



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: _____

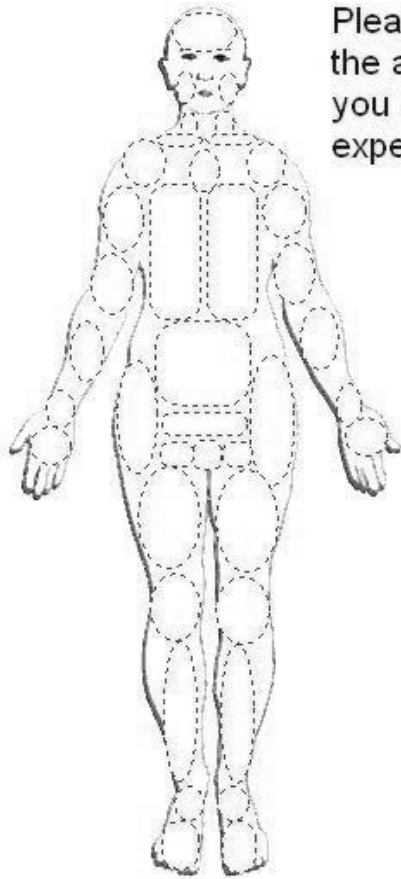
Patient Identification Number

Survey Date

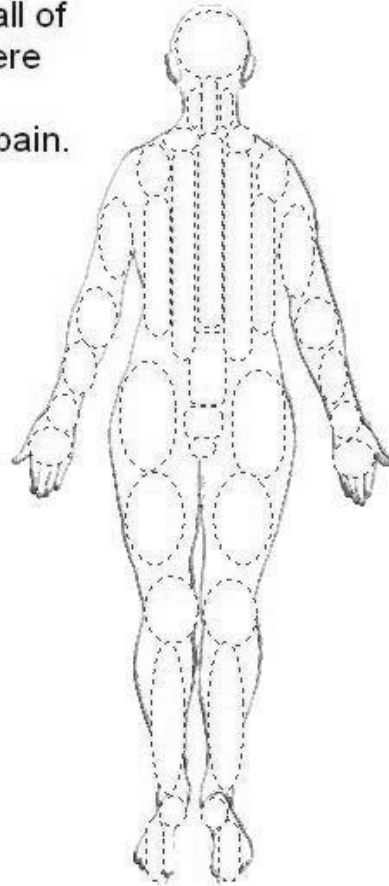
MM

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: _____

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

