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 – Lymphedema

Name:_____ Date:_____/_____/_____

Lymphedema Life Impact Scale

Instructions: Listed below are symptoms or problems reported by many individuals with lymphedema. Please indicate to what extent these problems associated with your lymphedema have affected you **in the past week**. Circle the number which best describes your symptom level.

I. Physical Concerns. NOTE: If swelling and symptoms are the same in both limbs, rate them the same; otherwise, rate **only** the worst limb.					
1. The amount of pain associated with my lymphedema is:	0 No pain	1	2	3	4 Severe pain
2. The amount of limb heaviness associated with my lymphedema is:	0 No heaviness	1	2	3	4 Extremely heavy
3. The amount of skin tightness associated with my lymphedema is:	0 No tightness	1	2	3	4 Extremely tight
4. The size of my swollen limb seems:	0 Normal size	1	2	3	4 Extremely large
5. Lymphedema affects the movement of my swollen limbs:	0 Normal movement	1	2	3	4 Extremely limited
6. The strength in my swollen limbs is:	0 Normal strength	1	2	3	4 Extremely weak
II. Psychosocial Concerns.					
7. Lymphedema affects my body image (how I think I look):	0 Not at all	1	2	3	4 Completely
8. Lymphedema affects my socializing with others.	0 No interference	1	2	3	4 Interferes completely
9. Lymphedema affects my intimate relations with spouse or partner (rate 0 if not applicable).	0 No interference	1	2	3	4 Interferes completely
10. Lymphedema "gets me down" (i.e., I have feelings of depression, frustration, or anger due to the lymphedema).	0 Never	1	2	3	4 Constantly
11. I must rely on others for help due to my lymphedema.	0 Not at all	1	2	3	4 Completely
12. I know what to do to manage my lymphedema.	0 Good understanding	1	2	3	4 No understanding
III. Functional Concerns.					
13. Lymphedema affects my ability to perform self-care activities (i.e., eating, dressing, hygiene).	0 No interference	1	2	3	4 Interferes completely
14. Lymphedema affects my ability to perform routine home or work-related activities.	0 No interference	1	2	3	4 Interferes completely
15. Lymphedema affects my performance of preferred leisure activities.	0 No interference	1	2	3	4 Interferes completely
16. Lymphedema affects the proper fit of clothing/shoes.	0 Fits normally	1	2	3	4 Unable to wear
17. Lymphedema affects my sleep.	0 No interference	1	2	3	4 Interferes completely
IV. Infection Occurrence. (For reference only; do not include in score).					
In the past year, I have become ill with an infection in my swollen limb requiring oral antibiotics or hospitalization.	0 times	1 time	2 times	3 times	4+ times
TO BE COMPLETED BY PHYSICAL THERAPIST. Total:					
Total Impairment Score: $\frac{Total\ score}{(\#\ of\ sections\ completed\ x\ 4)} x100\% =$ _____ = %	**PT Signature:** _____ Amy Waltz, PT, MPT, CLT				

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Do you experience swelling/lymphedema? (Please check all that apply)

☐ right arm ☐ left arm ☐ both arms ☐ breast ☐ right leg ☐ left leg ☐ both legs ☐ head & neck ☐ genital

Other, please explain: _____

Have you been diagnosed with Lymphedema? ☐ Yes ☐ No

If yes, by whom:_____

How long have you had swelling/lymphedema? _____

Was there a triggering event which caused the swelling/Lymphedema?_____

_____

Please briefly describe how and why your swelling/lymphedema have developed:

_____

_____

Have you had any surgery? ☐ Yes ☐ No

If yes, list surgeries and dates:_____

_____

Have you had any lymph nodes removed? ☐ Yes ☐ No

If yes, how many: _____

Have you ever received radiation therapy for cancer? ☐ Yes ☐ No

If yes, list areas of radiation and dates here: _____

_____

Have you had Chemotherapy? ☐ Yes ☐ No

If yes, how long ago?_____

Have you had any infections (Cellulitis)? ☐ Yes ☐ No

If yes, how long ago was the last one?_____

If there a family history of Lymphedema? ☐ Yes ☐ No

If yes, please explain:_____

Do you have pain? ☐ Yes ☐ No

If yes, please explain:_____

Do you experience any loss of function or mobility? ☐ Yes ☐ No

If yes, please explain:_____

Do you have difficulty with any of the following?

☐ Walking ☐ Reaching feet and toes ☐ Preparing meals

☐ Dressing ☐ Bathing/showering ☐ Other

If other, please explain:_____

_____

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What is your current living situation?

☐ Private home/apartment (alone)
☐ Home with spouse or companion
☐ Nursing home
☐ Assisted living
☐ Hospice
☐ Other

If other, please explain:_____

Do you currently suffer from (or have you had) any of the following:

☐ Asthma
☐ Bronchitis
☐ Difficulty breathing
☐ Irregular heart beat
☐ Heart edema
☐ Hypertension
☐ Hyperthyroidism
☐ Kidney failure
☐ Diabetes
☐ Infections (Cellulitis)
☐ Sleep apnea
☐ Malignancy (Cancer)
☐ Crohn's Disease
☐ Diverticulitis
☐ Recent abdominal surgery
☐ Unexplained pain
☐ Deep Venous Thrombosis (blood clot)
☐ Latex allergy

Do you have any other medical problems not listed above? ☐ Yes ☐ No
If yes, please explain:_____

Are you allergic to: Latex Surgical Tape Foam Products Other
If other, please explain:_____

At the time you are completing this, are you, or is there a chance you could be pregnant? Yes No

Have you had any previous treatment for swelling/lymphedema? ☐ Yes ☐ No
If yes, check all that apply:

☐ Manual Lymph Drainage (MLD)
☐ Compression Bandaging
☐ Lymphedema Exercise
☐ Compression Pump
☐ Flexitouch
☐ Low level laser
☐ Compression garments

If yes, please explain your experience, success, or lack of success:_____

_____

_____

Do you currently wear a compression sleeve or stocking? ☐ Yes ☐ No
If yes, how often do you wear it and how old is it?_____

_____

Do you currently use compression at night? ☐ Yes ☐ No
If yes, please explain:_____

_____

Do you exercise regularly? ☐ Yes ☐ No
If yes, please explain:_____

Are you familiar with the National Lymphedema Network? ☐ Yes ☐ No

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Are you familiar with the precautions (risk reduction practices) for Lymphedema? ☐ Yes ☐ No

Are you a member of a breast cancer or lymphedema support group? ☐ Yes ☐ No
If yes, please explain:_____

Is there anything else you would like to tell us at this time?_____

_____

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

Height: _____ feet _____ inches **Weight**: _____ lbs

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 (accompanied with the date of the surgery), recent hospitalizations, and pertinent past medical history:

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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_____ 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:_____)

Consent to Photography

By signing this form, I authorize Brostrom Physical Therapy, its employees, agents, and attending medical staff to record or document examinations, medical procedures, and other images of me through the means of photography or digital imaging, and any other later developed mediums which result in the permanent documentation of the patient's image for use in connection with my care and treatment only. I agree that duplicates may be made for and/or released to my referring Physician.

I agree photographs taken by Brostrom Physical Therapy, which are not required by law to be retained, may be disposed of by Brostrom Physical Therapy, provided the manner of disposition shall be permanent destruction.

I acknowledge that there were no promises of compensation for such use of medical photo(s) taken by Brostrom Physical Therapy as consented.

I hereby waive all rights and release Brostrom Physical Therapy from any claim or cause of action, whether now known or unknown, for defamation, invasion of right to privacy, publicity, or personality or any similar matter, or based upon or relating to the use and exploitation of my name, image, and likeness.

This consent may be revocable by me at any time.

_____
Patient Name

□ I was offered this service but politely decline.
□ I decline a personal copy of this form.

_____
Patient and/or Legal Representative's Signature

_____/_____/ 2024_____
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:	**COVID-19 Symptom Verification:** 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:** I have read The Client Bill of Rights and agree to maintain by its standards.
Initial:	**HIPAA Private Policy Statement:** 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:** I give my consent for treatment and assignment of claim at Brostrom Physical Therapy.
Initial:	**Financial Policy:** 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:** 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. **I can withdraw my consent to electronic communications by calling Brostrom Physical Therapy at (248) 446-0155.** Please initial in the corresponding boxes to indicate your consent to receive electronic appointment reminders: ☐ Text reminders ☐ Email reminders ☐ Decline electronic reminders

Printed name of Patient/Parent/Legal Guardian:_____

Signature of Patient/Parent/Legal Guardian:_____

Date: _____/_____/_____