# Brostrom Physical Therapy

Spine and Extremity Institute of South Lyon, LLC

## Patient Information

**First Name**:_____ **MI**:_____ **Last Name**:_____

*** Phone**: (h)_____(c)_____ (w)_____

*From time to time, it may be necessary for the Brostrom PT staff to leave a detailed message on your phone pertaining to appointment times, health insurance coverage, or treatment information. Please check phone numbers where you authorize the Brostrom PT staff to leave messages containing the specified content:

- **Appointment times** ☐ Home Phone ☐ Cell Phone ☐ Work Phone
- **Health insurance coverage** ☐ Home Phone ☐ Cell Phone ☐ Work Phone
- **Treatment information** ☐ Home Phone ☐ Cell Phone ☐ Work Phone

☐ I prefer that the Brostrom PT staff does not leave detailed messages on any of my phones.

**Address**:_____

**City**: _____ **Zip**:_____

**E-Mail Address:** _____

**Sex**: M F **Date of Birth**:_____ **Marital Status**: m s d w

**Student Status**: ☐ Full-time ☐ Part-time ☐ Not a Student

**Employment Status:** ☐ Full-time ☐ Part-time ☐ Unemployed ☐ Retired

**Primary Care Physician (PCP):** _____

**Are you being treated for an injury or illness in which a party <u>other than your health insurance company</u> has been found responsible? (Please circle.) No **Yes**

****If yes, please indicate:** ☐ Auto ☐ Work ☐ Liability ☐ Other:_____

****If yes, please indicate date of onset (injury)**: _____

**Emergency Contact with Phone Number.** Name:_____

Phone #:_____ Relationship:_____

☐ Appointment times ☐ Health insurance coverage ☐ Treatment information

**Optional: <u>Additional</u> person (besides emergency contact) to whom we can discuss your appointment times, health insurance coverage, and/or treatment information with (please check appropriate boxes):**

Name:_____ Relationship:_____

☐ Appointment times ☐ Health insurance coverage ☐ Treatment information

**How did you hear about Brostrom Physical Therapy?**

_____

**To be completed if you have <u>Medicare</u> as active insurance:**

| | | | |
|---|---|---|---|
| **1)** | Are you receiving any form of in-home care (such as in-home nursing or in-home PT)? | **Yes** | **No** |
| **2)** | Do you have **Group Health Coverage** through you or your spouse's current or former employer? (Note: if you have a **retirement plan** through your current or former employer, answer no and skip to question 3). | **Yes** | **No** |
| **2a)** | If yes, are there 20 or more employees working for the employer providing coverage? | **Yes** | **No** |
| **3)** | Do you have a Workers-Compensation Set-Aside Arrangement (WCMSA)? A WCMSA is a financial agreement that allocates a portion of a workers compensation settlement to pay for future medical services. | **Yes** | **No** |

**By signing, I authorize that the above information is accurate and complete to the best of my knowledge. I also understand this form will act as an authorization of release of information to the people and phones specified above.**

_____ _____

**Signature** **Date**

# Brostrom Physical Therapy

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## Health Questionnaire – Cervical Spine/Thoracic Spine

Name:_____Date:_____

****Please refer to the Comparative Pain Scale document to answer the following question:**

How much pain have you had in the past 24 hours (please circle)?

0 1 2 3 4 5 6 7 8 9 10

**Have you had any surgeries for this condition?** □ Yes □ No

a. If yes, please list the number of surgeries you have had: _____

**When did this condition begin?** _____ days ago

**Are you taking prescription medicine for this condition?** □ Yes □ No

a. If yes, please indicate the medications: _____

**In each section, please mark only the box which most closely describes your current condition:**

### Section 1 – Pain Intensity

- □ I have no pain at the moment. (0)
- □ The pain is very mild at the moment. (1)
- □ The pain is moderate at the moment. (2)
- □ The pain is fairly severe at the moment. (3)
- □ The pain is very severe at the moment. (4)
- □ The pain is the worst imaginable at the moment. (5)

### Section 2 – Personal Care (washing, dressing, etc.)

- □ I can look after myself normally but it is very painful. (0)
- □ I can look after myself normally but it causes extra pain. (1)
- □ It is painful to look after myself and I am slow and careful. (2)
- □ I need some help but can manage most of my care. (3)
- □ I need help every day in most aspects of self-care. (4)
- □ I do not get dressed, wash with difficulty, and stay in bed. (5)

### Section 3 - Lifting

- □ I can lift heavy weights without extra pain. (0)
- □ I can lift heavy weights but it gives extra pain. (1)
- □ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (i.e. on a table). (2)
- □ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned. (3)
- □ I can lift only very light weights. (4)
- □ I cannot lift or carry anything at all. (5)

### Section 4 – Reading

- □ I can read as much as I want to with no neck pain. (0)
- □ I can read as much as I want to with slight neck pain. (1)
- □ I can read as much as I want with moderate neck pain. (2)
- □ I can't read as much as I want because of moderate neck pain. (3)
- □ I can hardly read at all because of severe neck pain. (4)
- □ I cannot read at all. (5)

### Section 5 – Headaches

- □ I have no headaches at all. (0)
- □ I have slight headaches, which come infrequently. (1)
- □ I have moderate headaches, which come infrequently. (2)
- □ I have moderate headaches, which come frequently. (3)
- □ I have severe headaches, which come frequently. (4)
- □ I have headaches almost all the time. (5)

### Section 6 – Concentration

- □ I can concentrate fully when I want to with no difficulty. (0)
- □ I can concentrate fully when I want to with slight difficulty. (1)
- □ I have a fair degree of difficulty in concentrating when I want to. (2)
- □ I have a lot of difficulty in concentrating when I want to. (3)
- □ I have a great deal of difficulty in concentrating when I want to. (4)
- □ I cannot concentrate at all. (5)

### Section 7 – Work

- □ I can do as much work as I want to. (0)
- □ I can only do my usual work, but no more. (1)
- □ I can do most of my usual work, but no more. (2)
- □ I cannot do my usual work. (3)
- □ I can hardly do any work at all. (4)
- □ I can't do any work at all. (5)

### Section 8 – Driving

- □ I can drive my care without any neck pain. (0)
- □ I can drive my car as long as I want with slight neck pain. (1)
- □ I can drive my car as long as I want with moderate neck pain. (2)
- □ I can't drive my car as long as I want because of moderate neck pain. (3)
- □ I can hardly drive at all because of severe neck pain. (4)
- □ I can't drive my car at all. (5)

### Section 9 – Sleeping

- □ I have no trouble sleeping.
- □ My sleep is slightly disturbed (less than 1 hour sleepless). (1)
- □ My sleep is mildly disturbed (1-2 hours sleepless). (2)
- □ My sleep is moderately disturbed (2-3 hours sleepless). (3)
- □ My sleep is greatly disturbed (3-5 hours sleepless). (4)
- □ My sleep is completely disturbed (5-7 hours sleepless). (5)

### Section 10 – Recreation

- □ I am able to engage in all my recreation activities with no neck pain. (0)
- □ I am able to engage in all my recreation activities with some neck pain. (1)
- □ I am able to engage in most but not all my recreation activities because of neck pain. (2)
- □ I am able to engage in a few of my usual recreation activities because of neck pain. (3)
- □ I can hardly do any recreation activities because of neck pain. (4)
- □ I can't do any recreation activities at all. (5)

***Therapist Use Only:*** ***Initials:***

$$\left(\frac{\text{Patient's score}}{\text{\# of sections completed x 5}}\right) \text{x}100\%$$

$$\left(\frac{\quad}{\quad}\right) \text{x}100\% = \_\_\_\_\_\%$$

# BROSTROM PHYSICAL THERAPY

SPINE AND EXTREMITY INSTITUTE OF SOUTH LYON, LLC

**Have you received treatment for this condition before?** □ Yes □ No

a. If yes, please list the types of doctors you have seen: _____

_____

**Have you had 2 or more falls *or* a fall/falls with injury in the past 12 months?** □ Yes □ No

**Do you find that your employment duties are restricted by your current condition?** □ Yes □ No

**Please review the following list of health problems that you may have. Please place an X in the line provided directly to the left of the health condition if you experience(d) it.**

_____ Arthritis
_____ Osteoporosis
_____ Asthma
_____ Cancer
_____ Diabetes
_____ Heart Disease
_____ Angina/Chest Pain
_____ Stroke
_____ Muscular Weakness
_____ Headaches
_____ Seizures
_____ Pacemaker

_____ Shortness of breath
_____ Allergies ( □ seasonal □ food □ latex/adhesives □ meds □ lotions/scents)
(list:_____)
_____ High Blood Pressure
_____ Nausea/Vomiting
_____ Fever/ Chills/ Sweats
_____ Unexplained weight change
_____ Numbness or tingling
_____ Bowel or bladder changes
_____ Dizziness
_____ Night Pain
Other (please specify):_____

**Please provide a list of all current medications in the table below. If you are not taking any medications currently, simply check the box below.**

☐ I am not currently taking any medications

| **Medication Name** (including prescription, over-the-counter, herbal, vitamin, and dietary supplements) | **Dosage** | **Frequency** | **Route Taken** (for example: oral, injection, inhaler, etc.) |
|---|---|---|---|
| | | | |
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| | | | |
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| | | | |

**Please list all surgeries (accompanied with the date of the surgery), recent hospitalizations, and pertinent past medical history:**

| ***Surgery(ies):*** | ***Date:*** |
|---|---|
| | |
| | |
| | |

| ***Recent Hospitalization(s):*** | ***Date:*** |
|---|---|
| | |
| | |

***Pertinent Past Medical History:***

_____

_____

**By signing, I authorize that the above information is accurate and complete to the best of my knowledge.**

_____ _____

**Signature** **Date**

# Brostrom Physical Therapy

Spine and Extremity Institute of South Lyon, LLC

## Patient Policies

**If you are completing the forms via the Internet:** Please open the "Patient Policies Packet" and read the enclosed information regarding your Bill of Rights, Brostrom Physical Therapy's HIPAA Private Policy Statement, Consent to Treatment, Financial Policy, and Cancellation and No Show Policy. Once complete, initial in the corresponding boxes below to reflect your acceptance to comply with these Policies. **Please note that it is not necessary to print the Patient Policies Packet unless you desire a personal copy.**

**If you are completing the forms in-office:** Please read the attached Patient Policies Packet regarding your Bill of Rights, Brostrom Physical Therapy's HIPAA Private Policy Statement, Consent to Treatment, Financial Policy, and Cancellation and No Show Policy. Once complete, initial in the corresponding boxes below to reflect your acceptance to comply with these Policies.

**Note:** A parent or legal guardian must initial each of the boxes below if you are under the age of eighteen (18).

| | |
|---|---|
| Initial: | **Client Bill of Rights:**<br>I have read The Client Bill of Rights and agree to maintain by its standards. |
| Initial: | **HIPAA Private Policy Statement:**<br>I have been given the opportunity to read the *detailed* private policy statement. I understand this information and agree to comply with the policies set forth in the *detailed* disclosure policy. |
| Initial: | **Consent to Treatment:**<br>I give my consent for treatment and assignment of claim at Brostrom Physical Therapy. |
| Initial: | **Financial Policy:**<br>I authorize that I have read and understand Brostrom Physical Therapy's financial policy. I understand I am financially responsible for all charges for services rendered, including the balance remaining after all possible insurance payments or benefits. |
| Initial: | **Cancellation and No Show Policy:**<br>I have read, understand, and agree to the Brostrom Physical Therapy Cancellation and No Show Policy. It has been explained to me and my questions have been answered to my satisfaction.<br><br>By signing below, I hereby authorize my consent to Brostrom Physical Therapy to send appointment reminders electronically via text message to my mobile phone or by e-mail. I understand that this service is offered free of charge, but standard messaging rates from my mobile carrier may apply depending on my plan. **I can withdraw my consent to electronic communications by calling Brostrom Physical Therapy at (248) 446-0155.**<br><br>Please initial in the corresponding boxes to indicate your consent to receive electronic appointment reminders:<br>☐ Text reminders ☐ Email reminders ☐ Decline electronic reminders |

Printed name of Patient/Parent/Legal Guardian:_____

Signature of Patient/Parent/Legal Guardian:_____

Date: _____