



# 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)?<br>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

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

**\*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

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: \_\_\_\_\_

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 three (3) times per week      ☐ Once or twice a week      ☐ Seldom or never

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



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**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 provide a list of all current medications in the table below.** ☐ I am not currently taking any medications.

<b>Medication Name</b> (including prescription, over-the-counter, herbal, vitamin, and dietary supplements)	<b>Dosage</b>	<b>Frequency</b>	<b>Route Taken</b> (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:**

<b><i>Surgery(ies):</i></b>	<b><i>Date:</i></b>	<b><i>Surgery(ies):</i></b>	<b><i>Date:</i></b>
<b><i>Recent Hospitalization(s):</i></b>		<b><i>Date:</i></b>	
<b><i>Pertinent Past Medical History:</i></b>			

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

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Signature

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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:	<b>Client Bill of Rights:</b> I have read The Client Bill of Rights and agree to maintain by its standards.
Initial:	<b>HIPAA Privacy Policy Statement:</b> 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:	<b>Consent to Treatment:</b> I give my consent for treatment and assignment of claim at Brostrom Physical Therapy.
Initial:	<b>Financial Policy:</b> 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:	<b>Cancellation and No-Show Policy:</b> 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. <b>I can withdraw my consent to electronic communications by calling Brostrom Physical Therapy at (248) 446-0155.</b>  Please initial in the corresponding boxes to indicate your consent to receive electronic appointment reminders:  <div style="display: flex; justify-content: space-around;"><div><input type="checkbox"/> Text reminders</div><div><input type="checkbox"/> Email reminders</div><div><input type="checkbox"/> Decline electronic reminders</div></div>

Printed name of Patient/Parent/Legal Guardian: \_\_\_\_\_

Signature of Patient/Parent/Legal Guardian: \_\_\_\_\_

Date: \_\_\_\_\_