



# 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 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)?  
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 – VESTIBULAR

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

Please rate your ability to do the following activities in the last few days by circling the number aside the appropriate response:

### Dizziness Handicap Inventory (DHI)

	Always (4)	Sometimes (2)	No (0)
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P1 Does looking up increase your problem?	<input type="checkbox"/> P	<input type="checkbox"/> P	<input type="checkbox"/> P
E2 Because of your problem, do you feel frustrated?	<input type="checkbox"/> E	<input type="checkbox"/> E	<input type="checkbox"/> E
F3 Because of your problem, do you restrict your travel for business or pleasure?	<input type="checkbox"/> F	<input type="checkbox"/> F	<input type="checkbox"/> F
P4 Does walking down the aisle of a supermarket increase your problem?	<input type="checkbox"/> P	<input type="checkbox"/> P	<input type="checkbox"/> P
F5 Because of your problem, do you have difficulty getting into or out of bed?	<input type="checkbox"/> F	<input type="checkbox"/> F	<input type="checkbox"/> F
F6 Does your problem significantly restrict your participation in social activities, such as going out to dinner, going to the movies, dancing, or to parties?	<input type="checkbox"/> F	<input type="checkbox"/> F	<input type="checkbox"/> F
F7 Because of your problem, do you have difficulty reading?	<input type="checkbox"/> F	<input type="checkbox"/> F	<input type="checkbox"/> F
P8 Does performing more ambitious activities like sports, dancing, and household chores (such as sweeping or putting dishes away) increase your problem?	<input type="checkbox"/> P	<input type="checkbox"/> P	<input type="checkbox"/> P
E9 Because of your problem, are you afraid to leave your home without having someone accompany you?	<input type="checkbox"/> E	<input type="checkbox"/> E	<input type="checkbox"/> E
E10 Because of your problem, have you been embarrassed in front of others?	<input type="checkbox"/> E	<input type="checkbox"/> E	<input type="checkbox"/> E
P11 Do quick movements of your head increase your problem?	<input type="checkbox"/> P	<input type="checkbox"/> P	<input type="checkbox"/> P
F12 Because of your problem, do you avoid heights?	<input type="checkbox"/> F	<input type="checkbox"/> F	<input type="checkbox"/> F
P13 Does turning over in bed increase your problem?	<input type="checkbox"/> P	<input type="checkbox"/> P	<input type="checkbox"/> P
F14 Because of your problem, is it difficult for you to do strenuous housework or yard work?	<input type="checkbox"/> F	<input type="checkbox"/> F	<input type="checkbox"/> F
E15 Because of your problem, are you afraid people may think you are intoxicated?	<input type="checkbox"/> E	<input type="checkbox"/> E	<input type="checkbox"/> E
F16 Because of your problem, is it difficult for you to go on a walk by yourself?	<input type="checkbox"/> F	<input type="checkbox"/> F	<input type="checkbox"/> F
P17 Does walking down a sidewalk increase your problem?	<input type="checkbox"/> P	<input type="checkbox"/> P	<input type="checkbox"/> P
E18 Because of your problem, is it difficult for you to concentrate?	<input type="checkbox"/> E	<input type="checkbox"/> E	<input type="checkbox"/> E
F19 Because of your problem, is it difficult for you to walk around your house in the dark?	<input type="checkbox"/> F	<input type="checkbox"/> F	<input type="checkbox"/> F
E20 Because of your problem, are you afraid to stay home alone?	<input type="checkbox"/> E	<input type="checkbox"/> E	<input type="checkbox"/> E
E21 Because of your problem, do you feel handicapped?	<input type="checkbox"/> E	<input type="checkbox"/> E	<input type="checkbox"/> E
E22 Has your problem placed stress on your relationship with members of your family or friends?	<input type="checkbox"/> E	<input type="checkbox"/> E	<input type="checkbox"/> E
E23 Because of your problem, are you depressed?	<input type="checkbox"/> E	<input type="checkbox"/> E	<input type="checkbox"/> E
F24 Does your problem interfere with your job or household responsibilities?	<input type="checkbox"/> F	<input type="checkbox"/> F	<input type="checkbox"/> F
P25 Does bending over increase your problem?	<input type="checkbox"/> P	<input type="checkbox"/> P	<input type="checkbox"/> P

**Therapist Use Only**

Total P =      Total E =      Total F =      Total =      / 100

Initials:



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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 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 ) (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"/> Degenerative 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"/> Prostheses/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: _____)
<input type="checkbox"/> Depression	

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:

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

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> 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: <input type="checkbox"/> Text reminders <input type="checkbox"/> Email reminders <input type="checkbox"/> Decline electronic reminders		

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

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

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