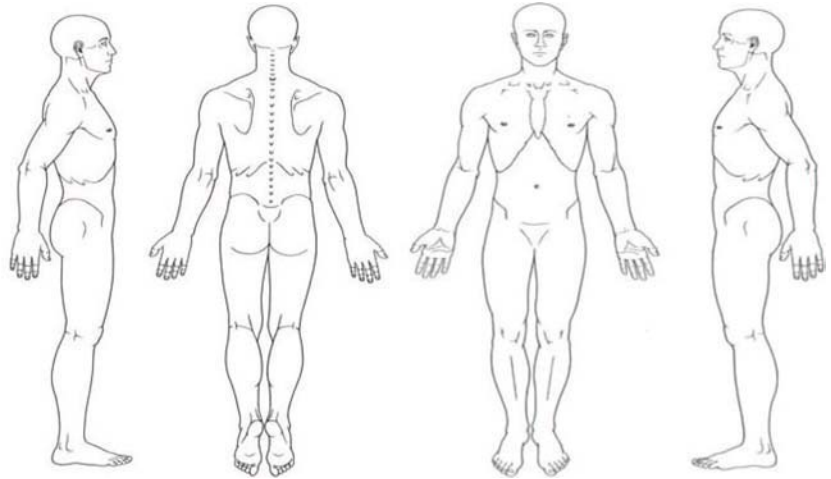
\_\_\_\_\_

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
- ② Dull ache
- ③ Numb
- ④ Shooting
- ⑤ Burning
- 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 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: \_\_\_\_\_
- ② MRI date: \_\_\_\_\_
- ③ CT Scan 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 \_\_\_\_\_

# Colletti Sports Med Physical Therapy

543 Orchard Street  
Antioch, Illinois 60002

--NOTICE OF PRIVACY PRACTICES--

**THIS TELLS YOU HOW YOUR MEDICAL INFORMATION MAY BE USED AND HOW YOU CAN GET ACCESS TO THIS DATA.**

**PLEASE REVIEW THIS NOTICE CAREFULLY.**

Colletti Sports Med Physical Therapy knows that medical information about your health is personal. We protect your medical information. We prepare a record of your care and services, for quality care.

We have the right to change our practices and make new provisions for the protected health information we maintain.

For additional information regarding matters covered by this notice, please contact Steve, our Privacy Contact, by calling 847-395-6100. All written requests should be delivered to Steve, at Colletti Sports Med Physical Therapy

The following describes different ways that we use and disclose medical information: (Not every use or disclosure will be listed.)

**FOR TREATMENT:** We may provide medical information about you to doctors, physical therapist, medical secretaries, nurses, technicians, or others who provide services that are part of your care.

**FOR PAYMENT:** We may provide medical information about you to allow the billing and payment of your treatment and services.

**APPOINTMENT REMINDERS:** We may use medical information to contact you regarding your medical appointments. A message may be left regarding your appointment at your home or work.

**HEALTH-RELATED BENEFITS AND SERVICES:** We may use medical information about you to tell you about health related benefits or services that might be of interest to you.

**INDIVIDUALS INVOLVED IN YOUR CARE OR IN THE PAYMENT FOR YOUR CARE:** We may release medical information about you to a friend or family member who is involved in your medical care with consent.

**AS REQUIRED BY LAW OR PUBLIC HEALTH OR RESEARCH OR TO AVERT A SERIOUS THREAT TO HEALTH OR SAFETY OR FOR SPECIALIZED GOVERNMENT FUNCTIONS OR FOR WORKERS' COMPENSATION:** We may disclose medical information about you, if required to do so.

You have the following rights, regarding the medical information we keep about you:

**TO REQUEST RESTRICTIONS, TO ASK FOR CONFIDENTIAL COMMUNICATIONS, TO INSPECT AND COPY:** You can ask for a limitation on the medical information we use, what we communicate about you in a certain way or at a certain location. You must make your request in writing to our Privacy Contact. You have the right to request medical information used to make decisions about your care. You must submit these requests in writing to our Privacy Contact. There may be a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request. You may request that this denial be reviewed.

**RIGHT TO AMEND:** If you believe that medical information about you is incorrect or incomplete, you may ask us by writing to our Privacy Contact, to amend the information. You must provide a reason that supports your request. We may deny your request.

If you believe your privacy rights have been violated, you can file a complaint with our Privacy Contact or with the Secretary of the Department of Health and Human Services. Please submit any complaints to us in writing.

My signature indicates that I have read and understand the above privacy practices.

\_\_\_\_\_  
PATIENT NAME (printed)

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
SIGNATURE of patient or guardian (if patient is a minor)

\_\_\_\_\_  
Date