

Lakeshore Sports

PHYSICAL THERAPY

Personal Information:

First Name: _____ MI: _____ Last Name: _____

Prefers to be called: _____ Date of Birth: _____ Sex: Male Female

E-mail: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Where do you prefer to receive calls? Home Work Cell

How do you prefer to receive appointment reminders? Text Message (Standard rates will apply) Phone Message

May we notify you of upcoming classes and lectures? Yes No

Select the locations where we may leave messages that may contain health information about you:

Home Work Cell None (please do not leave messages containing health information)

Is there anyone involved in your care with whom we may discuss your health information?

Spouse: _____ Other: _____

Referring Physician: _____ Internist: _____

In the event of an emergency, whom should we contact?

Name: _____ Relationship: _____

Daytime Phone: _____ Evening Phone: _____

Marital Status: Single Married Divorced Widowed Separated Partnered

Employment Status: Active Duty Full-Time Part-Time Retired Student None

Is this injury related to an auto accident? Yes No If so, in which state did the accident occur? _____

Is this injury related to another type of accident? Yes No Is an attorney involved? Yes No

Is this a work-related injury? Yes No

Primary Insurance:

Secondary Insurance:

Name of Insured Party: _____

Date of Birth of Insured: _____

Relationship to Insured: _____

Insurance Company: _____

Insured's Employer Information:

Employer's Name: _____ Occupation: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

Consent to Treat, Authorization and Release:

I, for myself (or the patient/client named below), hereby consent to such medical treatment as necessary and appropriate for my condition or illness in the judgment of my physical therapist, to be performed by my physical therapist. I certify that the information given by me for purposes of payment for this treatment is, to the best of my knowledge, complete and accurate. I authorize the release of any information to third party payers and entities involved in billing and collection in order to process my claims. I authorize and request my insurance company to pay directly to Lakeshore Sports Physical Therapy insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I acknowledge that I have received the *New Client Information* and *Privacy Policies* brochures. I understand that members of Lakeshore Sports Physical Therapy's professional staff may be employees of the organization or independent associates of the practice and that I may ask if I would like to clarify my therapist's relationship with Lakeshore Sports Physical Therapy, PC.

Signature: _____

Date: _____

OFFICE USE ONLY

Referral Source: Physician Patient Returning Patient Insurance Yellow Pages Other: _____

Primary Therapist: AWP SP IH KBB EF

Date of Injury: _____ Have you had this injury before? Yes No If so, when? _____

Name: _____

DOB: _____

HEALTH HISTORY

1. **Are you:** Right-handed?
 Left-handed?

2. Employment/Task Demands

How many hours do you spend in computer/desk work per day? _____

How much and how often do you lift objects heavier than 10 pounds?

of times/day: _____

Average weight of items lifted: _____

3. Where do you live?

- House Apartment

4. **Accessible by:** Stairs Elevator

5. With whom do you live?

- Alone Spouse Partner
 Child Other relative
 Pets Other

6. Do you use an assistive device for mobility?

- Yes No

If yes, please name: _____

7. Do you have any uncorrected vision or hearing problems?

- Yes No

8. Medications

Do you currently take any prescription medications?

- Yes No

If yes, please list (include dosages): _____

Do you currently take any nonprescription medications?

- Antacids Ibuprofen/
 Antihistamines Naproxen
 Aspirin Laxatives
 Decongestants Tylenol
 Herbal supplement Vitamins

Other: _____

If yes, please list dosages: _____

9. Health Habits

Please rate your health:

- Excellent Good
 Fair Poor

Do you exercise beyond your daily activities or participate in any hobbies or sports?

- Yes

Please describe the exercise, sport or hobby:

How many days per week do you exercise or perform physical activity? _____

For how many minutes, on an average day? _____

- No

Do you currently use or have you previously used tobacco?

- Yes Cigarettes, # of packs/day: _____
 Cigars, # per day/week: _____
 Chewing tobacco: _____
 Year quit, if applicable: _____

- No

How many days per week do you drink beer, wine or other alcoholic beverages? _____

How many caffeinated beverages do you drink on an average day?

Do you have a history of chemical dependency?

- Yes No

10. Within the past year, have you had any of the following medical tests?

<input type="checkbox"/> Angiogram	<input type="checkbox"/> MRI
<input type="checkbox"/> Arthroscopy	<input type="checkbox"/> Myelogram
<input type="checkbox"/> Biopsy	<input type="checkbox"/> NCV (nerve conduction velocity)
<input type="checkbox"/> Bone scan	<input type="checkbox"/> Pulmonary function test
<input type="checkbox"/> Doppler ultrasound	<input type="checkbox"/> Stress test (such as treadmill, bicycle)
<input type="checkbox"/> Echocardiogram	<input type="checkbox"/> X-rays
<input type="checkbox"/> EKG (electrocardiogram)	
<input type="checkbox"/> EMG (electromyogram)	

11. Have you ever had surgery?

- Yes No

If yes, please describe and include year:

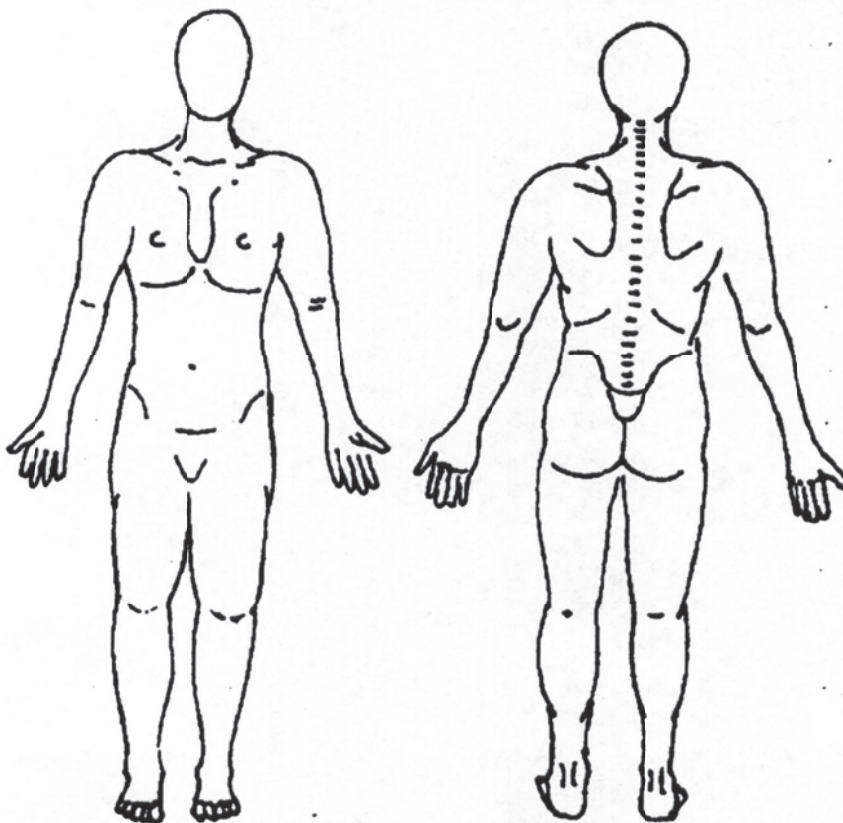
Pain Diagram and Pain Rating.

Name: _____

Date: ____/____/____
mm dd yy

Please use the diagram below to indicate the symptoms you have experienced over the past 24 hours. **Be VERY precise when drawing the location of your pain.** Use the key to indicate the type of symptoms.

Key: Pins and Needles = 000000 Stabbing = /////
Burning = xxxxxx Deep Ache = zzzzzz



Please rate your current level of pain on the following scale (check one):

0 1 2 3 4 5 6 7 8 9 10
(no pain) (worst imaginable pain)

Please rate your worst level of pain in the last 24 hours on the following scale (check one):

0 1 2 3 4 5 6 7 8 9 10
(no pain) (worst imaginable pain)

Please rate your best level of pain in the last 24 hours on the following scale (check one):

0 1 2 3 4 5 6 7 8 9 10
(no pain) (worst imaginable pain)

Lower Extremity Functional Scale

Name: _____ Date: _____

Activities	Extreme difficulty or unable to perform	Quite a bit of difficulty	Moderate difficulty	A little bit of difficulty	No difficulty
a. Any of your usual work, housework or school activities	0	1	2	3	4
b. Your usual hobbies, recreational or sporting activities	0	1	2	3	4
c. Getting into or out of the bath	0	1	2	3	4
d. Walking between rooms	0	1	2	3	4
e. Putting on your shoes or socks	0	1	2	3	4
f. Squatting	0	1	2	3	4
g. Lifting an object, like a bag of groceries from the floor	0	1	2	3	4
h. Performing light activities around your home	0	1	2	3	4
i. Performing heavy activities around your home	0	1	2	3	4
j. Getting into or out of a car	0	1	2	3	4
k. Walking 2 blocks	0	1	2	3	4
l. Walking a mile.	0	1	2	3	4
m. Going up or down 10 stairs (about one flight)	0	1	2	3	4
n. Standing for 1 hour	0	1	2	3	4
o. Sitting for 1 hour	0	1	2	3	4
p. Running on even ground	0	1	2	3	4
q. Running on uneven ground	0	1	2	3	4
r. Making sharp turns while running	0	1	2	3	4
s. Hopping	0	1	2	3	4
u. Rolling over in bed	0	1	2	3	4
Column Totals	0	1	2	3	4
Score _____/80					

*To score, sum the circled items