



# 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 – HIP, PELVIS, UPPER LEG

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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

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

| Would you have any difficulty using your affected hip(s) to: | Extreme/<br>Unable       | Quite a<br>bit           | Moderate                 | A little<br>bit          | No                       |
|--------------------------------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Perform your usual work, housework, or school activities?    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Make sharp turns while running fast?                         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Roll over in bed?                                            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Get in and out of the bath?                                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Squat?                                                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| Would you have any difficulty using your affected hip(s) to: | Unable                   | Extreme                  | Quite<br>a bit           | Moderate                 | A little<br>bit          | No                       |
|--------------------------------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Put on socks or shoes?                                       | <input type="checkbox"/> | <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 few days by circling the number below the appropriate response:

### Hip FOTO\*

|                                                                                               | Extreme<br>difficulty/<br>unable | Quite a<br>bit of<br>difficulty | Moderate<br>difficulty | A little<br>bit of<br>difficulty | No<br>difficulty |
|-----------------------------------------------------------------------------------------------|----------------------------------|---------------------------------|------------------------|----------------------------------|------------------|
| 1. Are you having any difficulty going up or down 10 stairs (about 1 flight of stairs)?       | 1                                | 2                               | 3                      | 4                                | 5                |
| 2. Are you having any difficulty getting into or out of the car?                              | 1                                | 2                               | 3                      | 4                                | 5                |
| 3. Are you having any difficulty standing for 1 hour?                                         | 1                                | 2                               | 3                      | 4                                | 5                |
| 4. Are you having any difficulty walking a mile?                                              | 1                                | 2                               | 3                      | 4                                | 5                |
| 5. Are you having any difficulty running on even ground?                                      | 1                                | 2                               | 3                      | 4                                | 5                |
| 6. Are you having any difficulty walking between rooms?                                       | 1                                | 2                               | 3                      | 4                                | 5                |
| 7. Are you having any difficulty hopping?                                                     | 1                                | 2                               | 3                      | 4                                | 5                |
| 8. Are you having any difficulty performing heavy activities around the home?                 | 1                                | 2                               | 3                      | 4                                | 5                |
| 9. Are you having any difficulty performing light activities around the home?                 | 1                                | 2                               | 3                      | 4                                | 5                |
| 10. Are you having any difficulty lifting an object, like a bag of groceries, from the floor? | 1                                | 2                               | 3                      | 4                                | 5                |

TOTAL

| *Non-risk adjusted version |          | <i>Therapist Use Only</i> |          | Sum = | FS Score = | %   | Initials: |     |          |
|----------------------------|----------|---------------------------|----------|-------|------------|-----|-----------|-----|----------|
| Sum                        | FS Score | Sum                       | FS Score | Sum   | FS Score   | Sum | FS Score  | Sum | FS Score |
| 10                         | 5.96     | 19                        | 36.18    | 27    | 49.12      | 35  | 59.95     | 43  | 71.99    |
| 11                         | 12.74    | 20                        | 38.06    | 28    | 50.52      | 36  | 61.31     | 44  | 73.84    |
| 12                         | 17.44    | 21                        | 39.84    | 29    | 51.90      | 37  | 62.70     | 45  | 75.84    |
| 13                         | 21.25    | 22                        | 41.53    | 30    | 53.26      | 38  | 64.12     | 46  | 78.07    |
| 14                         | 24.44    | 23                        | 43.15    | 31    | 54.60      | 39  | 65.58     | 47  | 80.59    |
| 15                         | 27.24    | 24                        | 44.71    | 32    | 55.93      | 40  | 67.08     | 48  | 83.57    |
| 16                         | 29.75    | 25                        | 46.22    | 33    | 57.26      | 41  | 68.64     | 49  | 87.45    |
| 17                         | 32.05    | 26                        | 47.69    | 34    | 58.60      | 42  | 70.27     | 50  | 94.05    |
| 18                         | 34.19    |                           |          |       |            |     |           |     |          |



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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<br>(including prescription, over-the-counter, herbal, vitamin, and dietary supplements) | Dosage | Frequency | Route Taken<br>(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:**

|                                               |  |       |  |
|-----------------------------------------------|--|-------|--|
| Condition for which you're seeking treatment: |  |       |  |
| 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: | <b>Client Bill of Rights:</b><br>I have read The Client Bill of Rights and agree to maintain by its standards.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| Initial: | <b>HIPAA Privacy Policy Statement:</b><br>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><br>I give my consent for treatment and assignment of claim at Brostrom Physical Therapy.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| Initial: | <b>Financial Policy:</b><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: | <b>Cancellation and No-Show Policy:</b><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. <b>I can withdraw my consent to electronic communications by calling Brostrom Physical Therapy at (248) 446-0155.</b><br><br>Please initial in the corresponding boxes to indicate your consent to receive electronic appointment reminders:<br><br><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: \_\_\_\_\_