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)

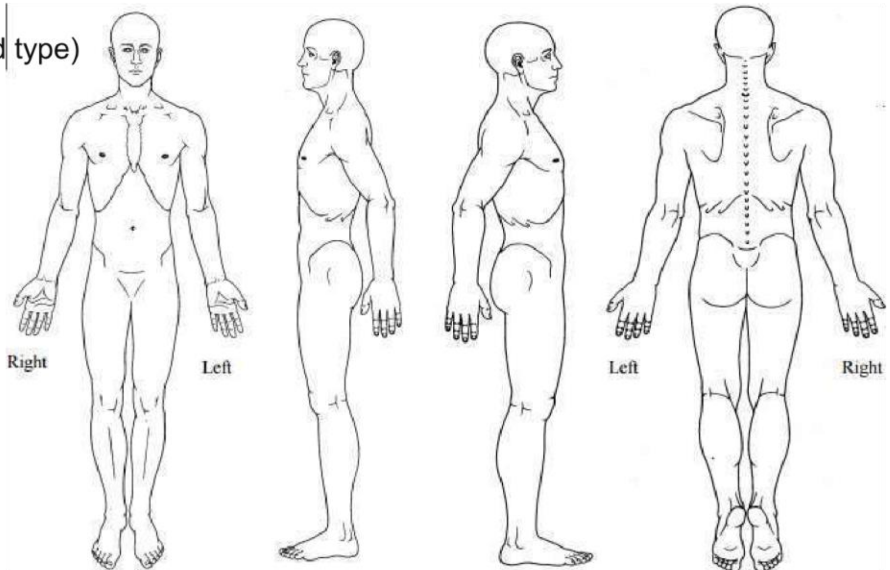
NUMBNESS
****

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___________________

NECK DISABILITY INDEX

This questionnaire has been designed to give the doctor information as to how your neck 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 have no pain at the moment.
☐ The pain is very mild at the moment.
☐ The pain is moderate at the moment.
☐ The pain is fairly severe at the moment.
☐ The pain is very severe at the moment.
☐ The pain is the worst imaginable at the moment.

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 – Reading

☐ I can read as much as I want to with no pain in my neck.
☐ I can read as much as I want to with slight pain in my neck.
☐ I can read as much as I want with moderate pain.
☐ I can't read as much as I want because of moderate pain in my neck.
☐ I can hardly read at all because of severe pain in my neck.
☐ I cannot read at all.

Section 5-Headaches

☐ I have no headaches at all.
☐ I have slight headaches which come infrequently.
☐ I have slight headaches which come frequently.
☐ I have moderate headaches which come infrequently.
☐ I have severe headaches which come frequently.
☐ I have headaches 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 a significant activities of daily living disability.
(Score___ x 2) / (____Sections x 10) = ____________ %ADL______

Section 6 – Concentration

☐ I can concentrate fully when I want to with no difficulty.
☐ I can concentrate fully when I want to with slight difficulty.
☐ I have a fair degree of difficulty in concentrating when I want to.
☐ I have a lot of difficulty in concentrating when I want to.
☐ I have a great deal of difficulty in concentrating when I want to.
☐ I cannot concentrate at all.

Section 7—Work

☐ I can do as much work as I want to.
☐ I can only do my usual work, but no more.
☐ I can do most of my usual work, but no more.
☐ I cannot do my usual work.
☐ I can hardly do any work at all.
☐ I can't do any work at all.

Section 8 – Driving

☐ I drive my car without any neck pain.
☐ I can drive my car as long as I want with slight pain in my neck.
☐ I can drive my car as long as I want with moderate pain in my neck.
☐ I can't drive my car as long as I want because of moderate pain in my neck.
☐ I can hardly drive my car at all because of severe pain in my neck.
☐ I can't drive my car at all.

Section 9 – Sleeping

☐ I have no trouble sleeping.
☐ My sleep is slightly disturbed (less than 1 hr. sleepless).
☐ My sleep is moderately disturbed (1-2 hrs. sleepless).
☐ My sleep is moderately disturbed (2-3 hrs. sleepless).
☐ My sleep is greatly disturbed (3-4 hrs. sleepless).
☐ My sleep is completely disturbed (5-7 hrs. sleepless).

Section 10 – Recreation

☐ I am able to engage in all my recreation activities with no neck pain at all.
☐ I am able to engage in all my recreation activities, with some pain in my neck.
☐ I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
☐ I am able to engage in a few of my usual recreation activities because of pain in my neck.
☐ I can hardly do any recreation activities because of pain in my neck.
☐ I can't do any recreation activities at all.

Comments____
%ADL

Reference: Vernon, Mior. JMPT 1991; 14(7): 409-15