Thank you for providing the following information below so that we can provide you the highest quality care and service possible.

Consent: I authorize the medical provider to render Physical Therapy as deemed medically necessary.

Initial _____

Records Release: I authorize the release of any private health information necessary to process my claims or provide continuation of medical care. Initial _____

How did you hear about us? (circle)

DOCTOR RECCOMENDATION WEBSITE GOOGLE YELP SOCIAL NETWORK FRIEND/COLLEAGE

OTHER_____

Cancellation Policy: $50.00 fee for appointment no-shows or Cancellations with less than 24 hours' notice.

Email Policy: We will NEVER give or sell your email address. You can unsubscribe from occasional messages at any time.

Email Address_____ Is it OK to send billing statements to this email? Y N

Appointment Reminders: I would like to receive TEXT reminders:

TEXT MESSAGE: Cell number _____ Cell Carrier name: _____

INJURY DATE_____

Have you received any other physical Therapy this year (2018): Y N

If Yes, how many visits of PT, have you received this year _____

IS YOUR INJURY: (PLEASE CIRCLE) WORK RELATED AUTO RELATED NOT APPLICABLE

ADJUSTER NAME: _____ADJUSTER PHONE NUMBER:_____

ATTORNEY NAME:_____ ATTORNEY PHONE NUMBER:_____

PATIENT NAME: _____ DATE: _____

SIGNATIURE: _____

Please circle all that apply

High blood pressure	Heart problems	Shortness of breath
Changes in hair or nails	Diabetes	Low blood sugar
Thyroid problems	Difficulty sleeping while lying flat	Lung problems
Asthma	Ulcers	Cancer
Night sweats	Nausea/vomiting	Bleeding/bruising
Tumors/lumps/bumps	Unexpected weight gain/loss	Long term steroid use
Osteoporosis	Head trauma/Stroke/TIA	Fainting/Blackouts
Change in vision	Dizziness	Balance problems
Ringing in ears	Major dental work	Difficulty eating/swallowing
Change in ability to taste food	Abuse	Vocal changes
Ear pain	Headaches	Mental illness
Numbness/Tingling	Arthritis	Muscle cramps
Broken bones in last year	Surgery	Varicose veins
Hot or cold intolerance	Productive coughing	Contagious disease
Rash	Fever	Bowel or bladder changes
Pelvic inflammatory disease	Difficulty urinating	Blood in urine
Bladder or kidney infection	Abnormal or painful menstruation	Incontinence
Currently pregnant	Current smoker	Alcohol use (how often)

Additional comments/conditions: _____

Why are you here? _____

Prior physical therapy for this condition? _____

What makes this condition **worse**?_____

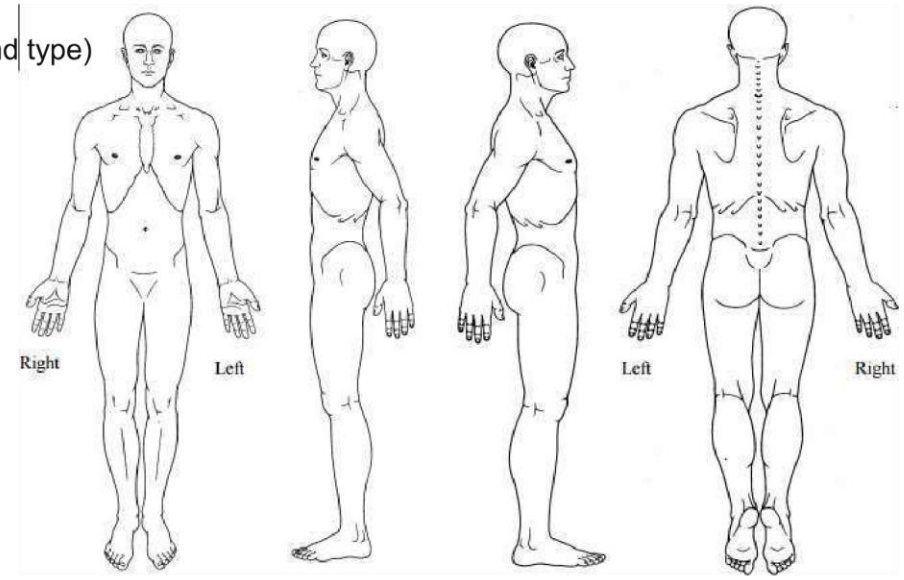
What makes this condition **better**? _____

Current medications: _____

Pain rating Please mark on scale: (NO PAIN)◆·····◆(WORST PAIN EVER)

Pain map (please indicate location and type)

NUMBNESS
****
PINS & NEEDLES
0000
BURNING
XXXX
STABBING
////
ACHING
^^^^



I have stated all my known medical conditions, answered all questions honestly, and agree to keep the therapist updated with changes. There will be no liability on the therapist shall I fail to do so.

SIGN:_____ DATE:_____

Patient's Name_____ Number_____ Date_____

LOW BACK DISABILITY QUESTIONNAIRE (REVISED OSWESTRY)

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage in everyday life. **Please answer every section and mark in each section only ONE box** which applies to you. We realize you may consider that two of the statements in any one section relate to you, but **please just mark the box which MOST CLOSELY describes your problem.**

Section 1 - Pain Intensity

☐ I can tolerate the pain without having to use painkillers.
☐ The pain is bad but I can manage without taking painkillers.
☐ Painkillers give complete relief from pain.
☐ Painkillers give moderate relief from pain.
☐ Painkillers give very little relief from pain.
☐ Painkillers have no effect on the pain and I do not use them.

Section 2 -- Personal Care (Washing, Dressing, etc.)

☐ I can look after myself normally without causing extra pain.
☐ I can look after myself normally but it causes extra pain.
☐ It is painful to look after myself and I am slow and careful.
☐ I need some help but manage most of my personal care.
☐ I need help every day in most aspects of self care.
☐ I do not get dressed, I wash with difficulty and stay in bed.

Section 3 – Lifting

☐ I can lift heavy weights without extra pain.
☐ I can lift heavy weights but it gives extra pain.
☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
☐ I can lift very light weights.
☐ I cannot lift or carry anything at all.

Section 4 – Walking

☐ Pain does not prevent me from walking any distance.
☐ Pain prevents me from walking more than one mile.
☐ Pain prevents me from walking more than one-half mile.
☐ Pain prevents me from walking more than one-quarter mile
☐ I can only walk using a stick or crutches.
☐ I am in bed most of the time and have to crawl to the toilet.

Section 5 -- Sitting

☐ I can sit in any chair as long as I like
☐ I can only sit in my favorite chair as long as I like
☐ Pain prevents me from sitting more than one hour.
☐ Pain prevents me from sitting more than 30 minutes.
☐ Pain prevents me from sitting more than 10 minutes.
☐ Pain prevents me from sitting almost all the time.

Scoring: Questions are scored on a vertical scale of 0-5. Total scores and multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered significant activities of daily living disability.
(Score___ x 2) / (____Sections x 10) = _____ %ADL

Section 6 – Standing

☐ I can stand as long as I want without extra pain.
☐ I can stand as long as I want but it gives extra pain.
☐ Pain prevents me from standing more than 1 hour.
☐ Pain prevents me from standing more than 30 minutes.
☐ Pain prevents me from standing more than 10 minutes.
☐ Pain prevents me from standing at all.

Section 7 -- Sleeping

☐ Pain does not prevent me from sleeping well.
☐ I can sleep well only by using tablets.
☐ Even when I take tablets I have less than 6 hours sleep.
☐ Even when I take tablets I have less than 4 hours sleep.
☐ Even when I take tablets I have less than 2 hours sleep.
☐ Pain prevents me from sleeping at all.

Section 8 – Social Life

☐ My social life is normal and gives me no extra pain.
☐ My social life is normal but increases the degree of pain.
☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing.
☐ Pain has restricted my social life and I do not go out as often.
☐ Pain has restricted my social life to my home.
☐ I have no social life because of pain.

Section 9 – Traveling

☐ I can travel anywhere without extra pain.
☐ I can travel anywhere but it gives me extra pain.
☐ Pain is bad but I manage journeys over 2 hours.
☐ Pain is bad but I manage journeys less than 1 hour.
☐ Pain restricts me to short necessary journeys under 30 minutes.
☐ Pain prevents me from traveling except to the doctor or hospital.

Section 10 – Changing Degree of Pain

☐ My pain is rapidly getting better.
☐ My pain fluctuates but overall is definitely getting better.
☐ My pain seems to be getting better but improvement is slow at the present.
☐ My pain is neither getting better nor worse.
☐ My pain is gradually worsening.
☐ My pain is rapidly worsening.

Comments_____

Reference: Fairbank, Physiotherapy 1981; 66(8): 271-3, Hudson-Cook. In Roland, Jenner (eds.), Back Pain New Approaches To Rehabilitation & Education. Manchester Univ Press, Manchester 1989: 187-204