

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:

Neck Disability Index

Name: _____ Date: _____

Please check one statement in each section that most closely describes your condition.

Section 1- Pain Intensity

- I have no pain at the moment.
- The pain is very mild at the moment.
- The pain is moderate at the moment.
- The pain is fairly severe at the moment.
- The pain is very severe at the moment.
- The pain is the worst imaginable at the moment.

Section 6- Concentration

- I can concentrate fully when I want to with no difficulty.
- I can concentrate fully when I want to with slight difficulty.
- I have a fair degree of difficulty in concentration when I want to.
- I have a lot of difficulty in concentrating when I want to.
- I have a great deal of difficulty in concentrating when I want to.
- I cannot concentrate at all.

Section 2- Personal Care (Washing, Dressing etc.)

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

Section 7- Work

- I can do as much work as I want to.
- I can only do my usual work, but no more.
- I can do most of my usual work, but no more.
- I cannot do my usual work.
- I can hardly do any work at all.
- I can't do any work at all.

Section 3- Lifting

- I can lift heavy weights without extra pain.
- I can lift heavy weights but it gives extra pain.
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
- Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- I can lift very light weights.
- I cannot lift or carry anything at all.

Section 8- Driving

- I can drive my car without any neck pain.
- I can drive my car as long as I want with slight neck pain.
- I can drive my car as long as I want with moderate neck pain.
- I can't drive my car as long as I want because of moderate pain in my neck.
- I can hardly drive at all because of severe pain in my neck.
- I can't drive my car at all.

Section 4- Reading

- I can read as much as I want to with no pain in my neck.
- I can read as much as I want to with slight pain in my neck.
- I can read as much as I want to with moderate pain in my neck.
- I can't read as much as I want because of moderate pain in my neck.
- I can hardly read at all because of severe pain my neck.
- I cannot read at all.

Section 9- Sleeping

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

Section 5- Headaches

- I have no headaches at all.
- I have slight headaches which come in-frequently.
- I have moderate headaches which come in-frequently.
- I have moderate headaches which come frequently.
- I have severe headaches which come frequently.
- I have headaches almost all the time.

Section 10- Recreation

- I am able to engage in all my recreation activities with no neck pain at all.
- I am able to engage in all my recreation activities, with some pain in my neck.
- I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
- I am able to engage in a few of my usual recreation activities because of pain in my neck.
- I can hardly do any recreation activities because of pain in my neck.
- I can't do any recreation activities at all.