# 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 <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

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 □ One 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
_____ Osteoporosis
_____ Asthma
_____ COPD, ARDS, emphysema
_____ Angina (chest pain)
_____ Heart disease
_____ Heart attack
_____ High blood pressure
_____ 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:_____)

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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 <u>current</u> 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: | **COVID-19 Symptom Verification:**<br>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. |
| Initial: | **Client Bill of Rights:**<br>I have read The Client Bill of Rights and agree to maintain by its standards. |
| Initial: | **HIPAA Private 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: _____/_____/_____