# Brostrom Physical Therapy

Spine and Extremity Institute of South Lyon, LLC

## Patient Information

**First Name**:_____ **Preferred:** (if applicable) **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 <u>other than your health insurance company</u> 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: <u>Additional</u> 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 <u>Medicare</u> 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? | ◉ | ○ | ○ | ○ | ○ |
| Reach the earlobe on the opposite side as your affected shoulder? | ○ | ○ | ○ | ○ | ○ |
| Turn a faucet in the same direction as your affected arm (e.g. turn right if your right shoulder is affected)? | ○ | ○ | ○ | ○ | ○ |
| Turn a faucet in the opposite direction as your affected arm (e.g. turn left if your right shoulder is affected)? | ○ | ○ | ○ | ○ | ○ |
| Reaching to work overhead for more than 2 minutes? | ○ | ○ | ○ | ○ | ○ |
| Pull a chair out from a table? | ○ | ○ | ○ | ○ | ○ |
| Place a can of soup (1 lb) on a shelf at shoulder height? | ○ | ○ | ○ | ○ | ○ |
| Reach and pull a string controlling a light of a fan? | ○ | ○ | ○ | ○ | ○ |
| Take off glasses or sunglasses? | ○ | ○ | ○ | ○ | ○ |
| Put on underpants using BOTH arms? | ○ | ○ | ○ | ○ | ○ |
| Put deodorant under your opposite arm? | ○ | ○ | ○ | ○ | ○ |
| Participate in rigorous contact sports? | ○ | ○ | ○ | ○ | ○ |
| Place a gallon of milk (8-10 lbs) on a shelf overhead? | ○ | ○ | ○ | ○ | ○ |
| Pick up and drink a full glass of water? | ○ | ○ | ○ | ○ | ○ |
| Open a new tight jar? | ○ | ○ | ○ | ○ | ○ |
| Placing a 25 lb box on a shelf overhead? | ○ | ○ | ○ | ○ | ○ |
| Placing a 50 lb box on a shelf overhead? | ○ | ○ | ○ | ○ | ○ |
| Touch an object in the back seat while sitting in the front seat of a car? | ○ | ○ | ○ | ○ | ○ |
| Flush a toilet? | ○ | ○ | ○ | ○ | ○ |
| Pull on socks or shoes with both hands? | ○ | ○ | ○ | ○ | ○ |
| Steady a jar (with affected arm) while loosening a lid (with unaffected arm)? | ○ | ○ | ○ | ○ | ○ |

**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.**

- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Asthma
- ☐ COPD, ARDS, emphysema
- ☐ Angina (chest pain)
- ☐ Heart disease
- ☐ Heart attack
- ☐ High blood pressure
- ☐ **Degenerative** neurological disease
- ☐ Stroke or TIA
- ☐ Pacemaker
- ☐ Seizures
- ☐ Peripheral Vascular Disease
- ☐ Headaches
- ☐ Diabetes Type I or II
- ☐ Sleep dysfunction
- ☐ Shortness of breath
- ☐ Nausea/Vomiting
- ☐ Depression
- ☐ Bipolar Disorder
- ☐ Allergies ( ☐ seasonal ☐ food ☐ latex/adhesives ☐ meds ☐ lotions/scents) (list:_____)
- ☐ Gastrointestinal Disease (ulcer, hernia, reflux, bowel, liver, gall bladder)
- ☐ Visual impairment (cataracts, glaucoma, macular degeneration)
- ☐ Hearing impairment (very hard of hearing, even with hearing aids)
- ☐ Back pain (neck pain, low back pain, DDD, spinal stenosis)
- ☐ Kidney, bladder, prostate, or urination problems
- ☐ Previous accidents
- ☐ Incontinence/bowel or bladder changes
- ☐ Anxiety or panic disorders
- ☐ Hepatitis, tuberculosis, or other blood-borne condition
- ☐ Prior surgery
- ☐ Prosthesis/Implants
- ☐ Cancer
- ☐ Dizziness
- ☐ Unexplained weight change
- ☐ Numbness or tingling
- ☐ 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 <u>not</u> 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:**<br>I have read The Client Bill of Rights and agree to maintain by its standards. |
| Initial: | **HIPAA Privacy Policy Statement:**<br>I have been given the opportunity to read the *detailed* private policy statement. I understand this information and agree to comply with the policies set forth in the *detailed* disclosure policy. |
| Initial: | **Consent to Treatment:**<br>I give my consent for treatment and assignment of claim at Brostrom Physical Therapy. |
| Initial: | **Financial Policy:**<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: | **Cancellation and No-Show Policy:**<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. **I can withdraw my consent to electronic communications by calling Brostrom Physical Therapy at (248) 446-0155.**<br><br>Please initial in the corresponding boxes to indicate your consent to receive electronic appointment reminders:<br>☐ Text reminders ☐ Email reminders ☐ Decline electronic reminders |

Printed name of Patient/Parent/Legal Guardian:_____

Signature of Patient/Parent/Legal Guardian:_____

Date: _____