Life's Work Physical Therapy

Patient Questionnaire

GENERAL INFORMATION

Today's date: ____________

Last Name *First* *Middle* *Date of Birth*

Street Address *City* *State* *Zip*

Status: ☐ Married ☐ Single ☐ Divorced ☐ Other

Contact methods: *indicate preference by checking box*

☐ Home #: ____________ ☐ Cell #: ____________

☐ Work #: ____________ ☐ Email: ____________

Your Employer: *Employer Phone*

Emergency contact *Relationship* *Phone*

INSURANCE:

Name of subscriber if different from yours Birth date of subscriber

PROVIDER INFORMATION

How did you hear about our clinic? ____________

1. MEDICATIONS

Please list any prescription medications you are taking:

Indicate any over-the-counter medications you are taking:

☐ Advil/Aleve ☐ Antihistamines
☐ Antacids ☐ Decongestants
☐ Aspirin ☐ Tylenol

Supplements/Other ____________

2. ☐ **Right Handed** ☐ **Left Handed**

3. FAMILY HISTORY

Indicate (**M**)Mother (**F**)Father (**B**)Brother (**S**)Sister have had:

_____ Arthritis _____ Heart disease _____ Psychological

_____ Cancer _____ Hypertension _____ Stroke

_____ Diabetes _____ Osteoporosis _____ Other

4. GENERAL HEALTH/LIFESTYLE HABITS

My health is currently: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Life changes in the past year (new baby, job etc)? ☐ Y ☐ N

☐ I smoke:_____ packs per day_____ cigars/pipes per day

☐ I stopped smoking in _____ (year)

I average _____ (beers, glasses of wine, cocktails) per week.

Beyond normal daily activities, I do the following exercise(s):

____

5. HEALTH CHANGES in the past year:

☐ Arm/Leg numbness/tingling ☐ Hoarseness
☐ Bladder problems/changes ☐ Joint pain or swelling
☐ Bowel problems/changes ☐ Loss of appetite
☐ Chest pain ☐ Loss of balance
☐ Coordination problem ☐ Nausea/vomiting
☐ Cough ☐ Other changes (hair loss, perspiration)
☐ Difficulty sleeping ☐ Pain at night
☐ Difficulty swallowing ☐ Pain with squatting/sitting
☐ Difficulty walking ☐ Ringing in ears
☐ Dizziness/blackouts ☐ Oral sensation changes
☐ Drop attacks ☐ Shortness of breath
☐ Fever/chills ☐ Vision problems
☐ Hearing problems ☐ Unexplained weight change
☐ Heart palpitations ☐ Other (explain):

6. PAST MEDICAL HISTORY

☐ Allergies ☐ Kidney problems
☐ Anxiety/Depression ☐ Low blood sugar
☐ Arthritis ☐ Lung problems
☐ Balance Disorders ☐ Multiple sclerosis
☐ Broken bones/fractures ☐ Muscular dystrophy
☐ Bronchitis ☐ Neurological
☐ COPD ☐ Osteoporosis
☐ Cancer ☐ Parkinson's Disease
☐ Development/growth problems ☐ Pneumonia
☐ Diabetes ☐ Motor Vehicle Accident(s)
☐ Epilepsy/seizures ☐ Repeated infections

6. PAST MEDICAL HISTORY *(continued)*

☐ Fibromyalgia
☐ Head injury
☐ Headaches/migraines
☐ Heart problems
☐ Hepatitis
☐ High Cholesterol
☐ Hypertension
☐ Infectious disease (eg TB)
☐ Skin diseases
☐ Sleep apnea
☐ Sprain or strain
☐ Stroke
☐ Thyroid problems
☐ Trauma
☐ Ulcer/stomach problems
☐ Whiplash

7. SURGERY

Please list where/when you've been hospitalized or had surgery.

____

____

8. REPRODUCTIVE HEALTH

Have you ever experienced:

☐ Prostate disease *(men only)*

☐ Pregnancy/delivery complications
☐ Current pregnancy
☐ Endometriosis
☐ Menstrual trouble
☐ Other OB/GYN difficulties
☐ Pelvic inflammatory disease

If so, please describe: ______________________________

9. CURRENT CONDITIONS / CHIEF COMPLAINT(S)

____

Please describe your problem

Date when current episode began: _____

____

Does anything make the problem(s) better?

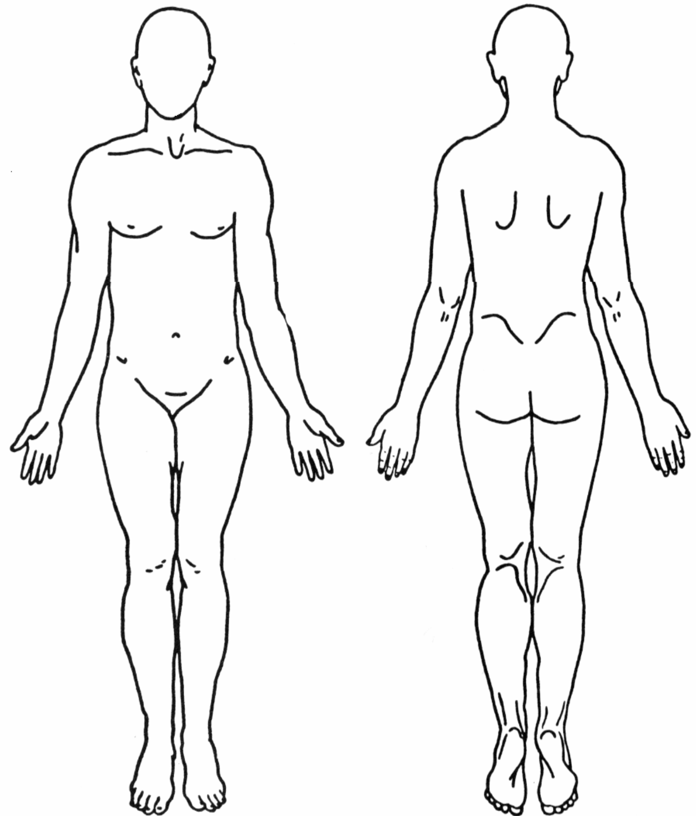
____

Does anything make the problem(s) worse?

OTHER CLINICAL TESTS in the past year:

☐ Angiogram
☐ Arthroscopy
☐ Biopsy
☐ Blood tests
☐ Bone scan
☐ Bronchoscopy
☐ CT scan
☐ Doppler ultrasound
☐ Echocardiogram
☐ EEG
☐ EKG
☐ EMG
☐ Mammogram
☐ MRI
☐ Myelogram
☐ Nerve conduction test
☐ Pap smear
☐ Pulmonary function test
☐ Spinal tap
☐ Stool test
☐ Ultrasound
☐ Urine test
☐ X-rays
☐ Other:

Place an X to indicate where you feel pain:



Place an X on the scale below to indicate your worst pain in the last 24 hrs.

0 ____ **10**

No Pain **Worst Pain Imaginable**

10. SOCIAL HISTORY

Are there any customs/religious beliefs that may impact your care? ☐ Y ☐ N

Have you completed an advanced directive (e.g. CPR)? ☐ Y ☐ N

I am *(check all that apply)* ☐ a full time or ☐ part-time student

Job title/duties: _____

Is this a ☐ full duty or ☐ light duty position?

CARE CONNECTIONS

LUMBAR

NAME ______________________ DATE ______________

TIME __________ AM/PM ☐ Initial Visit ☐ Discharge Visit

FUNCTIONAL INDEX

Choose the one answer in each section that best describes your condition.

WALKING

☐ Symptoms do not prevent me walking any distance.
☐ Symptoms prevent me walking more than 1 mile.
☐ Symptoms prevent me walking more than 1/2 mile.
☐ Symptoms prevent me walking more than 1/4 mile.
☐ I can only walk using a stick or crutches.
☐ I am in bed most of the time and have to crawl to the toilet.

WORK

(Applies to work in home and outside)

☐ I can do as much work as I want to.
☐ I can only do my usual work, but no more.
☐ I can do most of my usual work, but no more.
☐ I cannot do my usual work.
☐ I can hardly do any work at all (only light duty).
☐ I cannot do any work at all.

PERSONAL CARE

(Washing, Dressing, etc.)

☐ I can manage all personal care without symptoms.
☐ I can manage all personal care with some increased symptoms.
☐ Personal care requires slow, concise movements due to increased symptoms.
☐ I need help to manage some personal care.
☐ I need help to manage all personal care.
☐ I cannot manage any personal care.

SLEEPING

☐ I have no trouble sleeping.
☐ My sleep is mildly disturbed (less than 1 hr. sleepless).
☐ My sleep is mildly disturbed (1–2 hrs. sleepless).
☐ My sleep is moderately disturbed (2–3 hrs. sleepless).
☐ My sleep is greatly disturbed (3–5 hrs. sleepless).
☐ My sleep is completely disturbed (5–7 hrs. sleepless).

RECREATION/SPORTS

(Indicate Sport if Appropriate ________________________)

☐ I am able to engage in all my recreational/sports activities without increased symptoms.
☐ I am able to engage in all my recreational/sports activities with some increased symptoms.
☐ I am able to engage in most, but not all of my usual recreational/sports activities because of increased symptoms.
☐ I am able to engage in a few of my usual recreational/sports activities because of my increased symptoms.
☐ I can hardly do any recreational/sports activities because of increased symptoms.
☐ I cannot do any recreational/sports activities at all.

DRIVING

☐ I can drive my car or travel without any extra symptoms.
☐ I can drive my car or travel as long as I want with slight symptoms.
☐ I can drive my car or travel as long as I want with moderate symptoms.
☐ I cannot drive my car or travel as long as I want because of moderate symptoms.
☐ I can hardly drive at all or travel because of severe symptoms.
☐ I cannot drive my car or travel at all.

LIFTING

☐ I can lift heavy weights without extra symptoms.
☐ I can lift heavy weights, but it gives extra symptoms.
☐ My symptoms prevent me from lifting heavy weights, but I manage if they are conveniently positioned. (e.g. on a table)
☐ My symptoms prevent me from lifting heavy weights, but I manage light to medium weights if they are conveniently positioned.
☐ I can lift only very light weights.
☐ I cannot lift or carry anything at all.

STANDING

☐ I can stand as long as I want without increased symptoms.
☐ I can stand as long as I want, but it gives me extra symptoms.
☐ Symptoms prevent me from standing for more than 1 hour.
☐ Symptoms prevent me from standing for more than 30 minutes.
☐ Symptoms prevent me from standing for more than 10 minutes.
☐ Symptoms prevent me from standing at all.

SQUATTING

☐ I can squat fully without the use of my arms for support.
☐ I can squat fully, but with symptoms or using my arms for support.
☐ I can squat 3/4 of my normal depth, but less than fully.
☐ I can squat 1/2 of my normal depth, but less than 3/4.
☐ I can squat 1/4 of my normal depth, but less than 1/2.
☐ I am unable to squat any distance due to symptoms .

SITTING

☐ I can sit in any chair as long as I like.
☐ I can only sit in my favorite chair as long as I like.
☐ My symptoms prevent me sitting more than 1 hour.
☐ My symptoms prevent me sitting more than 1/2 hour.
☐ My symptoms prevent me sitting more than 10 minutes.
☐ My symptoms prevent me from sitting at all.

** Lumbar questions adapted from Oswestry.*

ACUITY *(Answer on initial visit.)*

How many days ago did onset/injury occur? __________ days

Please complete opposite side

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PAIN INDEX

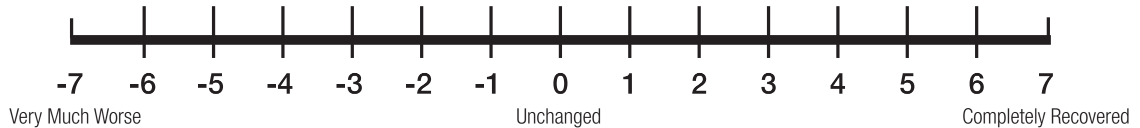
Please indicate the worst your pain has been in the last 24 hours on the scale below

No Pain Worst Pain Imaginable

PLEASE DO NOT COMPLETE THE FOLLOWING SECTIONS ON FIRST VISIT

GLOBAL RATING OF CHANGE

With respect to the reason you sought treatment, how would you describe yourself now compared to your first treatment at our clinic? (Circle one)



-7 -6 -5 -4 -3 -2 -1 0 1 2 3 4 5 6 7

Very Much Worse — Unchanged — Completely Recovered

■ WORK STATUS *(check most appropriate)*

1. ❐ No lost work time
2. ❐ Return to work without restriction
3. ❐ Return to work with modification
4. ❐ Have not returned to work
5. ❐ Not employed outside the home

Work days lost due to condition:_____________ days

I am aware that the information gathered on this form may be used anonymously for research or publication. Please initial: ____________

Pain Survey

Here are some of the things other patients have told us about their pain. For each statement please circle the number from 0 to 6 to indicate how much physical activities such as bending, lifting, walking or driving affect or would affect your pain.

	Completely Disagree			Unsure			Completely Agree
1. Physical activity makes my pain worse.	0	1	2	3	4	5	6
2. Physical activity might harm my ___________ (back, leg etc.)	0	1	2	3	4	5	6
3. I should not do physical activities which (might) make my pain worse.	0	1	2	3	4	5	6
4. I cannot do physical activities which (might) make my pain worse.	0	1	2	3	4	5	6

The following statements are about how your normal work affects or would affect your pain.

	Completely Disagree			Unsure			Completely Agree
5. My pain was caused by work or by an accident while working.	0	1	2	3	4	5	6
6. Work aggravated my pain.	0	1	2	3	4	5	6
7. My work is too heavy for me.	0	1	2	3	4	5	6
8. My work makes or would make my pain worse.	0	1	2	3	4	5	6
9. My work might harm my ________________ (back, leg etc.)	0	1	2	3	4	5	6
10. I should not do my regular work with my present pain.	0	1	2	3	4	5	6
11. I do not think that I will be back to my normal work within 3 months.	0	1	2	3	4	5	6

Name : ____ Date: ________________________

MEDICAL CONSENT

I authorize Life's Work Physical Therapy to perform an evaluation and any resulting treatments for my current condition and other conditions at my request. I understand that this may include manual testing, measurement of joint and muscle function, manual therapy techniques, palpation, and modalities such as electrical stimulation or ultrasound. I understand that I will be asked to fill out a medical questionnaire, my blood pressure may be taken and various evaluations will be performed to assure my safety and well being during the evaluation and treatment process. I understand that I am being seen under Direct Access in accordance with all appropriate regulatory agencies. I understand that no Life's Work representative will ask me to do anything that intentionally hurts or injures me. I understand that I have the right to revoke consent at any time in writing.

CONSENT FOR RELEASE OF INFORMATION

I authorize the release of any information required by my insurance carrier, government agency, or any entity responsible for processing or paying my claims for medical benefits and such consent is valid for the life of the claim. I authorize information from my medical record to be reviewed by employees of my insurance company, their agents or my health care providers. I authorize Life's Work to release a copy of my medical record to another health care provider to which I have been referred for the purpose of providing care. I understand that information from my medical record may be reviewed or released while I am receiving care or after discharge, and this information will be held confidential, except as allowed by law. I understand that a facsimile or photographic copy shall be as valid as the original.

RESPONSIBILITY FOR PERSONAL PROPERTY

I agree that Life's Work is not responsible for my personal items.

STATEMENT OF FINANCIAL RESPONSIBILITY

I understand that Life's Work Physical Therapy performs insurance billings and verification of benefits as a courtesy, but ultimate financial responsibility is mine, and I agree to pay for services rendered according to Life's Work Physical Therapy's rates and terms. I understand I am responsible for charges not covered by my insurance or other agency, which may include a deductible, co-pay, and/or co-insurance, within 30 days of receipt. I understand that outstanding balances will incur a penalty and may be turned over to a collection agency after 30 days. As a parent or legal guardian of a minor patient, I agree to pay in accordance with the terms and conditions set forth in this financial policy. As a self-paying patient, I understand that I am responsible for payment by personal check, credit card or cash at the time of service.

ASSIGNMENT OF INSURANCE BENEFITS

I authorize payment of all insurance or health plan benefits directly to Life's Work Physical Therapy. If I am applying for payment under Medicare or Medicaid, I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for services rendered to Life's Work Physical Therapy and authorize them to submit a claim to Medicare or Medicaid on my behalf. I am the patient, or I am authorized as the patient's agent to execute the terms of this document, or I assume individually all financial responsibility by signing below.

CANCELLATION POLICY

Patients who provide less than 24 hours notice of cancellation may be charged directly $35.00 for the first late cancellation. Future late cancellations or no-shows require full payment for the visit or $125.00. These fees will not be billed to your insurance; it is your responsibility and will need to be paid in full before your next visit. Patients who frequently fail to notify us of cancellation within 24 BUSINESS hours may be removed from the schedule.

I CERTIFY THAT I HAVE READ, FULLY UNDERSTAND, AND CONSENT TO THE TERMS SET FORTH IN THIS DOCUMENT. I ALSO CERTIFY THAT I RECEIVED THE NOTICE OF PATIENT PRIVACY PRACTICES AND I UNDERSTAND MY RIGHTS TO PRIVACY OF MY PERSONAL HEALTH INFORMATION AS DEFINED WITHIN THIS DOCUMENT

Patient name: ______________________________
(please print)

Patient Signature ______________________________ Date ______________

Witness Signature ______________________________ Date ______________

NOTICE OF PATIENT PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE READ IT CAREFULLY

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatments. This information is often referred to as your health or medical records and serves as a:

- Basis of planning your care and treatment
- Means of communication among the health professionals participating in your care
- Legal document describing the care you received
- Means by which you or a third-party payer can certify that the services billed were actually provided
- A source of information for public health officials charged with improving the health of the nation
- A tool with which we can assess and continually work on to improve the care we deliver and the outcomes we achieve

Understanding what is in your record and how your health information is used helps you to ensure its accuracy; make more informed decisions when authorizing disclosure to others; and better understand who, what, when, where, and why others may access your health information.

Understanding Your Health Information Rights

Although your health record is the physical property of the healthcare provider, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information (45 CFR 164.522)
- Obtain a paper copy of the notice of information practices upon request
- Inspect and obtain a copy of your health record (45 CFR 164.524)
- Request to amend your health record (45 CFR 164.528)
- Obtain an accounting of disclosures of your health information (45 CFR 164.528)
- Request communications of your health information by alternative means or at alternative locations
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken

Our Responsibilities

We are required to:

- Maintain privacy of your health information
- Provide you with a notice as to our legal duties & privacy practices with respect to your information
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction on disclosure or amendment to your record
- Accommodate reasonable requests you may have to communicate health information by alternative means or locations

We reserve the right to change our practices and to make the changes effective for all protected health information we maintain. If our information practices change, we will notify you the next time you come to our office for treatment.

If you have questions and would like additional information, you may contact our Privacy Officer at (503) 295-2585. If you believe your privacy rights have been violated, you can file a complaint with the Privacy Officer or with the secretary of Health and Human Services. We will not retaliate if you file a complaint.

<u>Examples of Disclosures for Treatment, Payment and Health Operations</u>

We will use and disclose your health information for treatment. For example, information obtained by us will be recorded in your record and used to determine the course of treatment that should work best for you. Members of your healthcare team will then record the actions they took and their observations. In that way, your physicians and other providers will know how you are responding to treatment. Copies of these records, as well as other reports will be provided to other providers participating in your care to assist them in treating you if you are referred to them for consultation.

We will use and disclose your health information for payment. For example, a bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used. Additionally, we may be required to forward additional information to substantiate the medical necessity of the care delivered and that the care for which the claim was submitted was actually delivered. Further, we may disclose health information to the extent authorized and to the extent necessary to comply with workers compensation or other similar programs established by law.

We will use your health information for regular health operations. For example, members of our quality improvement team may use the information in your health record to assess the care and outcomes in your case and others like it. The information will then be used to continually improve the quality & effectiveness of the healthcare and service we provide.

Business Associates: There may be at some point in time services provided in our organization through contracts with business associates. Examples could include services by laboratories, copy services, and transcription services. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do. However, to protect your health information we require the business associate to appropriately safeguard your information.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, of your location and general condition.

Family Communication: After careful judgment, we may disclose to a family member or other person you designate, health information relevant to that person's involvement in your care or payment related to your care.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Public Health: As required by law, we may disclose health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.

Law Enforcement and Correctional Institution: We may disclose health information for law enforcement purposes as required by law. Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority, provided that we or our business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers, or the public.

EFFECTIVE DATE: <u>April 1, 2003</u>

NPP Form 4/1/03