Clifton-Fine Hospital

Physical Therapy Patient Information

Name: ______________________________ DOB:_________________ Date:__________________

1. Please describe your reason for coming to therapy and what symptoms you are currently having:____
   ____
2. When did your problem begin?:____
3. Describe how your problem began.____
   ____
4. How much of the time do you have symptoms?
   [ ]Constant(76-100%) [ ]Occasional(26-50%)
   [ ]Frequent(51-75%) [ ]Intermittent(25% or less)
5. Indicate the intensity of your pain at rest. (circle the appropriate number)
   (No Pain) 1 2 3 4 5 6 7 8 9 10 (severe Pain)
6. Indicate the intensity of your pain with movement. (circle the appropriate number)
   (No Pain) 1 2 3 4 5 6 7 8 9 10 (severe Pain)
7. What makes your symptoms worse?____
   ____
8. What makes your symptoms better?____
   ____
9. Have you had this problem before?____
10. Medical History (check all that apply)

[ ] Heart Disease	[ ]Cancer	[ ]Osteoporosis
[ ]Pacemaker	[ ]High blood pressure	[ ]Osteoarthritis
[ ]High cholesterol	[ ]Lung Disease	[ ]Diabetes
[ ]Pain at night	[ ]Headaches	[ ]Low Back Pain
[ ]Cough	[ ]Dizziness/blackouts	[ ]Loss of balance
[ ]Nausea/vomiting	[ ]Weight loss/Gain	[ ]Current Pregnancy
[ ]Chest pain	[ ]Fibromyalgia	[ ]Coordination problems
[ ]Urinary Problems	[ ]Bowel problems	[ ]Vision Problems
[ ] Hearing Problems	[ ]GERD(Reflux)	[ ]Loss of Appetite
[ ]Fever/Chills/sweats	[ ]Shortness of Breath	[ ]Heart Palpitations
[ ]Weakness in arms or legs	[ ]History of smoking	[ ]Stroke
[ ]Asthma	[ ]Rheumatoid Arthritis	[ ] other______________

    Please list surgeries:____
11. Medications:____
    ____
12. Allergies[ ] None or list (including latex)____________________________________
13. Occupation(including housewife,student,retired)______________________________
14. What are your goals for physical therapy?_____________________________________
    ____
15. Have you fallen within the last 6 months? [ ]Yes [ ]No If so, how many times?_____

Back Index

ACN Group, Inc. Form BI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name ______________________ *Date* ____________

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

- ⓪ The pain comes and goes and is very mild.
- ① The pain is mild and does not vary much.
- ② The pain comes and goes and is moderate.
- ③ The pain is moderate and does not vary much.
- ④ The pain comes and goes and is very severe.
- ⑤ The pain is very severe and does not vary much.

Sleeping

- ⓪ I get no pain in bed.
- ① I get pain in bed but it does not prevent me from sleeping well.
- ② Because of pain my normal sleep is reduced by less than 25%.
- ③ Because of pain my normal sleep is reduced by less than 50%.
- ④ Because of pain my normal sleep is reduced by less than 75%.
- ⑤ Pain prevents me from sleeping at all.

Sitting

- ⓪ I can sit in any chair as long as I like.
- ① I can only sit in my favorite chair as long as I like.
- ② Pain prevents me from sitting more than 1 hour.
- ③ Pain prevents me from sitting more than 1/2 hour.
- ④ Pain prevents me from sitting more than 10 minutes.
- ⑤ I avoid sitting because it increases pain immediately.

Standing

- ⓪ I can stand as long as I want without pain.
- ① I have some pain while standing but it does not increase with time.
- ② I cannot stand for longer than 1 hour without increasing pain.
- ③ I cannot stand for longer than 1/2 hour without increasing pain.
- ④ I cannot stand for longer than 10 minutes without increasing pain.
- ⑤ I avoid standing because it increases pain immediately.

Walking

- ⓪ I have no pain while walking.
- ① I have some pain while walking but it doesn't increase with distance.
- ② I cannot walk more than 1 mile without increasing pain.
- ③ I cannot walk more than 1/2 mile without increasing pain.
- ④ I cannot walk more than 1/4 mile without increasing pain.
- ⑤ I cannot walk at all without increasing pain.

Personal Care

- ⓪ I do not have to change my way of washing or dressing in order to avoid pain.
- ① I do not normally change my way of washing or dressing even though it causes some pain.
- ② Washing and dressing increases the pain but I manage not to change my way of doing it.
- ③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- ④ Because of the pain I am unable to do some washing and dressing without help.
- ⑤ Because of the pain I am unable to do any washing and dressing without help.

Lifting

- ⓪ I can lift heavy weights without extra pain.
- ① I can lift heavy weights but it causes extra pain.
- ② Pain prevents me from lifting heavy weights off the floor.
- ③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- ④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- ⑤ I can only lift very light weights.

Traveling

- ⓪ I get no pain while traveling.
- ① I get some pain while traveling but none of my usual forms of travel make it worse.
- ② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
- ③ I get extra pain while traveling which causes me to seek alternate forms of travel.
- ④ Pain restricts all forms of travel except that done while lying down.
- ⑤ Pain restricts all forms of travel.

Social Life

- ⓪ My social life is normal and gives me no extra pain.
- ① My social life is normal but increases the degree of pain.
- ② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
- ③ Pain has restricted my social life and I do not go out very often.
- ④ Pain has restricted my social life to my home.
- ⑤ I have hardly any social life because of the pain.

Changing degree of pain

- ⓪ My pain is rapidly getting better.
- ① My pain fluctuates but overall is definitely getting better.
- ② My pain seems to be getting better but improvement is slow.
- ③ My pain is neither getting better or worse.
- ④ My pain is gradually worsening.
- ⑤ My pain is rapidly worsening.

Back Index Score ☐

Rehabilitation Services
Informed Consent

Conditions and Consent for Physical Therapy.

Informed Consent for Treatment I understand that the term 'informed consent' means that the potential risks, benefits, and alternatives of physical therapy have been explained to me. The therapist provides a wide range of services and I understand that I will receive information at the initial visit concerning the treatment and options available for my condition.

Cooperation with Treatment I understand that in order for Physical therapy treatment to be effective, I must come to scheduled appointments unless there are unusual circumstances. I understand and agree to cooperate with and perform the home Physical Therapy exercise program developed for me. If I have trouble with any part of my treatment program, I will discuss itm with my Physical Therapist.

Cancellation Policy I understand that to successfully achieve the goals of treatment established by myself and my physical therapist it is essential for consistent attendance as outlined in my plan of care. I understand that three (3) or more no shows could result in my discharge from therapy.

Financial and Insurance Responsibilities I understand that it is my responsibility to call my insurance company ahead of time to obtain pre-authorization that may be necessary for PT, and to obtain verification of my outpatient physical therapy benefits.

Potential Risk of PT I understand that during my initial evaluation or following treatment sessions I may experience an increase in current pain or aggravate my current condition. I agree to discuss any of aggravation of my current symptoms with my therapist if they last longer than 24 hours.

I have read the above and I consent to Physical Therapy evaluation and therapy treatments at Clifton-Fine Hospital.

____
Print Name

____
Date

____
Patient/Parent (Guardian) Signature if Patient Under age of 18 years of age

____
Witness