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 – Jaw

Name:_____ Date:____/____/____

TMD Disability Index: *Please check the one statement that best pertains to you (not necessarily exactly) in each of the following categories:*

Section 1: Communication (Talking)

____(0) I can talk as much as I want without pain, fatigue, or discomfort.
____(1) I talk as much as I want, but it causes some pain, fatigue and/or discomfort.
____(2) I can't talk as much as I want because of pain, fatigue and/or discomfort.
____(3) I can't talk much at all because of pain, fatigue and/or discomfort.
____(4) Pain prevents me from talking at all.

Section 2: Normal Living Activities (Brushing Teeth/Flossing)

____(0) I am able to care for my teeth and gums in a normal fashion without restriction, and without pain, fatigue or discomfort.
____(1) I am able to care for all my teeth and gums, but I must be slow and careful, otherwise pain/discomfort, jaw tiredness results.
____(2) I care for my teeth and gums in a normal fashion, but it usually causes some pain/discomfort/tiredness no matter how slow and careful I am.
____(3) I am unable to properly clean all my teeth and gums because of restricted opening and/or pain.
____(4) I am unable to care for most of my teeth and gums because of restricted opening and/or pain.

Section 3: Normal Living Activities (Eating, Chewing)

____(0) I can eat and chew as much of anything I want without pain/discomfort or jaw tiredness.
____(1) I can eat and chew most anything I want, but it sometimes causes pain/discomfort and/or jaw tiredness.
____(2) I can't eat much of anything I want, because it often causes pain/discomfort, jaw tiredness or because of restricted opening.
____(3) I must eat only soft foods (consistency of scrambled eggs or less) because of pain/discomfort, jaw fatigue and/or restricted opening.
____(4) I must stay on a liquid diet because of pain and/or restricted opening.

Section 4: Social/Recreational Activities (Singing, Playing Musical Instruments, Cheering, Laughing, Social Activities, Playing Amateur Sports/Hobbies, and Recreation, etc)

____(0) I am enjoying a normal social life and/or recreational activities without restriction.
____(1) I participate in normal social life and/or recreational activities but pain/discomfort is increased.
____(2) The presence of pain and/or fear of likely aggravation only limits the more energetic components of my social life.
____(3) I have restrictions socially, as I can't even sing, shout, cheer, play and/or laugh expressively because of increased pain/discomfort.
____(4) I have practically no social life because of pain.

Section 5: Non-Specialized Jaw Activities (Yawning, Mouth Opening and Opening my Mouth Wide)

____(0) I can yawn in a normal fashion, painlessly.
____(1) I can yawn and open my mouth fully wide open, but sometimes there is discomfort.
____(2) I can yawn and open my mouth wide in a normal fashion, but it almost always causes discomfort.
____(3) Yawning and opening my mouth wide are somewhat restricted by pain.
____(4) I cannot yawn or open my mouth more than two finger widths (2.8-3.2 cm) or, if I can, it always causes greater than moderate pain.

Section 6: Sexual Function (Including Kissing, Hugging, and Any and All Sexual Activities to Which You Are Accustomed)

____(0) I am able to engage in all my customary sexual activities and expressions without limitation and/or causing headache, face/jaw pain.
____(1) I am able to engage in all my customary sexual activities and expressions, but it sometimes causes headaches, face/jaw pain/fatigue.
____(2) I am able to engage in all my customary sexual activities and expressions, but it usually causes enough headache, face or jaw pain to markedly interfere with my enjoyment, willingness and satisfaction.
____(3) I must limit my customary sexual expression and activities because of headache, face or jaw pain or limited mouth opening.
____(4) I abstain from almost all sexual activities and expression because of the head, face or jaw pain it causes.

Section 7: Sleep (Restful, Nocturnal Sleep Pattern)

____(0) I sleep well in a normal fashion without any pain medication, relaxants or sleeping pills.
____(1) I sleep well with the use of pain pills, anti-inflammatory medication or medicinal sleeping aides.
____(2) I fail to realize 6 hours restful sleep even with the use of pills.
____(3) I fail to realize 4 hours restful sleep even with the use of pills.
____(4) I fail to realize 2 hours restful sleep even with the use of pills.

Section 8: Effects of Any Form of Treatment Including, But Not Limited to, Medications, In-office Therapy, Oral Orthotics (eg Splints, Mouthpieces, Ice/Heat, etc)

____(0) I do not need to use treatment of any type in order to control or tolerate headache, face or jaw pain and discomfort.
____(1) I get partial, but significant, relief through some form of treatment.
____(2) I get partial, but significant, relief through some form of treatment.
____(3) I don't get "a lot of" relief from any form of treatment.
____(4) There is no form of treatment that helps enough to make me want to continue.

Section 9: Tinnitus, or Ringing in the Ear(s)

____(0) I do not experience ringing in my ear(s).
____(1) I experience ringing in my ear(s) somewhat, but it does not interfere with my sleep and/or my ability to perform my daily activities.
____(2) I experience ringing in my ear(s) and it interferes with my sleep and/or daily activities, but I can accomplish set goals and I can get an acceptable amount of sleep.
____(3) I experience ringing in my ear(s) and it causes a marked impairment in the performance of my daily activities and/or results in an unacceptable loss of sleep.
____(4) I experience ringing in my ear(s) and it is incapacitating and/or forces me to use a masking device to get any sleep.

Section 10: Dizziness (Lightheaded, Spinning and/or Balance Disturbance)

____(0) I do not experience dizziness.
____(1) I experience dizziness, but it does not interfere with my daily activities.
____(2) I experience dizziness which interferes somewhat with my daily activities, but I can accomplish my set goals.
____(3) I experience dizziness, which causes a marked impairment in the performance of my daily activities.
____(4) I experience dizziness, which is incapacitating.

For Therapist Use Only:
/ = % Disability

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Health Questionnaire – Cervical Spine/Thoracic Spine

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 3 times per week □ Once or twice a week □ Seldom/never

Because of your neck, how much difficulty do you have:	**Extreme/Unable**	**Quite a bit**	**Moderate**	**A little bit**	**No**
Lifting medium weights (20-30 lbs) from the floor?	□	□	□	□	□
Lowering a lightweight object (1-5 lbs) from the top shelf of a closet?	□	□	□	□	□
Placing a 25 lb box on a shelf overhead?	□	□	□	□	□
Placing a 50 lb box on a shelf overhead?	□	□	□	□	□
Carrying objects on your shoulders (such as a small child or backpack)?	□	□	□	□	□
Lifting and carrying a heavy suitcase?	□	□	□	□	□
Using a vacuum cleaner?	□	□	□	□	□
Pushing or pulling a heavy door?	□	□	□	□	□
Using a shovel to dig a hole in the dirt?	□	□	□	□	□
Move your head quickly such as to follow a loud noise?	□	□	□	□	□
Reaching to work overhead for more than 2 minutes?	□	□	□	□	□
Touching an object in the back seat while sitting in the front seat of a car?	□	□	□	□	□
Bending over to clean a bathtub?	□	□	□	□	□

Please rate your ability to do the following activities in the last week:

Neck FOTO*	**Extreme/ Unable**	**Quite a bit of difficulty**	**Moderate difficulty**	**Little bit of difficulty**	**No difficulty**
1. Are you having any difficulty looking up to see a bird?	1	2	3	4	5
2. Are you having any difficulty performing personal care activities like washing, dressing, or bathing?	1	2	3	4	5
3. Are you having any difficulty moving your head quickly, such as to follow a loud noise?	1	2	3	4	5
4. Are you having any difficulty performing recreational activities that require little effort (e.g. card playing, knitting, etc.)?	1	2	3	4	5
5. Are you having any difficulty turning to look behind you to drive in a car?	1	2	3	4	5
6. Are you having any difficulty turning over in bed?	1	2	3	4	5
7. Are you having any difficulty sitting and reading a book for 1 hour?	1	2	3	4	5
8. Are you having any difficulty changing a light bulb overhead?	1	2	3	4	5
9. Are you having any difficulty sitting or performing light desk work for 8 hours?	1	2	3	4	5
10. Are you having any difficulty performing recreational activities in which you take some force or impact (e.g. golf, hammering, tennis, etc.)?	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**
10	0.0	**19**	38.4	**28**	47.8	**37**	56.4	**46**	69.8
11	18.4	**20**	39.6	**29**	48.7	**38**	57.4	**47**	72.6
12	24.1	**21**	40.8	**30**	49.6	**39**	58.6	**48**	76.2
13	27.6	**22**	41.9	**31**	50.5	**40**	59.8	**49**	82.0
14	30.2	**23**	42.9	**32**	51.4	**41**	61.1	**50**	100.0
15	32.3	**24**	43.9	**33**	52.4	**42**	62.5		
16	34.1	**25**	44.9	**34**	53.3	**43**	64.0		
17	35.7	**26**	45.9	**35**	54.3	**44**	65.7		
18	37.1	**27**	46.8	**36**	55.3	**45**	67.6		

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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 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:_____)

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:	**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: _____/_____/_____