



BROSTROM PHYSICAL THERAPY

SPINE AND EXTREMITY INSTITUTE OF SOUTH LYON, LLC

PATIENT INFORMATION

First Name: _____ Preferred: _____ Last Name: _____
(if applicable)

*Phone: (home) _____ (cell) _____ (work) _____

*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: _____ State: _____ 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 other than your health insurance company 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: Additional 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 Medicare 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



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HEALTH QUESTIONNAIRE – SHOULDER

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

Height: _____ feet _____ inches Weight: _____ lbs

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 any surgeries for this condition? Yes (#: _____) No

When did this condition begin? _____ days ago

Are you taking prescription medicine for this condition? Yes No

a. If yes, please indicate the medications: _____

How often have you completed at least 20 minutes of exercise such as jogging, cycling, or brisk walking prior to the onset of your condition? At least 3 times per week Once or twice a week Seldom/never

Would you have any difficulty using your affected arm to:

	I can't	Much	Some	Little	No
Wash the side of your face on the same side as your affected shoulder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reach the earlobe on the opposite side as your affected shoulder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Turn a faucet in the same direction as your affected arm (e.g. turn right if your right shoulder is affected)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Turn a faucet in the opposite direction as your affected arm (e.g. turn left if your right shoulder is affected)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching to work overhead for more than 2 minutes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pull a chair out from a table?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Place a can of soup (1 lb) on a shelf at shoulder height?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reach and pull a string controlling a light or a fan?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Take off glasses or sunglasses?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Put on underpants using BOTH arms?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Put deodorant under your opposite arm?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Participate in rigorous contact sports?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Place a gallon of milk (8-10 lbs) on a shelf overhead?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pick up and drink a full glass of water?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Open a new tight jar?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Placing a 25 lb box on a shelf overhead?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Placing a 50 lb box on a shelf overhead?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Touch an object in the back seat while sitting in the front seat of a car?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Flush a toilet?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pull on socks or shoes with both hands?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Steady a jar (with affected arm) while loosening a lid (with unaffected arm)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please rate your ability to do the following activities in the last week:

Shoulder FOTO*

	I can't do this	Much difficulty	Some difficulty	Little difficulty	No difficulty
1. Are you having any difficulty carrying a shopping bag or briefcase?	1	2	3	4	5
2. Are you having any difficulty pushing open a heavy door?	1	2	3	4	5
3. Are you having any difficulty reaching an overhead shelf?	1	2	3	4	5
4. Are you having any difficulty using your affected arm to lower a lightweight object (1-5 lb) from the top shelf of a closet?	1	2	3	4	5
5. Are you having any difficulty carrying a heavy object (over 10 lbs)?	1	2	3	4	5
6. Are you having any difficulty pulling a medium weight object (5-10 lbs) from under a bed?	1	2	3	4	5
7. Are you having any difficulty doing heavy household chores (e.g. washing walls or floors)?	1	2	3	4	5
8. Are you having any difficulty moving a heavy skillet (e.g. cast-iron skillet) from one stove burner to another?	1	2	3	4	5
9. Are you having any difficulty placing a can of soup (1 lb) on a shelf overhead?	1	2	3	4	5
10. Are you having any difficulty adjusting the back of your collar with your affected hand?	1	2	3	4	5

*Non-risk adjusted version **Therapist Use Only** Sum = FS Score = % Initials:

Sum	FS Score	Sum	FS Score	Sum	FS Score	Sum	FS Score	Sum	FS Score	Sum	FS Score	Sum	FS Score	Sum	FS Score	Sum	FS Score
10	0.0	15	39.5	20	46.2	25	51.3	30	56.0	35	60.7	40	65.6	45	72.2	50	100.0
11	26.7	16	41.1	21	47.3	26	52.2	31	56.9	36	61.6	41	66.8	46	74.1		
12	32.0	17	42.5	22	48.3	27	53.2	32	57.9	37	62.6	42	67.9	47	76.4		
13	35.2	18	43.8	23	49.3	28	54.1	33	58.8	38	63.6	43	69.2	48	79.6		
14	37.6	19	45.0	24	50.3	29	55.1	34	59.7	39	64.6	44	70.6	49	84.8		



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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

Are you a current tobacco user? Yes No

PHQ-2: Over the two weeks, how often have you been bothered by any of the following problems?

	Not at All	Several Days	More than Half the Days	Nearly Every Day
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

Have you been previously diagnosed with bipolar disorder? Yes No

Please review the following list of health problems that you may have. Please check the box provided directly to the left of the health condition if you experience(d) it.

- | | |
|--|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Bipolar Disorder |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Allergies (<input type="checkbox"/> seasonal <input type="checkbox"/> food <input type="checkbox"/> latex/adhesives <input type="checkbox"/> meds <input type="checkbox"/> lotions/scents) |
| <input type="checkbox"/> Asthma | (list: _____) |
| <input type="checkbox"/> COPD, ARDS, emphysema | <input type="checkbox"/> Gastrointestinal Disease (ulcer, hernia, reflux, bowel, liver, gall bladder) |
| <input type="checkbox"/> Angina (chest pain) | <input type="checkbox"/> Visual impairment (cataracts, glaucoma, macular degeneration) |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Hearing impairment (very hard of hearing, even with hearing aids) |
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Back pain (neck pain, low back pain, DDD, spinal stenosis) |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Kidney, bladder, prostate, or urination problems |
| <input type="checkbox"/> Degenerative neurological disease | <input type="checkbox"/> Previous accidents |
| <input type="checkbox"/> Stroke or TIA | <input type="checkbox"/> Incontinence/bowel or bladder changes |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Anxiety or panic disorders |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Hepatitis, tuberculosis, or other blood-borne condition |
| <input type="checkbox"/> Peripheral Vascular Disease | <input type="checkbox"/> Prior surgery |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Prosthesis/Implants |
| <input type="checkbox"/> Diabetes Type I or II | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Sleep dysfunction | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Unexplained weight change |
| <input type="checkbox"/> Nausea/Vomiting | <input type="checkbox"/> Numbness or tingling |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Other (list: _____) |

Please provide a list of all current medications in the table 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.)

Please list all surgeries, recent hospitalizations, and pertinent past medical history related to the condition for which you are seeking treatment:

Surgery(ies):	Date:	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



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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: I have read The Client Bill of Rights and agree to maintain by its standards.
Initial:	HIPAA Privacy Policy Statement: I have been given the opportunity to read the <i>detailed</i> private policy statement. I understand this information and agree to comply with the policies set forth in the <i>detailed</i> disclosure policy.
Initial:	Consent to Treatment: I give my consent for treatment and assignment of claim at Brostrom Physical Therapy.
Initial:	Financial Policy: 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: 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. 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. Please initial in the corresponding boxes to indicate your consent to receive electronic appointment reminders: <input type="checkbox"/> Text reminders <input type="checkbox"/> Email reminders <input type="checkbox"/> Decline electronic reminders

Printed name of Patient/Parent/Legal Guardian: _____

Signature of Patient/Parent/Legal Guardian: _____

Date: _____