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? _____

Neck Index

Managed Physical Network

MPN Use Only rev 5/7/99

Patient Name _____ **Date** _____

This questionnaire will give your provider information about how your neck 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 I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
③ The pain is fairly severe at the moment.
④ The pain is very severe at the moment.
⑤ The pain is the worst imaginable at the moment.

Sleeping

⓪ I have no trouble sleeping.
① My sleep is slightly disturbed (less than 1 hour sleepless).
② My sleep is mildly disturbed (1-2 hours sleepless).
③ My sleep is moderately disturbed (2-3 hours sleepless).
④ My sleep is greatly disturbed (3-5 hours sleepless).
⑤ My sleep is completely disturbed (5-7 hours sleepless).

Reading

⓪ I can read as much as I want with no neck pain.
① I can read as much as I want with slight neck pain.
② I can read as much as I want with moderate neck pain.
③ I cannot read as much as I want because of moderate neck pain.
④ I can hardly read at all because of severe neck pain.
⑤ I cannot read at all because of neck pain.

Concentration

⓪ I can concentrate fully when I want with no difficulty.
① I can concentrate fully when I want with slight difficulty.
② I have a fair degree of difficulty concentrating when I want.
③ I have a lot of difficulty concentrating when I want.
④ I have a great deal of difficulty concentrating when I want.
⑤ I cannot concentrate at all.

Work

⓪ I can do as much work as I want.
① I can only do my usual work but no more.
② I can only do most of my usual work but no more.
③ I cannot do my usual work.
④ I can hardly do any work at all.
⑤ I cannot do any work at all.

Personal Care

⓪ I can look after myself normally without causing extra pain.
① I can look after myself normally but it causes extra pain.
② It is painful to look after myself and I am slow and careful.
③ I need some help but I manage most of my personal care.
④ I need help every day in most aspects of self care.
⑤ I do not get dressed, I wash with difficulty and stay in bed.

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, but I can manage if they are conveniently positioned (e.g., on a table).
③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
④ I can only lift very light weights.
⑤ I cannot lift or carry anything at all.

Driving

⓪ I can drive my car without any neck pain.
① I can drive my car as long as I want with slight neck pain.
② I can drive my care as long as I want with moderate neck pain.
③ I cannot drive my car as long as I want because of moderate neck pain.
④ I can hardly drive at all because of severe neck pain.
⑤ I cannot drive my car at all because of neck pain.

Recreation

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

Headaches

⓪ I have no headaches at all.
① I have slight headaches which come infrequently.
② I have moderate headaches which come infrequently.
③ I have moderate headaches which come frequently.
④ I have severe headaches which come frequently.
⑤ I have headaches almost all the time.

Neck 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