

GAVILAN PEAK

PHYSICAL THERAPY

Patient Registration

Name: _____

City _____

Address: _____

State _____ Zip Code _____

Phone: _____

Work Phone: _____

DOB: _____ Age: _____

Employer _____

EMAIL: _____

Male Female Single

Married

Insurance Information

PRIMARY
Insurance _____

ID# _____

Insured Name: _____

Employer _____

DOB: _____

Relationship to patient: _____

SECONDARY
Insurance _____

ID# _____

Insured Name: _____

Employer _____

DOB: _____

Relationship to patient: _____

Reason for Visit

Workman's comp injury _____

Date of injury: _____ Auto Acc: _____

Date of accident: _____ What area(s) are we treating? _____

Emergency Contact

In case of a emergency contact: _____ Phone # _____

Signature

I agree that this office may release records pertaining to my treatment to my insurance company or other third parties responsible for payment of my medical charges, including review activities related to my physician's participation with my health plan. These records may be transmitted via fax. I hereby authorize payment directly to Gavilan Peak Physical Therapy, LLC for the medical benefits, if any, otherwise payable to me for physical therapy services rendered. I understand I am financially responsible for any charges not covered by my insurance unless otherwise stated.

Responsible Party Signature: _____ Date: _____

Patient Health Questionnaire - PHQ

Patient Name _____ Date _____

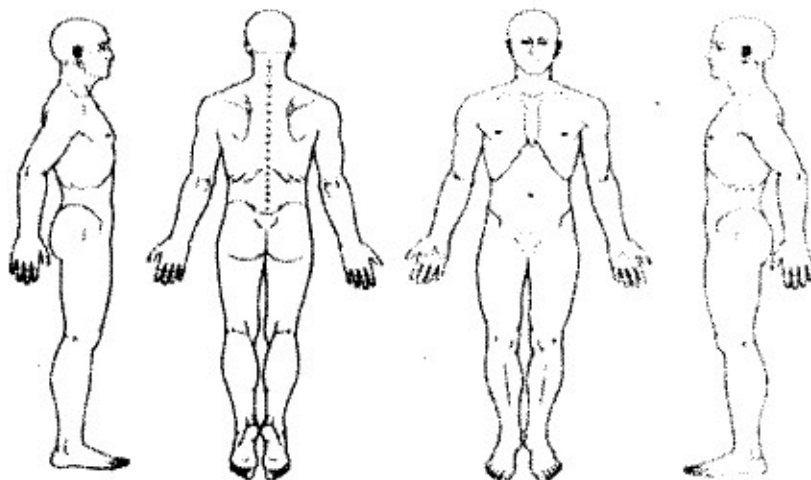
1. Describe your symptoms

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)



None ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ ⑪ Unbearable

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

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?

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

- ① Yes
- ② No
- ③ This Office
- ④ Chiropractor
- ⑤ Medical Doctor
- ⑥ Physical Therapist
- ⑦ Other

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
- ② White Collar/Secretarial
- ③ Tradesperson
- ④ Laborer
- ⑤ Homemaker
- ⑥ FT Student
- ⑦ Retired
- ⑧ Other
- ⑨ Full-time
- ⑩ Part-time
- ⑪ Self-employed
- ⑫ Unemployed
- ⑬ Off work
- ⑭ Other

Patient Signature _____ Date _____

PATIENT DISCLOSURE FORM

I understand that, under Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

I understand that by signing this consent form, I am giving Gavilan Peak Physical Therapy permission to disclose all medical, treatment, and billing information, unless otherwise indicated, to the following person or persons:

Authorized Person

Relationship to Patient

Patient Signature

Date

GAVILAN PEAK PHYSICAL THERAPY

3624 W. Anthem Way #C-106

Anthem, Arizona 85086

623-551-5121

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF
PRIVACY PRACTICES

I _____ acknowledge that I have received a copy of
Gavilan Peak Physical Therapy's Notice of Privacy Practices. This notice describes how my
protected health information may be used and disclosed by Gavilan Peak Physical Therapy,
the restrictions that apply to the use and disclosure of my healthcare information and rights
I may have regarding my protected health information.

Signature of Patient or Personal Representative

Date

Relationship to Patient