



**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: \_\_\_\_\_

Patient Identification Number

Survey Date

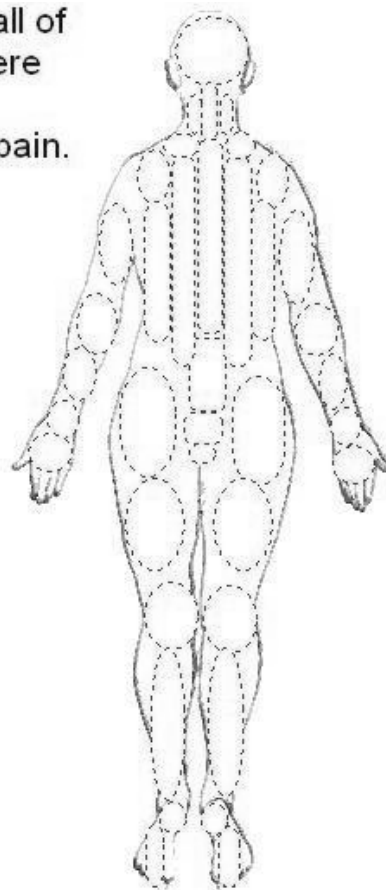
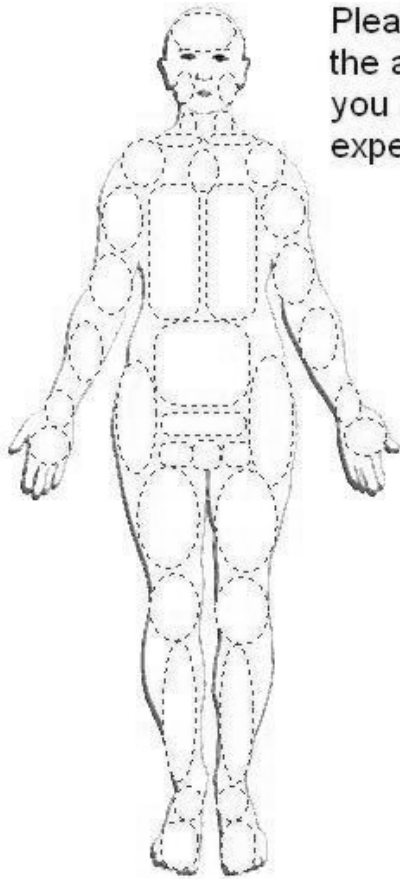
MM

DD

YYYY




Please mark all of the areas where you are experiencing pain.



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

Description of Pain	Intensity		
	Mild	Moderate	Severe
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→**

## 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: \_\_\_\_\_

# Lower Extremity Functional Scale (LEFS)

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Source: Binkley JM, Stratford PW, Lott SA, Riddle DL. The Lower Extremity Functional Scale (LEFS): scale development, measurement properties, and clinical application. North American Orthopaedic Rehabilitation Research Network. *Phys Ther.* 1999 Apr;79(4):371-83.

The Lower Extremity Functional Scale (LEFS) is a questionnaire containing 20 questions about a person's ability to perform everyday tasks. The LEFS can be used by clinicians as a measure of patients' initial function, ongoing progress and outcome, as well as to set functional goals.

The LEFS can be used to evaluate the functional impairment of a patient with a disorder of one or both lower extremities. It can be used to monitor the patient over time and to evaluate the effectiveness of an intervention.

## Scoring instructions

The columns on the scale are summed to get a total score. The maximum score is 80.

## Interpretation of scores

- The lower the score the greater the disability.
- The minimal detectable change is 9 scale points.
- The minimal clinically important difference is 9 scale points.
- % of maximal function =  $(\text{LEFS score}) / 80 * 100$

Performance:

- The potential error at a given point in time was +/- 5.3 scale points.
- Test-retest reliability was 0.94.
- Construct reliability was determined by comparison with the SF-36. The scale was found to be reliable with a sensitivity to change superior to the SF-36.

## Instructions

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
<b>Column Totals:</b>	0	1	2	3	4

Name: \_\_\_\_\_

Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
mm dd yy

This questionnaire has been designed to give your therapist information as to how your back pain has affected your ability to manage in every day life. Please answer every question by placing a mark in the **one** box that best describes your condition today. We realize you may feel that two of the statements may describe your condition, but **please mark only the box which most closely describes your current condition.**

#### **Pain Intensity**

- I can tolerate the pain I have without having to use pain medication.
- The pain is bad but I can manage without having to take pain medication.
- Pain medication provides me complete relief from pain.
- Pain medication provides me with moderate relief from pain.
- Pain medication provides me with little relief from pain.
- Pain medication has no affect on my pain.

#### **Personal Care (Washing, Dressing etc.)**

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

#### **Lifting**

- I can lift heavy weights without increased pain.
- I can lift heavy weights but it causes increased pain.
- Pain prevents me from lifting heavy weights off the floor, but I can manage if the weights are conveniently positioned (ex. on a table).
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- I can lift only very light weights.
- I can not lift or carry anything at all.

#### **Walking**

- Pain does not prevent me from walking any distance.
- Pain prevents me from walking more than 1 mile.
- Pain prevents me from walking more than ½ mile
- Pain prevents me from walking more than ¼ mile.
- I can only walk with crutches or a cane.
- I am in bed most of the time and have to crawl to the toilet.

#### **Sitting**

- I can sit in any chair as long as I like.
- I can only sit in my favorite chair as long as I like.
- Pain prevents me from sitting for more than 1 hour.
- Pain prevents me from sitting for more than ½ hour.
- Pain prevents me from sitting for more than 10 minutes.
- Pain prevents me from sitting at all.

#### **Standing**

- I can stand as long as I want without increased pain.
- I can stand as long as I want but increases my pain.
- Pain prevents me from standing more than 1 hour.
- Pain prevents me from standing more than ½ hour.
- Pain prevents me from standing more than 10 minutes.
- Pain prevents me from standing at all.

#### **Sleeping**

- Pain does not prevent me from sleeping well.
- I can sleep well only by using pain medication.
- Even when I take pain medication, I sleep less than 6 hours.
- Even when I take pain medication, I sleep less than 4 hours.
- Evens when I take pain medication, I sleep less than 2 hours.
- Pain prevents me from sleeping at all.

#### **Social Life**

- My social life is normal and does not increase my pain.
- My social life is normal, but it increases my level of pain.
- Pain prevents me from participating in more energetic activities (ex. sports, dancing etc.)
- Pain prevents me from going out very often.
- Pain has restricted my social life to my home.
- I have hardly any social life because of my pain.

#### **Traveling**

- I can travel anywhere without increased pain.
- I can travel anywhere but it increases my pain.
- My pain restricts travel over 2 hours.
- My pain restricts my travel over 1 hour.
- My pain restricts my travel to short necessary journeys under ½ hour.
- My pain prevents all travel except for visits to the doctor/therapist or hospital.

#### **Employment/Homemaking**

- My normal homemaking/job activities do not cause pain.
- My normal homemaking/job activities increase my pain, but I can still perform all that is required of me.
- I can perform most of my homemaking/job duties, but pain prevents me from performing more physically stressful activities (ex. lifting, vacuuming)
- Pain prevents me from doing anything but light duties.
- Pan prevents me from doing even light duties.
- Pain prevents me from performing any job or homemaking chores.