FORMS MUST BE
In ***BLACK INK***

Excellence in Physical and Occupational Therapies for Orthopedic, Spinal, TMJ, Hand, Sports, Industrial, and Neurological Conditions

Thank you for selecting Access Rehab Clinics and Fitness Center for your Rehabilitation needs. We offer to you specialized Physical Therapy service. Your satisfaction with our services is our number one priority.

You may fill out these forms before or after making an appointment. PLEASE read these first 2 pages carefully before filling out forms. You do not need to print or bring these 2 information pages with you.

YOUR APPOINTMENT

Physical Therapy is very difficult to schedule, as it is a very different service than a visit to the doctor.
Treatment is actually a collaborative effort between you and the therapist.
This is a Specialty Practice, with high level, complex care to give you the very best and fastest results.
You may need 2, or 20, or more visits, depending upon your condition.
How long you have had your problem, its complexity and how much you participate are all factors.

Please allow at least 2 hours for your first appointment. It is possible it may be shorter, or even a little longer.
If you think your case is complicated, you may be the one who is here for extra time.
If you have just had surgery, or have a very straight forward problem you might be in and out more quickly.

Please arrive in loose comfortable clothing. Jeans are not conducive to good treatment. Exercise clothes are best.
We have shorts and gowns available for your convenience, and you could be asked to change as needed for quality of care.
You will be in a private room in that case. Athletic shoes are best. You cannot exercise in flip-flops or heels.
We will likely muss your hair, jewelry and make-up. Keep it simple. Your room has a mirror to tidy up with!
Keep jewelry to a minimum; you will be asked to remove earrings and necklaces, as well bracelets if the affected area is your arm. We do not want you to misplace anything.

ASSUMING you have filled out ALL of your forms ahead of time, PLEASE arrive 15 minutes early so we can process the papers and prepare your chart for your Physical Therapist. This time is essential to manage your care.

If you have chosen to fill your paperwork out when you arrive, OR if you forget to bring your papers, we have all of the paperwork available, of course. Please be prepared to fill out the forms before your appointment time.
It can take 45 minutes or more to fill out the essential forms. Please be prepared and arrive an hour ahead.

If your forms take you past your appointment time WE understand, but we also ask YOU to understand that the Physical Therapist will have begun other activities and may not be free as quickly as otherwise planned.
Also, please understand when there is a wait. We work hard to keep the schedule.
We cannot plan ahead for all of the possible variables in life.
YOU may be the one who needs special and extra care at some point.

Sadly, some insurance companies only allow an initial evaluation at the first visit. We are opposed to this, but we are required to comply. Please understand if this affects you. We have filed protests on your behalf.

Anne H. Campbell, P.T., M.S., O.C.S., F.A.A.O.M.P.T.
Board Certified Orthopaedic Clinical Specialist
Fellow American Academy of Orthopaedic Manual Therapy

3115 College Park ., Ste 109
THE WOODLANDS, Tx 77384
In College Park Medical Plaza
Tel: 936-273-1095 Fax: 936-273-1074

FORMS:

Introduction and Information (2 Pages) - this is information for you
Consent for Treatment
Information Release
Designated Individuals
Consent to Use information
Privacy Practices
Financial Policy
ACKNOWLEDGMENT of Financial Policy
Consent to Treat a Minor is required if the patient is under 18 years old.
Patient Information and Pain Form
Outcome Forms (see below - please bring at least 2 filled out)

Depending on your problem, pain or condition, there are OUTCOME forms to be completed. Please fill out ALL of the Outcome Forms that even remotely cover the area in question. If you "overdo", we can omit them. If you "under do", we will have to stop and do them. These are required by insurances, Medicare, and if there is any question of litigation. All of the common ones are included - sometimes we need to do others. These forms **INCLUDE**:

Back Disability Index (do this if you have ANY pain in or from your back from mid chest and down)
Lower Extremity Functional Scale (do this if you have foot, ankle, knee or hip problems OR if your back affects your legs AT ALL)
Dizziness Handicap Index (do this if you are dizzy OR if you have ANY balance problem)
Neck Disability Index (do this if you have ANY pain in or from your neck from mid chest and above)
Disabilities of Arm, Hand and Shoulders (DASH - do this if your neck affects your arms in ANY way)
Craniomandibular Activities of Daily Living (do this one if you have ANY facial or jaw pain)

Try to do at least 2 of them.
There is a space to calculate the scores. We will do this. You do NOT need to do this.

Please call (936) 273-1095 if you have any questions. We look forward to seeing you soon.

Sincerely,

Access Rehab Clinics and Fitness Center.

and Thank you,

Anne H. Campbell, PT, MS, OCS, FAAOMPT

Anne H. Campbell, P.T., M.S., O.C.S., F.A.A.O.M.P.T.
Physical Therapist (TX PT # 1038511); Board Certified Orthopedic Clinical Specialist
Fellow of the American Academy of Orthopedic Manual Physical Therapy
Certified Manual Trigger Point Therapist
President, Access Rehab Clinics and Fitness Centers

(Read, Print, Fill in, Sign
and bring this Page with you Please)

CONSENT FOR TREATMENT

All procedures will be explained to you. Special tests and procedures may require an additional consent form

I, (print full names)_____
hereby consent to a general and specialized Physical Therapy or Occupational Therapy evaluation and treatment relating to my condition. I understand that the evaluation and treatment *may* include any of the following:

- History of my condition and related complaints, and relevant general medical history
- Inspection of areas of my body related to my condition
- Examination of reflexes and sensation
- Examination of movement
- Examination of strength
- Manual (palpation and touch) examination of relevant body structures
- Photographic or video documentation
- Application of appropriate Physical Therapy treatments, which may include, but is not limited to:
  heat, cold, application of topical medications, passage of electric currents, traction, joint mobilization or manipulation, soft tissue techniques (such as massage), fabrication and/or application of a splint or other support device, exercise and functional activities.

I understand that my personal and medical information, including photographs or videotapes, will be handled confidentially, and that my identity will remain anonymous in any presentation of case materials for professional education or other purposes.

I have the right to ask questions regarding the purposes, risks and costs of the examination, diagnostic studies and treatment options related to my condition, and to refuse some applications, without jeopardy.

I understand that this consent remains in effect for all subsequent clinic visits to Access Rehab Clinics and Fitness Center, and applies to all Physical and Occupational Therapy services provided by this facility, at any of it locations.

I understand that to be compliant with Insurance, Medicare and other Federal rules, I will be asked to, and need to be sure to return for my Discharge Re-evaluation when the Physical Therapist or I decide that further treatment is not necessary.

I am over 18 years of age, and therefore have the legal right to consent to this treatment.

_____ _____
Patient Signature Date

MINOR PATIENTS: If patient is a Minor *(under age 18 and not married, not financially independent, or not in the armed forces on active duty)*, a parent or legal guardian **MUST** SIGN BEFORE patient is examined or receives treatment.

Print Patient's Name:_____ Patient's Age:_____

_____ _____
Signature of parent of legal guardian Date

_____
Print Name of parent of legal guardian

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Anne H. Campbell, P.T., O.C.S., F.A.A.O.M.P.T.
Board Certified Orthopaedic Clinical Specialist
Fellow American Academy of Orthopaedic Manual Therapy

ACCESS REHAB CLINICS AND FITNESS CENTER

3115 College Park Dr., Ste 109
The Woodlands, Tx 77384
Tel: 936-273-1095 **Fax:** 936-273-1074

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ACCESS REHAB
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Information Release Authorization

Separate form must be used for any additional doctors or facilities from which you would like us to obtain or share information.

I hereby consent to the release and disclosure of my personal health information to and from:

Doctor or Facility: _____

Address: _____

_____

City: _____ **State:** _____ **Zip:** _____

Phone: _____ **Fax:** _____

This release authorization includes my personal health information consisting of:

☐ Complete Medical History/File ☐ Visit Notes ☐ Surgical and Procedure Reports
☐ Imaging Reports (such as x-ray, MRI, CT, Ultrasound, etc.) ☐ Test results (including reports in file from other physicians not listed here)

☐ Other (must specify) _____

_____

I understand that the information outlined in this release will be disclosed according to the instructions of this release within (2) business days of Access Rehab Clinics and Fitness Center having received this authorization. I understand that I am free to revoke this release authorization at any time by notifying the practice in writing. I also understand that the information disclosed under this release is subject to re-disclosure and no longer protected by the Privacy Regulations (45 C.F.R. 164).

_____ _____
Patient Name Date of Birth

_____ _____
Signature Date

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Anne H. Campbell, P.T., O.C.S., F.A.A.O.M.P.T.
Board Certified Orthopaedic Clinical Specialist
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Designated Individuals Authorization Form

I hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, appointments, payment and/or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information. I understand it is my responsibility to notify the office in person or in writing if anyone should be removed from this list.

Authorized Designees:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

_____
Patient Name

_____
Patient Signature

_____
Date

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Anne H. Campbell, P.T., O.C.S., F.A.A.O.M.P.T.
Board Certified Orthopaedic Clinical Specialist
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CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR THE TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS
and
PRIVACY POLICY RECEIPT ACKNOWLEDGMENT

NAME:_____

BIRTH DATE:_____ **SS#:**_____

I Understand that as part of my therapy, this organization originates and maintains health records describing my health history, symptoms, evaluation, diagnosis, treatment and any plans for future treatment.

I UNDERSTAND THAT THIS INFORMATION SERVES AS:

- A basis for planning my care and treatment.
- A means of communication among the healthcare professionals, and other therapists who contribute to my care.
- A source of information for applying my diagnosis and treatment information to my bill.
- A means by which a third party payer can verify that services billed were actually provided.
- A tool for routine treatment operations such as assessing care quality and reviewing the competence of the individuals providing me with care.

I UNDERSTAND THAT I HAVE THE RIGHT:

- To request restrictions as to how my health information may be used or disclosed to carry out treatment, or payment-and that the organization is not required to agree to the restrictions requested.
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

PRIVACY POLICY RECEIVED AND ACKNOWLEDGED

I have received a copy of Access Rehab Clinics and Fitness Center's Notice of Privacy Practices.

I give my permission of Access Rehab Clinics and Fitness Center to contact me at ANY number I have provided on my patient information sheet with regards to collection on my account.

I understand that I retain the right to revoke this consent by notifying this practice in writing at any time.

NAME (printed): _____

_____ _____ _____
Signature of Patient or Legal Representative Date Witness Signature

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You ***do not*** need to print OR
bring these 2 pages with you.

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

INTRODUCTION

(Read This Page Please)

We at Access Rehab Clinics and Fitness Center maintain protocols to ensure the security and confidentiality of your personal information. We have physical security in our building, passwords to protect our databases, compliance check points, and virus/intrusion software. Within our practice, access to your information is limited to those who need it to perform their jobs.

At Access Rehab Clinics and Fitness Center, we are committed to treating and using protected health information about you responsibly. This Notice of Privacy Policies describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information as defined by federal regulations.

UNDERSTANDING YOUR HEALTH RECORD

Each time you visit Access Rehab Clinics and Fitness Center, a record of your visit is made. This record contains your condition, diagnosis, treatment and a plan for future treatment. This information serves as a:

- Basis for planning your treatment,
- Means of communication to your referring doctor,
- Legal document describing your care,
- Means by which you or a third party payer can verify that services were billed accurately,
- Source of data for our planning and marketing,
- Tool by which we can assess and continually work to improve the care we provide and outcomes we achieve.

We at Access Rehab Clinics and Fitness Center feel it is important that you understand what is in your health record in order to help you: ensure its accuracy; better understand who, what, when, where, and why others may access your health information; and make more informed decisions when authorizing disclosure to others.

YOUR HEALTH INFORMATION RIGHTS

Although your health record is the physical property of Access Rehab Clinics and Fitness Center, the information belongs to you. You have the right to:

- Obtain a copy of this notice of privacy policies upon request,
- Inspect and obtain a copy of your health record (reasonable copy fees apply in accordance with state law),
- Amend your health record,
- Obtain an accounting of disclosures of your health information,
- Request confidential communications of your health information,
- Request a restriction on certain uses and disclosures of your personal information (however, we are not required by law to agree to a requested restriction)

OUR RESPONSIBILITIES

Our practice is required to:

- Maintain the privacy of your health information,
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction,
- Accommodate reasonable requests you may have to communicate your health information.

We reserve the right to change our practices and make new provisions effective for all protected health information we maintain.

We will not use or disclose your health information in a manner other than described in the section regarding Examples Of Disclosures For Treatment, Payment, And Health Operations, without your written authorization, which you may revoke, except to the extent that action has already been taken.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

(Read This Page Please)

If you have questions or would like additional information, please contact our Privacy Officer, our Office Manager at (936) 756-0086.

If you believe your privacy rights have been violated, you can either file a complaint with us or with the Office for Civil Rights, US Dept. of Health and Human Services (OCR).
There will be no retaliation for filing a complaint with either our practice or the OCR. The address for OCR is:

Office for Civil Rights
U.S. Dept. of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, DC 20201

EXAMPLES OF DISCLOSURES FOR TREATMENT, PAYMENT AND HEALTH OPERATIONS

We will use your health information for treatment.

Information obtained by a physical therapist, occupational therapist or assistant will be added to your record and used to determine your course of treatment. Your therapist will document in your record his or her expectations of any one who may be treating you in our facility. Any one who treats you will record the actions they took and their observations. In that way, your therapist will know how you are responding to treatment.

We will also provide your referring physician(s) or subsequent health care provider(s)(when applicable) with copies of initial evaluations and progress reports that should assist them in treating you.

For those patients who are being treated in a group setting, some information may be discussed in front of other patients. This includes patients who are being treated out in the gym area as well as patients seen by a hand therapist. If you wish not to discuss certain information in this type of setting, please notify the front desk or your therapist of your concern. We will be happy to accommodate your request.

We will use your health information for payment.

A bill might be sent to you or a third party payer. The information on the bill may include information that identifies you, as well as your diagnosis, procedures and supplies used.

We will use your health information for regular health operations.

Members of the staff of Access Rehab Clinics and Fitness Center may disclose information in your health record in order to conduct daily operations. These may include:

•Business Associates
There are some services provided in our organization through contacts with business associates. Examples include contracted therapists, therapy assistants and students. Due to the nature of their work, they must receive your health information in order to perform their duties. To protect your health information, we require these associates to appropriately safeguard your information.

•Workers' Compensation
We may disclose personal health information to the extent authorized by and necessary to comply with laws relating to workers compensation or other similar programs established by law.

•Appointment Reminders
We may contact you or a family member at the phone number(s) you have provided to us as a reminder that you have an appointment or to reschedule an appointment. Your emergency contact will only be contacted in case of an emergency, unless they have been listed also as a designated individual.

•Notification
We may use or disclose information to notify a family member or someone responsible for your care of your location and general condition.

•Communication With Family
Our therapists or office staff, using their best judgement, may disclose to a family member, or close personal friend health information relevant to that person's involvement in your care or payment related to your care.

•Law Enforcement
We may disclose information for law enforcement purposes as required by law or in response to a subpoena.

Federal Law makes provisions for your health information to be released to an appropriate health oversight agency, public health authority, or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers, or the public. Effective October 2, 2013

(Read, Print, Fill in, **Sign at the bottom**
and bring this Page with you Please)

FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is part of your treatment. The following is our financial policy which we require you read and sign prior to treatment. Feel free to ask questions before signing.

IF YOU DO NOT HAVE INSURANCE OR IF YOU HAVE NOT MET YOUR DEDUCTIBLE:

Full payment is due at the time of service. We accept cash, checks, Visa, MasterCard and Discover.

NON-CONTRACTED INSURANCE (we are an *Out of Network Provider* under your plan)

As a courtesy to our patients, we often accept assignment of benefits from your insurance company after benefits and eligibility has been established, even though we are "Out of Network". Under Federal Law, we must collect the patient portion established by your plan. This will be paid at the time services are rendered. Your account balance after the insurance has paid its portion is your responsibility. Balance owing will be billed after the insurance company has finished processing your claim. This can be a long time. Your insurance policy is a contract between you and your insurance company and we are not a party to that contract. If we have accepted assignment we will require you to be pre-approved on our extended payment plan, or you may provide a credit card or debit card with authorization to bill that card for your balance in the event that your insurance company has not paid within 45 days from the date services were rendered. Please be aware that some, and perhaps all, services provided may be considered non-covered services and not considered "reasonable and necessary" under the your plan and/or Medicare. We are not advised of this until after billing for services.

CONTRACTED INSURANCE (we are an *In Network Provider* under your plan)

All co-pays and deductibles are due prior to treatment. Should the patient portion of your insurance policy require you to pay a certain percentage, we will collect that amount before your visit. Occasionally charges are reduced due to contracted fee schedules, resulting in your portion being lower than what you actually paid. When all visits have been processed and paid by the insurance, we will at that time refund overpayments due to you, or bill you for any underpayment. We cannot do this in advance, as the insurance company can make many changes during processing. Please allow up to thirty (30) days for refunds to be confirmed and processed. Once this has been completed you will be contacted to confirm the address in which you would like your refund mailed to. In the event that you insurance coverage changes to a plan under which are not a provider, refer to the paragraph below.

Usual and Customary Rates

Our practice is committed to providing the best treatment to our patients. We charge no more than usual and customary for our area, and frequently less. You are responsible for payment regardless of what your insurance company calls "usual and customary" rates.

Minor Patients

The adult accompanying a minor or the parent/guardian of the minor is responsible for any patient portion due at the time services are rendered. Be aware that the parent/guardian must sign a Consent to Treat a Minor.

Missed appointments

Appointments must be canceled at least 24 hours in advance. Our policy is to charge $25.00 per missed appointment. Please help us serve you better by keeping scheduled appointments.

Treatment Consent

You must sign a Consent to Treat form prior to treatment. Parent/Guardian must sign before we treat a minor.

Financial Responsibility

I understand I am financially responsible for payment of all charges for services rendered to me, or the minor I signed for, including the balance remaining after payment of insurance benefits. I authorize payment of medical benefits to Access Rehab Clinics and Fitness Center. I authorize the release of medical information or records to the insurance company for the purpose of payment. I authorize release of my medical records to my doctor for continuity of care. I understand that a service charge of 1.5% per month will be added to all overdue accounts. As the responsible party, I will also be liable for all legal and collection fees. I have read the financial/treatment consent policy and I understand and agree to this policy.

_____ _____

Signature of Patient or Financially Responsible Party Date

Anne H. Campbell, P.T., O.C.S., F.A.A.O.M.P.T.
Board Certified Orthopaedic Clinical Specialist
Fellow American Academy of Orthopaedic Manual Therapy

ACCESS REHAB CLINICS AND FITNESS CENTER

3115 College Park Dr., Ste 109
The Woodlands, Tx 77384
Tel: 936-273-1095 **Fax:** 936-273-1074

(Read, Print, Fill in, Sign
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ACKNOWLEDGMENT OF FINANCIAL POLICY

**Please initial to left of each statement. Thank you.

_____ I understand that payment of deductibles, co-pays and/or co-insurance percentages as well as any charges not covered by my insurance carrier is due at the time services are rendered. If my insurance is contracted I understand that you will submit all of my claims to them. All charges not covered by my insurance carrier remains my immediate responsibility.

_____ If I am a Medicare recipient I understand that you are Medicare providers and will submit all claims to them. I understand that I will be responsible for annual deductibles, co-pays and/or co-insurance percentages and any charges that Medicare states that I am responsible for.

_____ I am aware that your office will file my supplementary insurance to Medicare and I will receive statements from your office until my account is paid in full.

_____ I understand that I am responsible for services rendered, including the cost of collection in the event of default.

_____ I understand that a $30.00 service charge will be made on all returned checks.

_____ I understand that the business office will request to copy the front and back of my insurance card, and drivers license. I further understand that it is my responsibility to notify the business office in the event of an insurance coverage change.

_____ I understand that it is imperative that I am aware of my insurance policy coverage, even though Access Rehab Clinics will verify my coverage before my first appointment. (This does not guarantee that your insurance carrier quoted us the correct benefit information.) There are many insurance companies that require preauthorization & referrals for various services.

_____ All information that I have provided pertaining to my account is accurate and true to the best of my knowledge.

_____ I understand that if I do not cancel an appointment at least 24 hours in advance, or fail to show up for a scheduled appointment, I will be charged a $25.00 No Show fee.

Printed Name _____ Date _____

Signature _____

If you should have any questions about the above information or any uncertainty regarding your insurance coverage, please do not hesitate to call us at (936) 273-1095, between the hours of **8:00 am and 5:00 pm.**

FOR INSURANCE BILLING:
I hereby authorize Access Rehab Clinics and Fitness Center to furnish my insurance company with all the information which the insurance company may request concerning my present illness or injury.

I hereby assign Access Rehab Clinics and Fitness Center all money to which I am entitled for medical expenses related to the service reported. I understand I am financially responsible to Access Rehab Clinics and Fitness Center for charges not covered by this assignment.

_____ _____
Signature Date

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Anne H. Campbell, P.T., O.C.S., F.A.A.O.M.P.T.
Board Certified Orthopaedic Clinical Specialist
Fellow American Academy of Orthopaedic Manual Therapy

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Please COMPLETE this page and BRING it with you **Handed:** RIGHT LEFT IE Re-Eval Date: _____

NAME:_____**Circle one:** Mrs. Ms. Mr. Dr. Other_____**DOB:** _____ **Age:**_____

AREA(s) of Pain/Injury/Surgery: _____Date **THIS EPISODE** Began_____

Surgeries & Dates_____ **Procedures & Dates**_____

WHAT HAPPENED? (circle) a Fall Work Related at Home Elsewhere MVA No Reason Other: _____

How & When: _____

CHIEF COMPLAINT(S) or the main reason you need Physical therapy? ____Pain ____Stiffness ____Weakness ____Swelling

____Loss of or poor Balance ____Dizziness ____Incontinence ___Decreased Function ____Worsening Existing Condition ____

____Worsening Ability to Do Work Activities ____Inability to Do Work Activities

(circle) Inability or Worsening Ability to Do Activities of Daily Living (circle) Inability or Worsening Ability to Do Recreational Activities

Other:_____

DO YOU HAVE or have you EVER had (Circle and explain): Pacemaker _____ Heart problems _____Breathing Problems_____

High blood pressure _____ Diabetes (Type) _____ Osteoporosis/penia (which?) _____ Hernia: _____

Broken bones: _____ Sprains/strains: _____Anxiety _____ Fibromyalgia _____ Arthritis (what kind & where)_____

Cancer (where & when)_____ Loose Joints or Double Joints:_____ Severe Stress:_____

Headaches_____ Implants (metal and cosmetic)_____

Circulation or Bleeding problems_____ Problems with healing_____

Dizziness: _____ Bowel/Bladder Leakage:_____ Seizures of any kind: _____

Parkinsons:_____ Alzheimers/Dementia:_____ Stroke/Head Injury/Neurologic:_____

Other:_____

Are your SLEEP HABITS (circle one): GOOD FAIR POOR ? **Do you SMOKE?** YES NO How many cigarettes per day? _____

TESTS: X-ray, MRI, other: Dates, results _____

MEDICATIONS for THIS condition: _____

Allergies: _____

LIVING ENVIRONMENT (circle): Steps Curbs Stairs WITH railing Stairs NO railing Ramps Uneven Terrain Elevator Escalator

CURRENT LIMITATIONS:(circle) Walking Running Stairs Lifting Objects Carrying Objects Pushing/Pulling Objects

Reaching Up Grooming Dressing Bathing Cooking Turning in Bed Sitting Standing Walking (long periods)

Rising from Sitting Driving Manipulating small objects Chewing Eating Other: _____

FALLS: Describe ANY Falls or Nearly Falling events**:**_____

# of Fall in the last 12 months:_____ (circle): Daily Weekly Monthly Yearly Injured in Fall? Y N _____

(circle): Tripped over Object Reaching for Support Stairs/Steps Fainted Unknown Other _____

LEISURE, Physical, Sport Activities: _____

EMPLOYMENT Status (circle): Full-time Part-time Full Duty Light Duty Disabled Retired Unemployment Date: _____

What WORK do you do? _____ Most strenuous work activities:_____

Work Injury: Does employer know of this injury? YES NO All MD's seen for this: _____

Date of Work Injury: _____ Date first seen by doctor: _____ Last time seen by doctor: _____ Last day worked _____

On light duty since: _____ Are you restricted at work? (Circle) Off Work NO restriction Restrictions_____

I need a (circle) Straight Cane Special Cane Crutches Walker Wheeled Walker Always Sometimes When Out

Do you have any other conditions that are impeding or delaying your recovery? _____

Is there anything we did not ask you think we should know?_____

What are your **Goals** for Physical Therapy?:_____

Current Functional Ability: Please rank your ABILITY to DO activities from **0 = (I CANNOT do it)** to **10 = (Perfect - NO PROBLEM** at all

Name **3 to 5** tasks that you have the most difficulty with because of the problems that brought you to Access Rehab Clinic:

Activity 1:_____is ___/10 **Activity 2:**_____is ___/10 **Activity 3:** _____is ___/10

Activity 4:_____is ___/10 **Activity 5:**_____is ___/10

***** If you cannot identify any tasks, consider these categories: **Work** _____/10 **Daily Chores** _____/10 **Recreation** _____/10

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Board Certified Orthopaedic Clinical Specialist
Fellow American Academy of Orthopaedic Manual Therapy

ACCESS REHAB CLINICS AND FITNESS CENTER

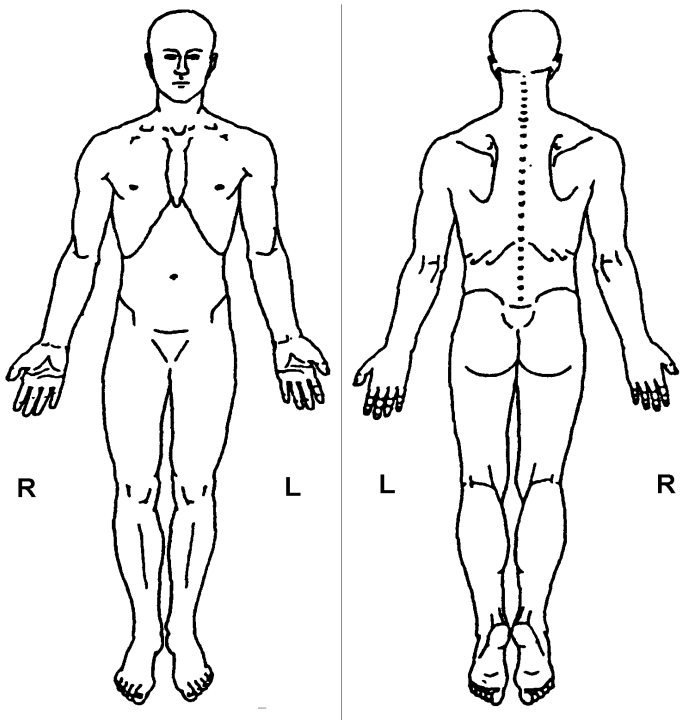
3115 College Park Dr., Ste 109
The Woodlands, Tx 77384
Tel: 936-273-1095 **Fax:** 936-273-1074

Please COMPLETE this page and BRING it with you

* * * * * * * * * * * * * **Now please DESCRIBE pains that you want us to know about** * * * * * * * * * * * *

Please **mark** the area or area(s) of your complaint(s):

Pain: Shade or color in the area. **Numbness**: Circle around the area. **Tingling, burning, and/or pins and needles**: Put a series of dots in the area.



Pain:

Below, for **EACH AREA**, estimate your pain levels. **0 means NO PAIN** whatsoever; **10 means the MOST PAIN** you can imagine (intolerable).

If you have difficulty, consider this line:

NO PAIN 0 1 2 3 4 5 6 7 8 9 10 MOST PAIN

Pain Location 1:_____ **Most Pain** since this began /10 **Today's** Pain **:** /10 **Least Pain** since this began : /10

When is pain Worse?(circle) Sitting Standing Lying Bending Walking Looking Up Looking Down Turning Head

a.m. As day progresses p.m. Other:_____

When is pain Better? (circle) Sitting Standing Lying Bending Walking Looking Up Looking Down Turning Head

a.m. As day progresses p.m. Other:_____

Is the pain localized to it's own area **OR** Describe how it radiates down an arm or leg?_____

Pain Location 2:_____ **Most Pain** since this began /10 **Today's** Pain **:** /10 **Least Pain** since this began : /10

When is pain Worse?(circle) Sitting Standing Lying Bending Walking Looking Up Looking Down Turning Head

a.m. As day progresses p.m. Other:_____

When is pain Better? (circle) Sitting Standing Lying Bending Walking Looking Up Looking Down Turning Head

a.m. As day progresses p.m. Other:_____

Is the pain localized to it's own area **OR** Describe how it radiates down an arm or leg?_____

Pain Location 3:_____ **Most Pain** since this began /10 **Today's** Pain **:** /10 **Least Pain** since this began : /10

When is pain Worse?(circle) Sitting Standing Lying Bending Walking Looking Up Looking Down Turning Head

a.m. As day progresses p.m. Other:_____

When is pain Better? (circle) Sitting Standing Lying Bending Walking Looking Up Looking Down Turning Head

a.m. As day progresses p.m. Other:_____

Is the pain localized to it's own area **OR** Describe how it radiates down an arm or leg?_____

Pain Location 4:_____ **Most Pain** since this began /10 **Today's** Pain **:** /10 **Least Pain** since this began : /10

When is pain Worse?(circle) Sitting Standing Lying Bending Walking Looking Up Looking Down Turning Head

a.m. As day progresses p.m. Other:_____

When is pain Better? (circle) Sitting Standing Lying Bending Walking Looking Up Looking Down Turning Head

a.m. As day progresses p.m. Other:_____

Is the pain localized to it's own area **OR** Describe how it radiates down an arm or leg?_____

FOR OTHER PAIN(S): Attach another sheet to give the same information about other additional pains that we need to know about.

Insurance **REQUIRES** us to collect this information.

The Medication, Reason for Medication, Dosage and Frequency columns must be filled for all prescription and non prescription medication you are taking.

If you have stopped taking a medication please put an X in the date column corresponding to that medication along with the date of the office visit.

Typical Frequency abbreviations are:
PRN = taken as needed; QID = 4x daily; TID = 3x daily; BID = 2x daily; QD = 1x daily

Name of Medication	Reason for Medication (IE: pain, allergy, blood thinner, etc.)	Dosage (IE: 250mg)	Frequency (use the abbreviations provided above)	Visit Date	Visit Date	Visit Date	Visit Date	Visit Date	Visit Date

Patient Name

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Anne H. Campbell, P.T., O.C.S., F.A.A.O.M.P.T.
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DHI - Dizziness Handicap Inventory

Name: _____ Date: _____

Instructions: The purpose of this scale is to identify difficulties that you may be experiencing because of your dizziness or unsteadiness. Please indicate answer by circling "yes or "no" or "sometimes" for each question. Answer each question as it pertains to your dizziness or unsteadiness problem only. **Choose only *ONE* answer for each question.**

1. Does looking up increase your problem?	Yes[1] No[2] Sometimes[3]
2. Because of your problem, do you feel frustrated?	Yes[1] No[2] Sometimes[3]
3. Because of your problem, do you restrict your travel for business or recreation?	Yes[1] No[2] Sometimes[3]
4. Does walking down the aisle of a supermarket increase your problem?	Yes[1] No[2] Sometimes[3]
5. Because of your problem, do you have difficulty getting into or out of bed?	Yes[1] No[2] Sometimes[3]
6. Does your problem significantly restrict your participation in social activities such as going out to dinner, going to the movies, dancing, or to parties?	Yes[1] No[2] Sometimes[3]
7. Because of your problem, do you have difficulty reading?	Yes[1] No[2] Sometimes[3]
8. Does performing more ambitious activities like sports, dancing, household chores such as sweeping or putting away dishes increase your problem?	Yes[1] No[2] Sometimes[3]
9. Because of your problem, are you afraid to leave your home without having someone accompany you?	Yes[1] No[2] Sometimes[3]
10. Because of your problem, have you been embarrassed in front of others?	Yes[1] No[2] Sometimes[3]
11. Do quick movements of your head increase your problem?	Yes[1] No[2] Sometimes[3]
12. Because of your problem, do you avoid heights?	Yes[1] No[2] Sometimes[3]
13. Does turning over in bed increase your problem?	Yes[1] No[2] Sometimes[3]
14. Because of your problem, is it difficult for you to do strenuous housework or yard work?	Yes[1] No[2] Sometimes[3]
15. Because of your problem, are you afraid people might think you are intoxicated?	Yes[1] No[2] Sometimes[3]
16. Because of your problem, is it difficult for you to go for a walk by yourself?	Yes[1] No[2] Sometimes[3]
17. Does walking down a sidewalk increase your problem?	Yes[1] No[2] Sometimes[3]
18. Because of your problem, is it difficult for you to concentrate?	Yes[1] No[2] Sometimes[3]
19. Because of your problem, is it difficult for you walk around the house in the dark?	Yes[1] No[2] Sometimes[3]
20. Because of your problem, are you afraid to stay home alone?	Yes[1] No[2] Sometimes[3]
21. Because of your problem, do you feel handicapped?	Yes[1] No[2] Sometimes[3]
22. Has your problem placed stress on your relationships with members of your family or friends?	Yes[1] No[2] Sometimes[3]
23. Because of your problem, are you depressed?	Yes[1] No[2] Sometimes[3]
24. Does your problem interfere with your job or household responsibilities?	Yes[1] No[2] Sometimes[3]
25. Does bending over increase your problem?	Yes[1] No[2] Sometimes[3]

Office use only **SCORE:** _____

Dizziness Handicap Inventory © 1990, American Medical Association. | H:\WP\FORMS\New Patient Intake Forms\Outcomes New 2017 07\DHI 2017 07.wpd

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TMJ - Craniomandibular ADL Scale

Name: _____ Date: _____

Instructions: Circle only ***ONE*** number which best describes your present ability to participate in each activity when you have pain / discomfort.

1. Socialize with family and close friends

1 2 3 4 5 6 7 8 9 10
Able to do without any pain/discomfort at all — activity impossible due to pain / discomfort

2. Perform daily work

1 2 3 4 5 6 7 8 9 10
Able to do without any pain/discomfort at all — activity impossible due to pain / discomfort

3. Perform daily household chores (preparing meals, taking care of small children, etc.)?

1 2 3 4 5 6 7 8 9 10
Able to do without any pain/discomfort at all — activity impossible due to pain / discomfort

4. Sit in company or participate in other social activities (e.g. parties)

1 2 3 4 5 6 7 8 9 10
Able to do without any pain/discomfort at all — activity impossible due to pain / discomfort

5. Exercise (walk, bicycle, jog, etc.)

1 2 3 4 5 6 7 8 9 10
Able to do without any pain/discomfort at all — activity impossible due to pain / discomfort

6. Hobbies (read, fish, knit, play and instrument, etc.)

1 2 3 4 5 6 7 8 9 10
Able to do without any pain/discomfort at all — activity impossible due to pain / discomfort

7. Sleep at night.

1 2 3 4 5 6 7 8 9 10
Able to do without any pain/discomfort at all — activity impossible due to pain / discomfort

8. Concentrate.

1 2 3 4 5 6 7 8 9 10
Able to do without any pain/discomfort at all — activity impossible due to pain / discomfort

9. Eat (chew, swallow)

1 2 3 4 5 6 7 8 9 10
Able to do without any pain/discomfort at all — activity impossible due to pain / discomfort

10. Talk (laugh, sing)

1 2 3 4 5 6 7 8 9 10
Able to do without any pain/discomfort at all — activity impossible due to pain / discomfort

11. Yawn, open mouth wide

1 2 3 4 5 6 7 8 9 10
Able to do without any pain/discomfort at all — activity impossible due to pain / discomfort

12. How much does the pain / discomfort affect your daily activities?

1 2 3 4 5 6 7 8 9 10
Not at all — Extremely

Office use only **SCORE: _____ %**

List, T. And Helkimo, M. (1995) A scale for measuring the activities of daily living (ADL) of patients with craniomandibular disorders. Swedish Dental Journal, 19, 33-40.

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Neck Disability Index

Name:_____Date:_____

INSTRUCTIONS: Please answer every question, based on your condition in the last week, by circling the appropriate number. If you did not have the opportunity to perform an activity in the past week, please make your best estimate of which response would be the most accurate. Choose only ***ONE*** answer for each question.

1. Pain Intensity

(0) I have no pain at the moment.
(1) The pain is very mild at the moment.
(2) The pain is moderate at the moment.
(3) The pain is fairly severe at the moment.
(4) The pain is very severe at the moment.
(5) The pain is the worse imaginable at the moment.

2. Personal Care (washing, dressing, etc)

(0) I can look after myself normally without extra pain.
(1) I can look after myself normally but it causes extra pain.
(2) It is painful to look after myself and I am slow and careful.
(3) I need some help but manage most of my personal care.
(4) I need help every day in most aspects of self care.
(5) I cannot get dressed, wash with difficulty and stay in bed

3. Lifting

(0) I can lift heavy weights without extra pain.
(1) I can lift heavy weights but it gives me extra pain.
(2) Pain prevents me from lifting heavy weights off the floor
(3) Pain prevents me from lifting heavy weights but I can manage if they are conveniently placed.
(4) I can lift only very light weights.
(5) I cannot lift or carry anything at all.

4. Headache

(0) I have no headaches at all.
(1) I have slight headaches which come infrequently.
(2) I have moderate headaches which come infrequently.
(3) I have moderate headaches which come frequently.
(4) I have severe headaches which come infrequently.
(5) I have headaches almost all the time.

5. Recreation

(0) I am able engage in all my recreational activities without pain.
(1) I am able to engage in my recreational activities with some pain.
(2) I am able to engage in most but not all of my usual recreational activities because of my neck pain.
(3) I am able to engage in a few of my usual recreational activities with some neck pain.
(4) I can hardly do any recreational activities because of neck pain.
(5) I can't do any recreational activities at all.

6. Reading

(0) I can read as much as I want with no pain in my neck.
(1) I can read as much as I want with slight neck pain.
(2) I can read as much as I want with moderate neck pain.
(3) I can't read as much as I want because of moderate
(4) I can hardly read at all because of severe neck pain.
(5) I cannot read at all because of neck pain.

7. Work

(0) I can do as much as I want to.
(1) I can only do my usual work but no more.
(2) I can do most of my usual work but no more.
(3) I cannot do my usual work.
(4) I can hardly do any usual work at all.
(5) I can't do any work at all.

8. Sleeping

(0) Pain does not prevent me from sleeping well.
(1) My sleep is slightly disturbed (<1 hr sleep loss).
(2) My sleep is mildly disturbed (1-2 hr sleep loss).
(3) My sleep is moderately disturbed (2-3 hr sleep loss).
(4) My sleep is greatly disturbed (3-4 hr sleep loss).
(5) My sleep is completely disturbed (5-7 hr sleep loss).

9. Concentration

(0) I can concentrate fully when I want with no difficulty.
(1) I can concentrate fully when I want with slight difficulty.
(2) I have a fair degree of difficulty concentrating
(3) I have a lot of difficulty concentrating when I want.
(4) I have great difficulty concentrating when I want.
(5) I cannot concentrate at all.

10. Driving

(0) I can drive my car without neck pain.
(1) I can drive my car as long as I want with slight neck pain.
(2) I can drive my car as long as I want with moderate neck pain.
(3) I can't drive my car as long as I want because of moderate pain.
(4) I can hardly drive my car at all because of severe neck pain.
(5) I can't drive my car at all.

Office use only **SCORE:_____%**

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DASH - Disabilities of the Arm, Hand, and Shoulder

Name: _____ Date: _____

INSTRUCTIONS: Please answer each question, based on your condition in the last week, by circling the appropriate number. If you did not have the opportunity to perform an activity in the past week, please make your best estimate of which response would be the most accurate. It doesn't matter which hand or arm you use to perform the activity; please answer based on your ability regardless of how you perform the task. Choose only ***ONE*** answer for each question.

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. Open a tight or new jar	*1*	*2*	*3*	*4*	*5*
2. Do heavy household chores (e.g., wash walls, floors).	*1*	*2*	*3*	*4*	*5*
3. Carry a shopping bag or briefcase.	*1*	*2*	*3*	*4*	*5*
4. Wash your back	*1*	*2*	*3*	*4*	*5*
5. Use a knife to cut food.	*1*	*2*	*3*	*4*	*5*
6. Recreational activities in which you take some force or impact through your arm, shoulder or hand(e.g., golf, hammering, tennis, etc.).	*1*	*2*	*3*	*4*	*5*

	NOT AT ALL	SLIGHTLY	MODERATELY	SEVERE DIFFICULTY	UNABLE
7. During the past week, to what extent has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbors or groups?	*1*	*2*	*3*	*4*	*5*

	NOT LIMITED AT ALL	SLIGHTLY LIMITED	MODERATELY LIMITED	VERY LIMITED	UNABLE
8. During the past week, how limited were you in your work or other regular daily activities as a result of your arm, shoulder or hand problem?	*1*	*2*	*3*	*4*	*5*

	NONE	MILD	MODERATE	SEVERE	EXTREME
9. Please rate the severity of Arm, shoulder or hand pain in the last week .	*1*	*2*	*3*	*4*	*5*
10. Please rate the severity of tingling (pins and needles) in your arm, shoulder or hand in the last week.	*1*	*2*	*3*	*4*	*5*

	NONE	MILD	MODERATE	SEVERE DIFFICULTY	SO MUCH DIFFICULTY THAT I CAN'T SLEEP
11. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand? (circle number)	*1*	*2*	*3*	*4*	*5*

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BDI - Back Disability Index

Name: _____ Date: _____

INSTRUCTIONS: Please answer each question, based on your condition in the last week, by circling the appropriate number. If you did not have the opportunity to perform an activity in the past week, please make your best estimate of which response would be the most accurate. It doesn't matter which hand or arm you use to perform the activity; please answer based on your ability regardless of how you perform the task. Choose only ***ONE*** answer for each question.

1. Pain Intensity

(0) I can tolerate the pain I have without having to use pain medication.
(1) The pain is bad, but I can manage without having to take pain medication.
(2) Pain medication provides me with complete relief from pain.
(3) Pain medication provides me with moderate relief from pain.
(4) Pain medication provides me with little relief from pain.
(5) Pain medication has no effect on my pain.

2. Personal Care (washing, dressing, etc.)

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

3. Lifting

(0) I can lift heavy weights without increased pain.
(1) I can lift heavy weights, but it causes increased pain.
(2) Pain prevents me from lifting heavy weights off the floor, but I can manage if the weights are conveniently positioned (eg, on a table).
(3) Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
(4) I can lift only very light weights.
(5) I cannot lift or carry anything at all.

4. **Walking**

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

5. Sitting

(0) I can sit in any chair as long as I like.
(1) I can only sit in my favorite chair as long as I like.
(2) Pain prevents me from sitting more than 1 hour.
(3) Pain prevents me from sitting more than ½ hour.
(4) Pain prevents me from sitting more than 10 minutes.
(5) Pain prevents me from sitting at all.

6. Standing

(0) I can stand as long as I want without increased pain.
(1) I can stand as long as I want but, it increases my pain.
(2) Pain prevents me from standing more than 1 hour.
(3) Pain prevents me from standing more than a 1/2 hour.
(4) Pain prevents me from standing more than 10 minutes.
(5) Pain prevents me from standing at all.

7. Sleeping

(0) Pain does not prevent me from sleeping well.
(1) I can sleep well only by using pain medication.
(2) Even when I take pain medication, I sleep less than 6 hours.
(3) Even when I take pain medication, I sleep less than 4 hours.
(4) Even when I take pain medication, I sleep less than 2 hour
(5) Pain prevents me from sleeping at all.

8. Social Life

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

9. Traveling

(0) I can travel anywhere without increased pain.
(1) I can travel anywhere, but it increases my pain.
(2) My pain restricts my travel over 2 hours.
(3) My pain restricts my travel over 1 hour.
(4) My pain restricts my travel to short necessary journeys under 1/2 hour.
(5) My pain prevents all travel except for visits to the physician/therapist or hospital.

10. Employment / Homemaking

(0) My normal homemaking/job activities do not cause pain.
(1) My normal homemaking/job activities increase my pain, but I can still perform all that is required of me.
(2) I can perform most of my homemaking/job duties, but pain prevents me from performing more physically stressful activities (eg, lift, vacuum).
(3) Pain prevents me from doing anything but light duties.
(4) Pain prevents me from doing even light duties.
(5) Pain prevents me from performing any job or homemaking chores.

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LEFS - Lower Extremity Functional Scale

Name: _____ Date: _____

INSTRUCTIONS: Please answer each question, based on your condition in the last week, by circling the appropriate number. If you did not have the opportunity to perform an activity in the past week, please make your best estimate of which response would be the most accurate. It doesn't matter which hand or arm you use to perform the activity; please answer based on your ability regardless of how you perform the task.

Choose only ***ONE*** answer for each question.	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*

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PATIENT INFORMATION/INSURANCE VERIFICATION *WC HMO PPO PRIVATE POS MC SelfPay*

Intake Date: *Employee:* *Tax I.D. # 76-0436269*

Patient: _____ **Patient DOB** _____
(Legal First) (M.I.) (Legal Last)

Phone H: _____ **C:** _____ **email:** _____

Area(s) Affected: _____ **Gender: M F Minor Y N**

Address: _____ **City :** _____ **Zip:** _____

Emergency Contact Name _____ **Phone#** _____ **Relationship** _____ _____

Referring Physician: _____ **Phone #** _____ **Next Visit?** _____

PCP: _____ **Phone #** _____ **Next Visit?** _____

Have you ever been treated here before? Y N **If yes, Approximate last date seen:** _____ **This Condition: Y N**

Had P.T. at another Clinic this year? Y N **Last Treatment Date:** _____ **# of visits:** _____ **This Condition: Y N**

What is your Primary Language? English Spanish French Other: _____ **Translator Needed? Y N**

Accident Information: **WC? Y N MVA? Y N HOME? Y N DoI** _____ **DoS** _____
(See back side of page)

Have you had related X-Rays, CT, MRI, Lab Work: Y N *Patient will bring ☐ OR We request from Dr. before 1st visit ☐*

Primary Insurance Co.: _____ **Phone:** _____

Primary Insured Name: _____ **Relation:** _____ **DOB:** _____

Insurance Claims Address: _____

POLICY ID # _____ **GROUP#** _____ *PAYOR ID#* _____

Policy Eff. Date: _____ *Plan Year:* _____ *Fixed Co-Pay: $* _____ *%Pay: Ins:* _____ *% Patient:* _____ *%*

Deductible Amt: $ _____ *OOP Maximum: $* _____ *LIMIT on PT? #* _____ *OR $* _____

Ded. Amt Met: $ _____ *OOP Amt Met: $* _____ *LIMIT on PT used? #* _____ *OR $* _____

Pre-Auth Req Y N FORMS: PSF (ACN) Orthonet MNR Other _____

Pre-Auth # _____ *# Of Visits Auth:* _____ *Start Date:* _____ *End Date:* _____

Referral req (PCP) Y N Letter of Medical Necessity Y N SUPPLIES Covered Y N

Spoke With: _____ *Verified by:* _____ *Date:* _____ *REF #:* _____

Secondary Insurance Co.: _____ **Phone:** _____

Primary Insured Name: _____ **Relation:** _____ **DOB:** _____

Insurance Claims Address: _____

POLICY ID # _____ **GROUP#** _____ *PAYOR ID#* _____

Policy Eff. Date: _____ *Plan Year:* _____ *Fixed Co-Pay: $* _____ *%Pay: Ins:* _____ *% Patient:* _____ *%*

Deductible Amt: $ _____ *OOP Maximum: $* _____ *LIMIT on PT? #* _____ *OR $* _____

Ded. Amt Met: $ _____ *OOP Amt Met: $* _____ *LIMIT on PT used? #* _____ *OR $* _____

Pre-Auth Req Y N FORMS: PSF (ACN) Orthonet MNR Other _____

Pre-Auth # _____ *# Of Visits Auth:* _____ *Start Date:* _____ *End Date:* _____

Referral req (PCP) Y N Letter of Medical Necessity Y N SUPPLIES Covered Y N

Spoke With: _____ *Verified by:* _____ *Date:* _____ *REF #:* _____

Entered into System by: *Date:*

1st Appt Date: *PT:*

Paperwork Delivery Method
☐ **Emailed on** _____ ☐ **Pick-up prior to IE date**
☐ **Patient to come in at least 1hr early** ☐ **Directed to website**

COMPLETE BACK SIDE IF WORKMAN'S COMPENSATION CLAIM, MVA, HOME OR OTHER INCIDENT CLAIM

Workman's Compensation

Claim Number#: _____

Employer: _____ **Pho ne** _____ **Address:** _____

Adjuster: _____ **Phone** _____ **Fax** _____

Case Manager _____ **Phone** _____ **Fax** _____

Insurance Co: _____ **Phone** _____ **Fax** _____

Insurance Address _____

Pre-Auth Req Y N Pre Auth # _____ *# Of Visits Auth*: _____ *Expiration Date*: _____

Pre-Auth Co. _____ *Phone #* _____ *Fax#* _____

Referral req (PCP) Y N Letter of Medical Necessity Y N SUPPLIES Covered Y N _____

MVA

(MAY REQUIRE COMPLETION OF FORM "AGREEMENT TO PAY FOR SERVICES RENDERED" AND A LETTER OF PROTECTION)

Claim Number#: _____

Adjuster: _____ **Phone** _____ **Fax** _____

Insurance Co: _____ **Phone** _____ **Fax** _____

Insurance Address _____

Pre-Auth Req Y N Pre Auth # _____ *# Of Visits Auth*: _____ *Expiration Date*: _____

Pre-Auth Co. _____ *Phone #* _____ *Fax#* _____

Referral req (PCP) Y N Letter of Medical Necessity Y N SUPPLIES Covered Y N _____

HOME OR OTHER INCIDENT

(MAY REQUIRE COMPLETION OF FORM "AGREEMENT TO PAY FOR SERVICES RENDERED" AND A LETTER OF PROTECTION)

Claim Number#: _____

Adjuster: _____ **Phone** _____ **Fax** _____

Insurance Co: _____ **Phone** _____ **Fax** _____

Insurance Address _____

Pre-Auth Req Y N Pre Auth # _____ *# Of Visits Auth*: _____ *Expiration Date*: _____

Pre-Auth Co. _____ *Phone #* _____ *Fax #* _____

Referral req (PCP) Y N Letter of Medical Necessity Y N SUPPLIES Covered Y N _____

NOTES / OTHER INFORMATION: