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? _____

THE LOWER EXTREMITY FUNCTIONAL SCALE

We are interested in knowing whether you are having any difficulty at all with the activities listed below **because of your lower limb** problem for which you are currently seeking attention. Please provide an answer for each activity.

TODAY, do you or would you have any difficulty at all with:

	Activities	Extreme Difficulty or Unable to Perform Activity	Quite a Bit of Difficulty	Moderate Difficulty	A Little Bit of Difficulty	No Difficulty
1	Any of your usual work, housework, or school activities	0	1	2	3	4
2	Your usual hobbies, recreational or sporting activities	0	1	2	3	4
3	Getting into or out of bath	0	1	2	3	4
4	Walking between rooms	0	1	2	3	4
5	Putting on your shoes and socks	0	1	2	3	4
6	Squatting	0	1	2	3	4
7	Lifting an object, like a bag of groceries from the floor	0	1	2	3	4
8	Performing light activities around your home	0	1	2	3	4
9	Performing heavy activities around your home	0	1	2	3	4
10	Getting into or out of a car	0	1	2	3	4
11	Walking 2 blocks	0	1	2	3	4
12	Walking a mile	0	1	2	3	4
13	Going up or down 10 stairs (about 1 flight)	0	1	2	3	4
14	Standing for 1 hour	0	1	2	3	4
15	Sitting for 1 hour	0	1	2	3	4
16	Running on even ground	0	1	2	3	4
17	Running on uneven ground	0	1	2	3	4
18	Making sharp turns while running fast	0	1	2	3	4
19	Hopping	0	1	2	3	4
20	Rolling over in bed	0	1	2	3	4
	Column totals:					

Minimum level of Detectable Change (90% Confidence): 9 points **SCORE: _____/80**

Reprinted from Binkley, J., Stratford, P., Lott, S., Riddle, D., & The North American Orthopaedic Rehabilitation Research Network, The Lower Extremity Functional Scale: Scale development, measurement properties, and clinical application, Physical Therapy, 1999, 79, 4371-383, with permission of the American Physical Therapy Association.

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