Geriatric Depression Scale (GDS) Scoring Instructions

Instructions: Score 1 point for each bolded answer. A score of 5 or more suggests depression.

1.	Are you basically satisfied with your life?	yes	**no**
2.	Have you dropped many of your activities and interests?	**yes**	no
3.	Do you feel that your life is empty?	**yes**	no
4.	Do you often get bored?	**yes**	no
5.	Are you in good spirits most of the time?	yes	**no**
6.	Are you afraid that something bad is going to happen to you?	**yes**	no
7.	Do you feel happy most of the time?	yes	**no**
8.	Do you often feel helpless?	**yes**	no
9.	Do you prefer to stay at home, rather than going out and doing things?	**yes**	no
10.	Do you feel that you have more problems with memory than most?	**yes**	no
11.	Do you think it is wonderful to be alive now?	yes	**no**
12.	Do you feel worthless the way you are now?	**yes**	no
13.	Do you feel full of energy?	yes	**no**
14.	Do you feel that your situation is hopeless?	**yes**	no
15.	Do you think that most people are better off than you are?	**yes**	no

A score of ≥ 5 suggests depression ***Total Score*** _____

Ref. Yes average: The use of Rating Depression Series in the Elderly, in Poon (ed.): Clinical Memory Assessment of Older Adults, American Psychological Association, 1986

Alpine Physical Therapy

Patient Health Questionnaire – PHQ

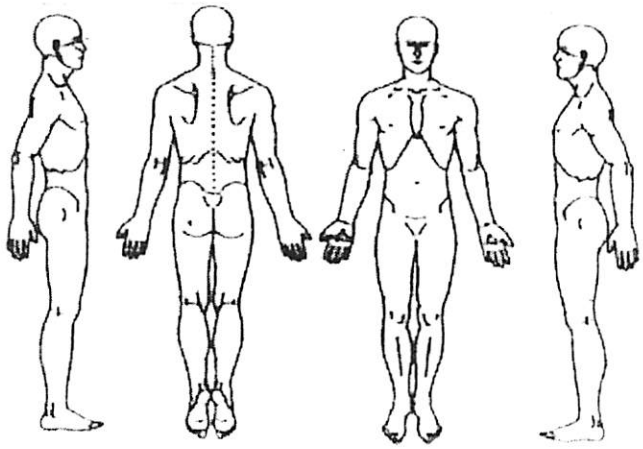
Patient Name: _____ Date: _____

1. **Describe your symptoms:** _____

_____

2. **When did your symptoms start?** _____
3. **How did your symptoms begin?** _____
4. **How often do you experience your symptoms?**
   - ☐ Constantly (76-100% of the day)
   - ☐ Frequently (51-75% of the day)
   - ☐ Occasionally (26-50% of the day)
   - ☐ Intermittently (0-25% of the day)
5. **What describes the nature of your symptoms?**
   - ☐ Sharp ☐ Shooting ☐ Dull Ache ☐ Throbbing
   - ☐ Burning ☐ Numb ☐ Tingling ☐ Other: _____
4. **How are your symptoms changing?**
   - ☐ Getting Better
   - ☐ Not Changing
   - ☐ Getting Worse

Indicate where you have pain or other symptoms:



6. **During the last month:**
   a. Indicate the average intensity of your symptoms (circle) 0 1 2 3 4 5 6 7 8 9 10
   None Unbearable
   b. How much has pain interfered with you normal work (including both work outside the home, and housework)
   ☐ Not at all ☐ A little bit ☐Moderately ☐ Quite a bit ☐ Extremely
   c. How much of the time has your condition interfered with you social activities?
   ☐ All of the time ☐Most of the time ☐Some of the time ☐A little of the time ☐ None of the time
7. **In general would you say your overall health right now is...**
   ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor
8. **What have you tried to improve your symptoms?**
   - ☐ Physical Therapy ☐ Chiropractic ☐ Medical Doctor ☐ Injections
   - ☐ CBD/Alternative ☐ Prescription Medication ☐ Non-prescription Medication ☐ Cold/Hot Packs
   - ☐ Other: _____

   a. **What** tests have you had for your symptoms and **when** were they performed? ☐ Xrays: _____ ☐ CT Scan: _____ ☐ MRI: _____ ☐ Other: _____
9. **Have you had similar symptoms in the past?** ☐ Yes ☐ No
10. **Have you ever served in the military?** ☐ Yes ☐ No
11. **What is your occupation?** _____ ☐ Retired ☐ Student

    a. What is your current work status? ☐ Full-time ☐ Part-time ☐ Unemployed ☐ Off work due to injury
    ☐ Other: _____

Patient Signature: _____ **Date:** _____

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Medical History Form

Name: _____ Date: _____

List all medications (**prescription & non-prescription**): _____

_____

_____

List all allergies: _____

Have you had a fall in the last year? (circle) **Yes** **No**

In the last month, have you been (circle): feeling down, depressed or hopeless? **Yes** **No**

bothered by having little interest or pleasure in doing things? **Yes** **No**

List 1-2 important activities that you are unable to do or are having difficulty with as a result of your symptoms:

1._____ 0 1 2 3 4 5 6 7 8 9 10

(Able to perform at the same level before injury) (Unable to perform)

2._____ 0 1 2 3 4 5 6 7 8 9 10

Do you now have or ever had ANY of the following? Please include all history:

- ☐ Coronary Heart Disease
- ☐ Do you have a Pacemaker?
- ☐ Shortness of Breath
- ☐ High/Low Blood Pressure
- ☐ Stroke/TIA/Emboli/Blood Clot
- ☐ Chest Pain (Angina)
- ☐ Heart Attack
- ☐ Congestive Heart Failure
- ☐ Anemia
- ☐ Pins or Metal Implants
- ☐ Cancer
- ☐ Hepatitis
- ☐ Do you smoke?
- ☐ Asthma/Bronchitis/Emphysema
- ☐ Epilepsy Seizures
- ☐ Thyroid Disease
- ☐ Diabetes
- ☐ Gout
- ☐ Osteoporosis
- ☐ Bowel/Bladder Problems
- ☐ Numbness/Tingling
- ☐ Vision/Hearing Problems
- ☐ Arthritis
- ☐ Dizziness
- ☐ Are you pregnant?
- ☐ Sleeping Difficulty
- ☐ Weakness
- ☐ Unexplained Weight Loss
- ☐ Fatigue
- ☐ Emotional/Psychological
- ☐ Shoulder Injury
- ☐ Back Injury
- ☐ Elbow/Hand Injury
- ☐ Knee Injury
- ☐ Neck Injury
- ☐ Foot/Ankle Injury
- ☐ Hip Injury

Surgical History (including year): _____

_____

_____

_____

Other: _____

Patient/Guardian Signature: _____ Date: _____

Alpine Physical Therapy

Please Read and initial each of the following paragraphs

Benefit Assignment/Release of Information

_____I hereby assign all medical benefits to **include major medical** and/or **durable medical equipment benefits** to which I am entitled, including Medicare, MediCal, private insurance, and third party payers to Alpine Physical Therapy. A photocopy pf this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary, including medical records, to secure payment.

*****Cancellation Policy***(Strict policy)**

_____It is the patient's responsibility to give **Alpine Physical Therapy 24-hour notice** if they will be unable to attend and appointment. It is **Alpine Physical Therapy's** policy that patients who fail to give a **24 hour notice** will be charged **$50.00 cancellation/no show fee**. Our time is valuable to our patients and this policy makes it possible for us to offer appointments to all patients in a timely and effective manner.

Notice of Privacy Practices

_____I acknowledge and agree that I have been informed to read the Notice of Privacy Practices below:

*We recommend that you schedule your appointments ad minimum of two weeks in advance.

* Please let us know of **any follow-up appointments** that you have with your referring physician.

* Please provide a minimum of **twenty-four-hour** notice if you cannot attend your scheduled appointments.

* Your **co-payment/deductible** are due at the time of service. Three no show or cancellations may cause a patient to be discharged.

Alpine Physical Therapy Payment Policy

Payment Policy

Thank you for choosing us as your physical therapy provider. We are committed to providing you with quality physical therapy services. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. Insurance. We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. Non-covered services. Please be aware that some services you receive may be non covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

4. Proof of insurance. All patients must complete our patient information form before seeing the physical therapist. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. An example of this is a COB (coordination of benefits) Your claim will be denied if you do not update your COB as requested by your insurance company. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

7. Nonpayment. If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency.

8. Missed appointments. Our policy is to charge for missed appointments not canceled within a reasonable amount of time (24 hours unless an emergency). These charges will be your responsibility and billed directly to you at $50 per no show visit. Please help us to serve you better by keeping your regularly scheduled appointments.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Signature of patient or responsible party **Date**

_____ _____

Print full name here **Date**