



# BROSTROM PHYSICAL THERAPY

SPINE AND EXTREMITY INSTITUTE OF SOUTH LYON, LLC

## PATIENT INFORMATION

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_

\*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 <b>Group Health Coverage</b> through you or your spouse's current or former employer? (Note: if you have a <b>retirement plan</b> 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 – CERVICAL SPINE/THORACIC SPINE

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 3 times per week  One or twice a week  Seldom/never

Because of your neck, how much difficulty do you have:	Extreme/ Unable	Quite a bit	Moderate	A little bit	No
Lifting medium weights (20-30 lbs) from the floor?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lowering a lightweight object (1-5 lbs) from the top shelf of a closet?	<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"/>
Carrying objects on your shoulders (such as a small child or backpack)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting and carrying a heavy suitcase?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Using a vacuum cleaner?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pushing or pulling a heavy door?	<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 by circling the number below the appropriate response:

<b>Neck FOTO</b>	Extreme/ Unable	Quite a bit of difficulty	Moderate difficulty	Little bit of difficulty	No difficulty
1. Are you having any difficulty looking up to see a bird?	1	2	3	4	5
2. Are you having any difficulty performing personal care activities like washing, dressing, or bathing?	1	2	3	4	5
3. Are you having any difficulty moving your head quickly, such as to follow a loud noise?	1	2	3	4	5
4. Are you having any difficulty performing recreational activities that require little effort (e.g. card playing, knitting, etc.)?	1	2	3	4	5
5. Are you having any difficulty turning to look behind you to drive in a car?	1	2	3	4	5
6. Are you having any difficulty turning over in bed?	1	2	3	4	5
7. Are you having any difficulty sitting and reading a book for 1 hour?	1	2	3	4	5
8. Are you having any difficulty changing a light bulb overhead?	1	2	3	4	5
9. Are you having any difficulty sitting or performing light desk work for 8 hours?	1	2	3	4	5
10. Are you having any difficulty performing recreational activities in which you take some force or impact (e.g. golf, hammering, tennis, etc.)?	1	2	3	4	5

### Therapist Use Only

Sum =    FS Score =    %    Initials:

Sum	FS Score	Sum	FS Score	Sum	FS Score	Sum	FS Score	Sum	FS Score
10	0.0	19	38.4	28	47.8	37	56.4	46	69.8
11	18.4	20	39.6	29	48.7	38	57.4	47	72.6
12	24.1	21	40.8	30	49.6	39	58.6	48	76.2
13	27.6	22	41.9	31	50.5	40	59.8	49	82.0
14	30.2	23	42.9	32	51.4	41	61.1	50	100.0
15	32.3	24	43.9	33	52.4	42	62.5		
16	34.1	25	44.9	34	53.3	43	64.0		
17	35.7	26	45.9	35	54.3	44	65.7		
18	37.1	27	46.8	36	55.3	45	67.6		



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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

**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 depression or bipolar disorder?  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.

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

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

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:	<p align="center"><b>COVID-19 Symptom Verification:</b></p> <p>I understand and will comply with BPT's request to cancel and/or reschedule my appointment(s) if I develop a fever (100.4°F), uncontrolled cough, or atypical new onset of shortness of breath, or at least two of the following not explained by a known physical condition: loss of taste or smell, muscle aches, sore throat, severe headache, diarrhea, vomiting, or abdominal pain.</p>
Initial:	<p align="center"><b>Client Bill of Rights:</b></p> <p>I have read The Client Bill of Rights and agree to maintain by its standards.</p>
Initial:	<p align="center"><b>HIPAA Private Policy Statement:</b></p> <p>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.</p>
Initial:	<p align="center"><b>Consent to Treatment:</b></p> <p>I give my consent for treatment and assignment of claim at Brostrom Physical Therapy.</p>
Initial:	<p align="center"><b>Financial Policy:</b></p> <p>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.</p>
Initial:	<p align="center"><b>Cancellation and No-Show Policy:</b></p> <p>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.</p> <p>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></p> <p>Please initial in the corresponding boxes to indicate your consent to receive electronic appointment reminders:</p> <p> <input type="checkbox"/> Text reminders      <input type="checkbox"/> Email reminders      <input type="checkbox"/> Decline electronic reminders </p>

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

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

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