MEDICAL HISTORY

Date:______________ **Name:**____

Address:____ **City:**______________________**State:**________ **Zip Code:**______________

Date of Birth:_____________________ **Phone #:**_______________________________ **Sex: Male** ____ **Female** ____

Emergency Contact:___________________________________ **Relationship:**_____________________ **Phone #**_____________________

Occupation:____

Activities and hours involved in occupation (e.g. sitting, standing, bending, lifting, walking, etc.):________________________________
____

Reason for therapy (traumatic or gradual onset):____

Date of injury/onset:____________________________ **Surgical Procedure and Date:**_________________________________

Are your symptoms (check one): [ ] Getting worse [ ] The same [ ] Improving

Are you able to sleep at night (check one): [ ] Fine [ ] Moderate difficulty [ ] Only with medication

Do you have problems with: [ ] Hearing [ ] Vision [ ] Speech or English

Do you drink alcoholic beverages? [ ] Yes [ ] No **Do you or have you in the past smoked tobacco?** [ ] Yes [ ] No

Do you have any open wounds? [ ] Yes [ ] No

Do you have a fear of water? [ ] Yes [ ] No **Do you know how to swim?** [ ] Yes [ ] No

Do you have bowel/bladder incontinence? [ ] Yes [ ] No

Are you currently : **Pregnant?** [ ] Yes [ ] No **Depressed?** [ ] Yes [ ] No **Under Stress?** [ ] Yes [ ] No

Have you had any of the following? [ ] X-Rays [ ] MRI [ ] CT Scan [ ] EMG

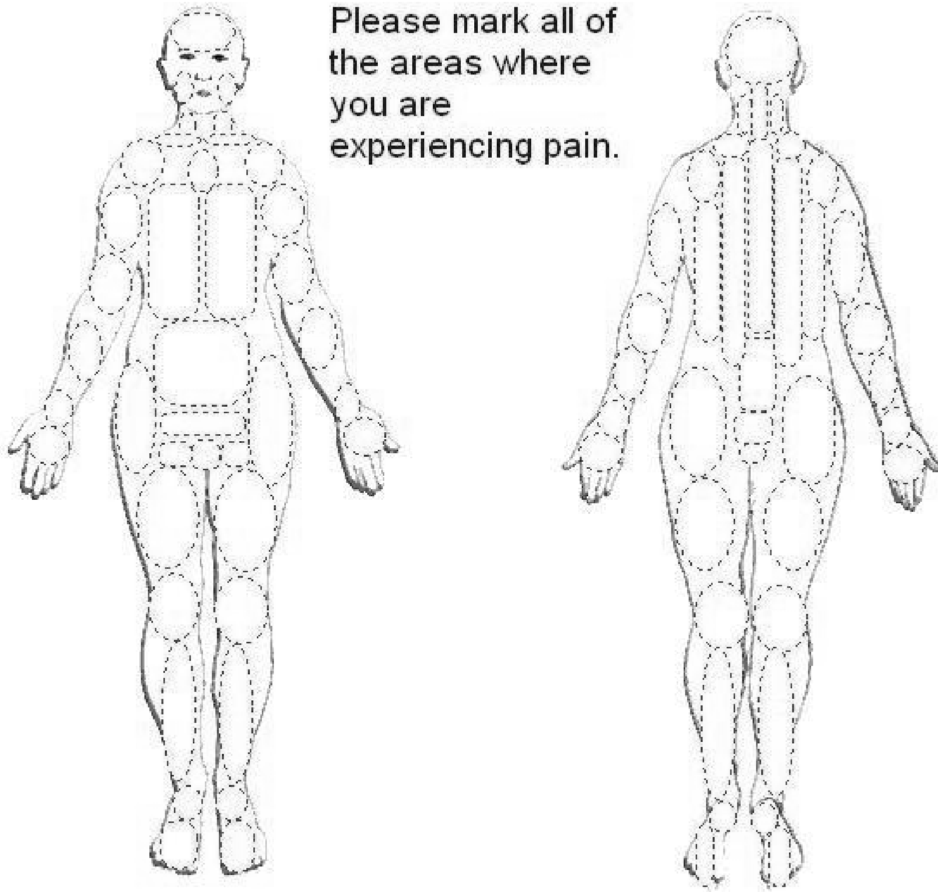
If yes, what were the results?____

List any medications you are currently using: ____

Signature:____

AquatiCare

Patient Identification Number	Survey Date MM DD YYYY



Please select all that describes your pain and circle the intensity for each one selected:

Description of Pain	Intensity		
Throbbing	Mild	Moderate	Severe
Shooting	Mild	Moderate	Severe
Stabbing	Mild	Moderate	Severe
Sharp	Mild	Moderate	Severe
Cramping	Mild	Moderate	Severe
Gnawing	Mild	Moderate	Severe
Hot / Burning	Mild	Moderate	Severe
Aching	Mild	Moderate	Severe
Heavy	Mild	Moderate	Severe
Tender	Mild	Moderate	Severe
Splitting	Mild	Moderate	Severe
Tiring / Exhausting	Mild	Moderate	Severe
Sickening	Mild	Moderate	Severe
Fearful	Mild	Moderate	Severe
Punishing / Cruel	Mild	Moderate	Severe

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, ***AquatiCare Physical Therapy*** may use and disclose protected health information (PHI) from the past, present or future about me to carry out treatment, payment and healthcare operations (TPO). Please refer to ***AquatiCare Physical Therapy's*** Notice of Privacy Practices for a more complete description of such uses and disclosures.
I have the right to review the Notice of Privacy Practices prior to signing this consent. ***AquatiCare Physical Therapy*** reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to ***AquatiCare Physical Therapy*** Privacy Officer at 15501 Metropolitan Parkway Suite 102 Clinton Twp., MI 48036

With my consent, ***AquatiCare Physical Therapy*** may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, ***AquatiCare Physical Therapy*** may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With my consent, ***AquatiCare Physical Therapy*** may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that ***AquatiCare Physical Therapy*** restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to ***AquatiCare Physical Therapy*** use and disclosure of my PHI to carry out TPO.
I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, ***AquatiCare Physical Therapy*** may decline to provide treatment to me.

Cancellation/No Show Policy

Private Insurance and Medicare Patients:
Any no show or cancellations that are not made **24 hours prior** to your scheduled appointment time are subject to a $40 cancellation fee, which will be billed to your account.

Workers Compensation Patient:
Any no show or cancellations that are not made **24 hours prior** to your scheduled appointment time are subject to a $40 cancellation fee, which will be billed to your account. Workers comp will not be responsible for cancellation or no show appointment fees. All cancellations will be reported to your Workers comp Insurance Adjuster.

Cell Phones
As a courtesy to others, cell phone use is strongly discouraged during all treatment sessions. We ask that you please turn your phone, or set it to silent mode before your appointment.

____
Signature of Patient or Legal Guardian

______________________________ ____________________
Patient's Name Date

____
Print Name of Patient or Legal Guardian

OVER→

© Gates, Moore & Company

SOCIAL WORK QUESTIONNAIRE

We are interested in the total well being of our patients. In keeping with this philosophy, we feel that social worker intervention may some times be appropriate. During your rehabilitation, you, your physician, therapist, or our Social Worker might agree that this service may be helpful. The Social Worker is available by appointment to evaluate the social or vocational factors involved in your rehabilitation, to counsel and advise you on social problems arising from your illness or injury, and to make appropriate referrals for required services, if any. You may schedule a meeting with our Social Worker through the receptionist or through your therapist.

Please answer the following questions to assist us in determining whether you might benefit from social work or vocational consulting services:

1. Are you presently out of work because of your illness or injury? Yes____ No____

2. Are you experiencing stress or related problems because of your illness or injury? Yes_____ No_____

3. Are you receiving social work, psychological counseling or vocational counseling through your physician or insurance company? Yes_____ No_____

4. Are you interested in speaking to the Social Worker? Yes_____ No_____

5. Do you live alone? Yes_____ No_____

6. Are you your own primary caregiver? Yes_____ No_____

7. Are you the primary caregiver for a spouse or family member? Yes_____ No_____

8. Are you able to perform the following daily tasks?

   a. Self-care (bathing, washing hair, etc.) Yes_____ No_____
   b. Driving Yes_____ No_____
   c. Grocery shopping Yes_____ No_____
   d. Preparing food Yes_____ No_____
   e. Housekeeping Yes_____ No_____

9. If you answered "no" to any question in #8, who is currently helping you with these tasks?____

Patient Signature:_____________________________________Date:______________

FOR AGENCY USE ONLY

I feel that this patient may benefit from social work services Yes_____ No_____

Therapist Signature:____________________________________ Date:______________

Social Worker Contacted: Yes_____ No_____ Date:______________

Comments:____

"THE LOWER EXTREMITY FUNCTIONAL SCALE"

Name:____ Date:___________________

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 the bath	0	1	2	3	4
4	Walking between rooms	0	1	2	3	4
5	Putting on your shoes or 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 of stairs)	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 Brinkley, J.Stafford, P., Lott, S., Ridle, D., & The North American Orthopedic Rehabilitation Reseasch 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

Signature:____

FOTO Patient Intake Survey
Medical / Neurological

Staff to Complete
PATIENT NAME:_______________________________________ Patient ID: ___________________________________

Gender: Male / Female Date of Birth: _______ / ______ / _________ Clinician: ________________________________

Body Part ______________________ Impairment ______________________________ Care Type ___________________________

Payer Source ____ Date of Survey: _______ / _______ / ________

We are interested in how you feel about how well you are able to do your usual activities. This information will help us take better care of you. Please answer the questions based on the problem for which you are receiving treatment. If you do not do or have not done this activity, please make your best guess as to which response is most accurate.

Today, does or would your health problem limit:	**Yes, limited a lot**	**Yes, limited a little**	**No, not limited at all**
1. Vigorous activities like running, lifting heavy objects, sports?			
2. Walking more than a mile?			
3. Climbing several flights of stairs?			
4. Moderate activities like moving a table or pushing a vacuum cleaner?			
5. Lifting or carrying items like groceries?			
6. Bending, kneeling, or stooping?			
7. Going on vacation?			
8. Climbing one flight of stairs?			
9. Lifting overhead to a cabinet?			
10. Getting in and out of a chair?			

11. Please indicate the number of surgeries for your primary condition. ☐ None ☐ 1 ☐ 2 ☐ 3 ☐ 4+

12. How many days ago did the condition begin? ☐ 0-7 days ☐ 8-14 ☐ 15-21 ☐ 22-90 ☐ 91 days to 6 mos. ☐ Over 6 mos. ago

13. Are you taking prescription medication for this condition? ☐ Yes ☐ No

14. Have you received treatments for this condition before? ☐ Yes ☐ No

15. How often have you completed at least 20 minutes of exercise, such as jogging, cycling, or brisk walking, prior to the onset of your condition? ☐ At least 3 times a week ☐ Once or twice per week ☐ Seldom or never

Patient Name: ____ Patient ID ______________________

16. Other health problems may affect your treatment. Please check (✓) any of the following that apply to you:

- ☐ Arthritis (rheumatoid / osteoarthritis)
- ☐ Osteoporosis
- ☐ Asthma
- ☐ Chronic Obstructive Pulmonary Disease (COPD), acquired respiratory distress syndrome (ARDS), or emphysema
- ☐ Angina
- ☐ Congestive heart failure (or heart disease)
- ☐ Heart attack (Myocardial infarction)
- ☐ High blood pressure
- ☐ Neurological Disease (such as Multiple Sclerosis or Parkinson's)
- ☐ Stroke or TIA
- ☐ Peripheral Vascular Disease
- ☐ Headaches
- ☐ Diabetes Types I and II
- ☐ Gastrointestinal Disease (ulcer, hernia, reflux, bowel, liver, gall bladder)
- ☐ Visual impairment (such as cataracts, glaucoma, macular degeneration)
- ☐ Hearing impairment (very hard of hearing, even with hearing aids)
- ☐ Back pain (neck pain, low back pain, degenerative disc disease, spinal stenosis)
- ☐ Kidney, bladder, prostate, or urination problems
- ☐ Previous accidents
- ☐ Allergies
- ☐ Incontinence
- ☐ Anxiety or Panic Disorders
- ☐ Depression
- ☐ Other disorders
- ☐ Hepatitis / AIDS
- ☐ Prior surgery
- ☐ Prosthesis / Implants

17. Height: ____________ ft. ____________ in. Weight: ____________ lbs.

18. This is a statement other patients have made. ***"I should not do physical activities which (might) make my pain worse."*** Please rate your level of agreement with this statement below. (*Circle number*)

0	1	2	3	4	5	6
▼ Completely Disagree			▼ Unsure			▼ Completely Agree