



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

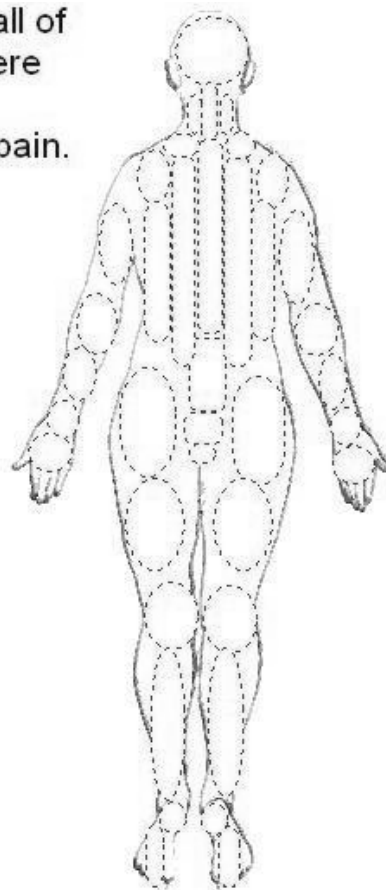
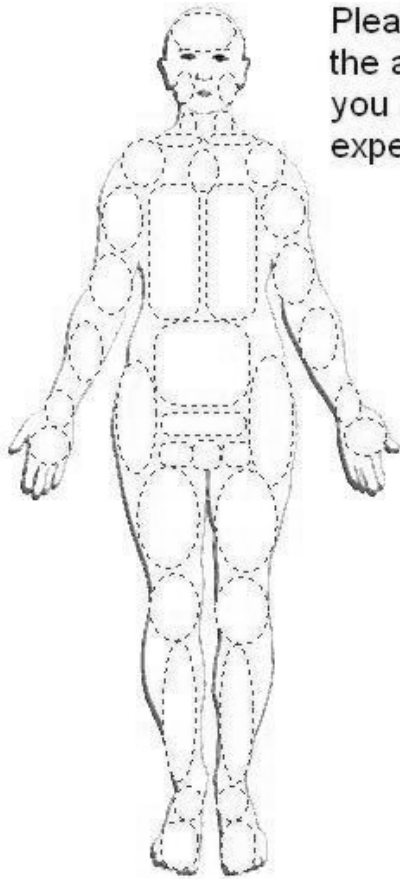
Survey Date

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→

FOTO Patient Intake Survey Shoulder

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, how much difficulty do you or would you have...	I can't do this	Much difficulty	Some difficulty	Little difficulty	No difficulty
1. Combing or brushing hair using your affected arm?					
2. Using your affected arm to place a can of soup (1 lb) on a shelf at shoulder height?					
3. Using your affected arm to pick up and drink out of a full water glass?					
4. Using your affected arm to reach a shelf that is at shoulder height?					
5. Using your affected arm to reach an overhead shelf?					
6. Pushing yourself out of a chair using both arms?					
7. Reaching across to the middle of the table with your affected arm to get a salt shaker while sitting?					
8. Getting a scarf or necktie over your head and around your neck, using both hands?					
9. Putting deodorant under the arm opposite your affected shoulder?					
10. Pulling a chair out from a table using your affected arm?					

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

Patient Name: _____ Patient ID _____

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
16. Other health problems may affect your treatment. Please check (✓) any of the following that apply to you:
- | | |
|--|---|
| <input type="checkbox"/> Arthritis (rheumatoid / osteoarthritis) | <input type="checkbox"/> Visual impairment (such as cataracts, glaucoma, macular degeneration) |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Hearing impairment (very hard of hearing, even with hearing aids) |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Back pain (neck pain, low back pain, degenerative disc disease, spinal stenosis) |
| <input type="checkbox"/> Chronic Obstructive Pulmonary Disease (COPD), acquired respiratory distress syndrome (ARDS), or emphysema | <input type="checkbox"/> Kidney, bladder, prostate, or urination problems |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Previous accidents |
| <input type="checkbox"/> Congestive heart failure (or heart disease) | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Heart attack (Myocardial infarction) | <input type="checkbox"/> Incontinence |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Anxiety or Panic Disorders |
| <input type="checkbox"/> Neurological Disease (such as Multiple Sclerosis or Parkinson's) | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Stroke or TIA | <input type="checkbox"/> Other disorders |
| <input type="checkbox"/> Peripheral Vascular Disease | <input type="checkbox"/> Hepatitis / AIDS |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Prior surgery |
| <input type="checkbox"/> Diabetes Types I and II | <input type="checkbox"/> Prosthesis / Implants |
| <input type="checkbox"/> Gastrointestinal Disease (ulcer, hernia, reflux, bowel, liver, gall bladder) | |
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 |

Name _____ Date _____ Patient ID# _____

Upper Extremity Functional Scale

We are interested in knowing whether you are having any difficulty with the activities listed below because of your upper limb problem for which you are currently seeking attention. Provide an answer for each activity.

Today, do you or would you have any difficulty with: (Circle one number on each line)

Activities	Extreme Difficulty or Unable to Perform Activity	Quite a Bit of Difficulty	Moderate Difficulty	A Little Bit of Difficulty	No Difficulty
a. Any of your usual work, household, or school activities.	0	1	2	3	4
b. Your usual hobbies, recreational or sporting activities.	0	1	2	3	4
c. Lifting a bag of groceries to waist level.	0	1	2	3	4
d. Lifting a bag of groceries above your head.	0	1	2	3	4
e. Grooming your hair.	0	1	2	3	4
f. Pushing up on your hands (e.g., from bathtub or chair).	0	1	2	3	4
g. Preparing food (e.g., peeling, cutting).	0	1	2	3	4
h. Driving.	0	1	2	3	4
i. Vacuuming, sweeping, or raking.	0	1	2	3	4
j. Dressing.	0	1	2	3	4
k. Doing up buttons.	0	1	2	3	4
l. Using tools or appliances.	0	1	2	3	4
m. Opening doors.	0	1	2	3	4
n. Cleaning.	0	1	2	3	4
o. Tying or lacing shoes.	0	1	2	3	4
p. Sleeping.	0	1	2	3	4
q. Laundering clothes (e.g., washing, ironing, folding).	0	1	2	3	4
r. Opening a jar.	0	1	2	3	4
s. Throwing a ball.	0	1	2	3	4
t. Carrying a small suitcase with your affected limb).	0	1	2	3	4

COLUMN TOTALS (for physical therapist use)

Score is the sum of all circled items. (range = 0-80)

Score: ___/80