Webster Wellness Center

**PATIENT HEALTH QUESTIONNAIRE**

Name: _____ Date: _____/_____/_____

Age: _____ Date of Birth: _____/_____/_____ Height: _____ Weight: _____

Describe current complaint or limitation: _____

_____

How and when your problem began: _____

_____ Specific Date (If possible): _____/_____/_____

Did you have Surgery for this Issue? □ No □ Yes Procedure & Date: _____

Other Surgical Procedures: _____

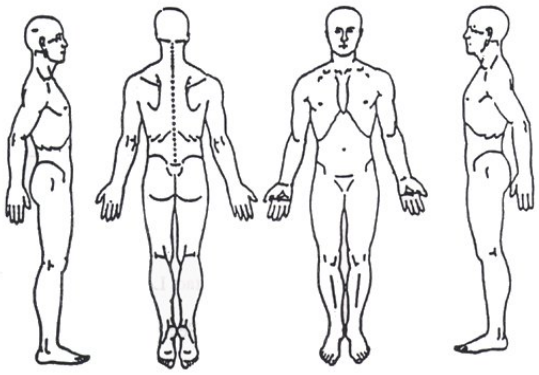
Indicate the intensity of your **pain at rest**:

(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable Pain)

Indicate the intensity of your **pain with movement**:

(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable Pain)

**MARK ON PICTURE WHERE YOU HAVE PAIN**



Since this condition began your symptoms have:

□ Decreased □ Not Changed □ Increased

Have you had Physical Therapy treatment for this condition **in the past**? □ No □ Yes

If yes, where were you seen: _____ Was treatment effective? □ No □ Yes

Have you ever had a broken bone or fracture? □ No □ Yes Location & Date: _____

How would you describe your overall health? □ Excellent □ Very Good □ Good □ Fair □ Poor

Occupation: _____ Has your work status changed because of this condition? □ No □ Yes

| PAST | PRESENT | | PAST | PRESENT | |
|---|---|---|---|---|---|
| □ | □ | High Blood Pressure | □ | □ | Diabetes |
| □ | □ | Heart Attack/Pacemaker | □ | □ | Arthritis |
| □ | □ | Stroke | □ | □ | Pregnancy |
| □ | □ | Asthma | □ | □ | Musculoskeletal Disorder (ie: osteoporosis, muscle pain, fracture) |
| □ | □ | HIV/AIDS | | | |
| □ | □ | Smoking, packs per day? _____ | □ | □ | Depression |
| □ | □ | Systemic Lupus | □ | □ | Cancer Location: _____ Date: _____ |
| □ | □ | Hepatitis | | | |
| □ | □ | Epilepsy | □ | □ | Multiple Sclerosis |
| □ | □ | Fibromyalgia | □ | □ | Other: _____ |

Medications: _____

Allergies: _____

What are your goals of therapy? _____

_____ _____

Patients Signature Date

Webster
Sports Physical Therapy & Hand Therapy Center
Experience. Excellence.

Medical Director: Thomas W. Peatman, MD & J. Theodore Schwartz, Jr., MD
Director of Physical Therapy: Maggi Cary, PT, NASM-PES

Deborah Vanderbilt-Anderson, MOTR/L, CHT
Allyson Lachman, OTR/L
Matthew Lee, MPT, CSCS
Kerri Lewis, PT, DPT, CHT
Lisa Yee, ORT/L, CHT, L-AC, DAOM
Elizabeth Sakaldasis, MA, OTR/L, CHT, CAE
Patricia Tores, OTR/L
Julie Choate, MPT
Erik Hendricksen, PTA
Matthew Silva, ATC, PTA CSCS
Brianna Cosentino, DPT
Brianne Spencer, DPT

# CONSENT FOR TREATMENT

Patient's Name:_____ Date:_____

I hereby authorize the therapists at Webster Sport & Hand Therapy to perform the treatments or procedures approved by my referring physician.

I acknowledge that no guarantees, either expressed or implied, have been made to me regarding the outcome of any treatments and/or procedures. I fully understand that it is impossible to make any guarantees regarding the outcome of any medical treatment or procedure.

_____

(Authorized Signature) Date

Webster
Wellness Center
& Hand Therapy Center
Experience. Excellence.

Medical Director: Thomas W. Peatman, MD & J. Theodore Schwartz, Jr., MD
Director of Physical Therapy: Maggi Cary, PT, NASM-PES

Deborah Vanderbilt-Anderson, MOTR/L, CHT
Allyson Lachman, OTR/L
Matthew Lee, MPT, CSCS
Kerri Lewis, PT, DPT, CHT
Lisa Yee, ORT/L, CHT, L-AC, DAOM
Elizabeth Sakaldasis, MA, OTR/L, CHT, CAE
Patricia Tores, OTR/L
Julie Choate, MPT
Erik Hendricksen, PTA
Matthew Silva, ATC, PTA CSCS
Brianna Cosentino, DPT
Brianne Spencer, DPT

# WEBSTER SPORTS PHYSICAL THERAPY AND WEBSTER HAND CLINIC
# CANCELLATION / NO SHOW POLICY

We are looking forward to helping you achieve your therapeutic goals and consistent attendance is vital! If you are unable to attend your appointment, please contact our office a minimum of 24 hours in advance. If you fail to contact our office 24 hours in advance or "no show" for an appointment there is a $50.00 charge. The Televox automated system will usually contact you 48 hours in advance however please do not rely on that system to remind you of your appointment. We will provide you with a printed copy of your appointment schedule on your first day of Therapy and would be happy to give you a second copy upon request.

**Worker's Compensation:**
If you are a patient under worker's compensation, we are unable to charge for late cancel/no show appointments however we are obligated to contact your carrier which may have negative repercussions with your benefits. If you cancel/no show for 3 appointments, we will also require you to call daily to schedule appointments vs. arranging appointments in advance.

Thank you for choosing our facility for your care and for your cooperation with our policy! Please make sure you have our phone number by keeping a business card in your wallet or by putting our number directly into your phone, (510) 849-8060.

I have read and understand the cancellation/no show policy of Webster Sports Physical Therapy and Webster Hand Clinic.

Signature _____ Date _____