 PLEASE COMPLETE BEFORE FOR YOUR APPOINTMENT - ALLOW 45 MINUTES
FORMS MUST BE FILLED OUT
IN ***BLACK INK***

ACCESS REHAB
CLINIC
AND FITNESS CENTER

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

PLEASE read these first 2 pages carefully before filling out forms

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.
They need to be completed 15 minutes BEFORE your appointment time. Allow at least 45 minutes..

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 Physical 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 good. Exercise clothes are good. Athletic shoes are best. We cannot examine you, and you cannot exercise, in flip-flops, heels or boots. We have shorts and gowns for your convenience, and will ask you to change as needed for good care. You will be in a private room in that case.
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 necklace, bracelets if it is your arm.
We do not want you to misplace anything.

ASSUMING you have filled out ALL forms ahead of time, PLEASE arrive 15 minutes early so we can process 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. Be prepared to fill out the forms before your appointment time.
It can take 45 minutes or more to fill out the forms. Please arrive an hour before your appointment to complete this.

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.

FORMS:

1. Introduction and Information (2 Pages) - this is for your information
2. Consent for Treatment - return to us, signed please
3. Information Release - return to us, signed please
4. Designated Individuals - return to us, signed please
5. Consent to Use information - return to us, signed please
6. Privacy Practices - this is for your information but please return the signature page, signed.
7. Financial Policy - this is for your information.
8. ACKNOWLEDGEMENT of Financial Policy - return to us, signed please

ALSO you must print, fill out and sign a Consent to Treat a Minor if you are bringing someone under 18 years old.

9. Patient Information and Pain Forms - for the Physical Therapist - fill this out as much as you can with details
10. Functional Questionnaires (see below - please bring at least **2** filled out).

Please fill out the questionnaires that are pertinent your areas of pain even if you have more than area of pain. They are required by insurances, Medicare, and if there is any question of litigation. All of the common ones are included: These forms **INCLUDE**:

Backs: Back Disability Index

Leg,Hip,Knee,Foot, Ankle: Lower Extremity Functional Scale (do this if you have foot, ankle, knee or hip problems OR if your back affects you legs AT ALL)

Dizziness Handicap Index (do this if you are dizzy OR if you have ANY balance problem)

Neck: Neck Disability Index(do this if you have ANY pain in or from your neck from mid chest/shoulder blades 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.

You don't have to calculate the scores. We will do it.

Please call if you have any questions at 936-273-1095. We look forward to seeing you soon.
Thank You.

Sincerely,

Administrator and Office Manager
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 Orthopaedic Clinical Specialist
Fellow of the American Academy of Orthopaedic Manual Physical Therapy
Certified Manual Trigger Point Therapist
President, Access Rehab Clinics and Fitness Centers

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ACCESS REHAB CLINIC AND FITNESS CENTER

CONSENT FOR TREATMENT

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

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 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, exercise, functional activities, intramuscular trigger point therapy.

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 Clinic and Fitness Center, and applies to all Physical Therapy services provided by this facility.

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

*If patient is a Minor (under age 18 and not married, not financially independent, or not in the armed forces on active duty), 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

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 CLINIC 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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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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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:_____

Name:_____ Relationship:_____

_____
Patient Name

_____
Patient Signature

_____
Date

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CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR THE TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS
and
PRIVACY PRACTICES RECEIPT ACKNOWLEDGMENT

NAME:_____

BIRTH DATE:_____ SS#:_____

I Understand that as part of my Physical 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.

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR THE TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS - RECEIVED AND ACKNOWLEDGED
and
PRIVACY POLICY - RECEIVED AND ACKNOWLEDGED

I have read and agree to the **Consent to the Use and Disclosure of Health Information for the Treatment, Payment, or Healthcare Operations**
and
I have received a copy of Access Rehab Clinic and Fitness Center's **Notice of Privacy Practices**.

I give my permission of Access Rehab Clinic 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. In that case, I understand that I am fully responsible for the outstanding portion of my treatment billing.

NAME (printed): _____

X_____ _____
Signature of Patient or Legal Representative Date

Witness Name:_____

_____ _____
Signature of Witness Date

Anne H. Campbell, P.T., O.C.S., F.A.A.O.M.P.T.
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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 Clinic 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 Clinic 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 Clinic 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 Clinic 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 Clinic 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.

Anne H. Campbell, P.T., O.C.S., F.A.A.O.M.P.T.
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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

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 CLINIC AND FITNESS CENTER

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ACCESS REHAB CLINIC AND FITNESS CENTER

ELECTION TO SELF-PAY FOR SERVICES

I, _____ , the undersigned Patient/Representative/Guardian, acknowledge that I understand and agree to the six conditions below, in order elect to self-pay for services rendered by Access Rehab Clinic and Fitness Center.

1. Choose which applies to your situation:

☐ I do not have insurance coverage or my plan does not recognize Access Rehab Clinic as an in network provider.

OR

☐ Access Rehab Clinic And Fitness Center may be a participating provider with _____, of which I am a covered member.

The health plan under which I am covered may include benefits for some or all of the services provided by Access Rehab Clinic And Fitness Center. Due to financial hardships, which may be heightened considering Deductible and/or Out of Pocket amounts, I ***do not*** wish Access Rehab Clinic And Fitness Center to submit a claim to my health insurance carrier for services provided to me by them. This agreement forfeits any previous agreement for this episode of care stating otherwise. I understand that in this insurance coverage year, I cannot alter this arrangement with Access Rehab Clinic and Fitness Center

2. I elect to pay for all services I receive from Access Rehab Clinic and Fitness Center at their self-pay rate. Supplies are not included in the visit rate. Supplie are billed as a separate charge. I understand that all charges are to be paid at the time of service. Self-Pay rates are subject to change and are at the discretion of the Access Rehab Clinic and Fitness Center

3. By electing to self-pay for services, any payments I make to Access Rehab Clinic and Fitness Center will not be credited toward satisfying any Deductible or Out Of Pocket Maximum I may be subject to under my health insurance plan. I understand that this agreement forfeits my ability to claim against my insurance plan and/or receive reimbursement for any fees paid to Access Rehab Clinic and Fitness Center in the current year of insurance coverage.

4. I have read this Election to Self-Pay for Services form and have had the opportunity to ask any questions I may have had about the form. Any questions I may have had about this form have been answered to my satisfaction.

5. I have freely chosen to self-pay for services after having asked Access Rehab Clinic and Fitness Center about payment options and having carefully considered those options.

6. I understand I may receive a copy of this signed agreement upon request.

7. Self-pay Initial Evaluation Rate: $_____ Self-pay Per Visit Rate: $_____

_____ _____

Patient/Representative/Guardian Printed Name Date

_____ _____

Patient/Representative/Guardian Signature Date

_____ _____ _____

Witness Name Witness Signature DATE

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

ACCESS REHAB CLINIC AND FITNESS CENTER

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
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ACCESS REHAB CLINIC AND FITNESS CENTER

ACKNOWLEDGMENT OF FINANCIAL POLICY

**Please initial to left of each statement that applies to you. 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

Anne H. Campbell, P.T., O.C.S., F.A.A.O.M.P.T.
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Excellence in Physical and Occupational Therapies for Orthopaedic, Spinal, TMJ, Hand, Sports, Industrial, and Neurological Conditions

CONSENT TO TREAT A MINOR

Access Rehab Clinic and Fitness Center requires the written, signed permission of parent or LEGAL guardian to Evaluate and carry out Treatment on Minor children (under the age of 18)

I, (print full name) _____ (Circle One: Parent Legal Guardian)

give Access Rehab Clinic and Fitness Center permission to Evaluate and Treat my child,

(Print full name)_____.

I have indicated below whether this is allowable without my constant presence.

check one below:

_____ I must be present throughout the treatment time. This requires I be on site for the entire duration of treatment at all times. If I leave the premises for any reason, all evaluation, treatment and exercise will cease until I return.

_____ I hereby grant permission for Access Rehab Clinic and Fitness Center to Evaluate and Treat my child in my absence. I will always return within a reasonable time, as indicated to the Clinic, so that I am present when treatment is complete, and prior to closing of the clinic.

_____ _____
Signature of Parent or Legal Guardian Date

_____
Print nave of Parent of Legal Guardian

_____ _____
Signature of Witness, Access Rehab Clinics and Fitness Center Date

_____
Print name of Witness

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ACCESS REHAB
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AND FITNESS CENTER

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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_____

Related Surgeries, Procedures, Dates _____

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

How & When: _____

Chief Complaint-The Main Reason you need Physical therapy? ___Pain ___Swelling ___Decreased Function ___ Worsening Existing Condition

___ Loss of, or Poor, Balance ___ Dizzy ___ Unable or Worsening Ability to Do Physical Activities ___ Unable or Worsening ability to Work

___ Inability or Worsening Ability to Do Activities of Daily Living ___ Inability or Worsening Ability to Do Recreational Activities

Other:_____

Do **you HAVE** or have you **EVER** had (Circle, Date, explain): **Pacemaker**_____ **Heart problems**_____ **Breathing Problems**_____

High blood pressure_____ **Diabetes** (Type)_____ **Anxiety**_____ **Fibromyalgia**_____ **Hernia**_____

Osteoporosis/penia_____ **Broken bones**_____ **Seizure disorder or seizures of any kind**_____

Cancer (where & when) _____ **Arthritis** (what kind & where)_____

Headaches_____ Frequency: _____ **Implants** (metal and cosmetic)_____

Circulation or Bleeding problems_____ **Problems with healing**_____

Dizziness_____ **Loose Joints or Double Joints**_____ **Bowel or Bladder Leakage**_____

Parkinsons_____ **Alzheimers/Dementia**_____ **Stroke/Head Injury/Neurologic**_____

Other Surgical History_____

X-ray, MRI, other tests: Dates, results_____

Medications for THIS condition: _____

Drug Allergies: None or:_____ Other Allergies_____

Do you consider your sleep habits (circle one): GOOD FAIR POOR ? **Do you SMOKE?** YES NO How many cigarettes per day? _____

I need to use (circle): Steps Curbs Stairs with railings Stairs no railings Ramps Uneven Terrain Elevator Escalator

Current Limitations:(circle) Sitting Standing Walking Running Stairs Lifting Objects Carrying Objects Reaching Up

Push/Pull Objects Grooming Dressing Bathing Cooking Turn in Bed Rise from Sitting Desk/Computer Work Driving

Manipulate small objects Chew Eat Talk Bend Down Move Head Other: _____

Describe any Falling or Nearly Falling events:_____

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

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

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

Sport, Physical, Leisure Activities_____

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

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

What we did we not ask, that you think we should know?_____

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 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_____

****

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

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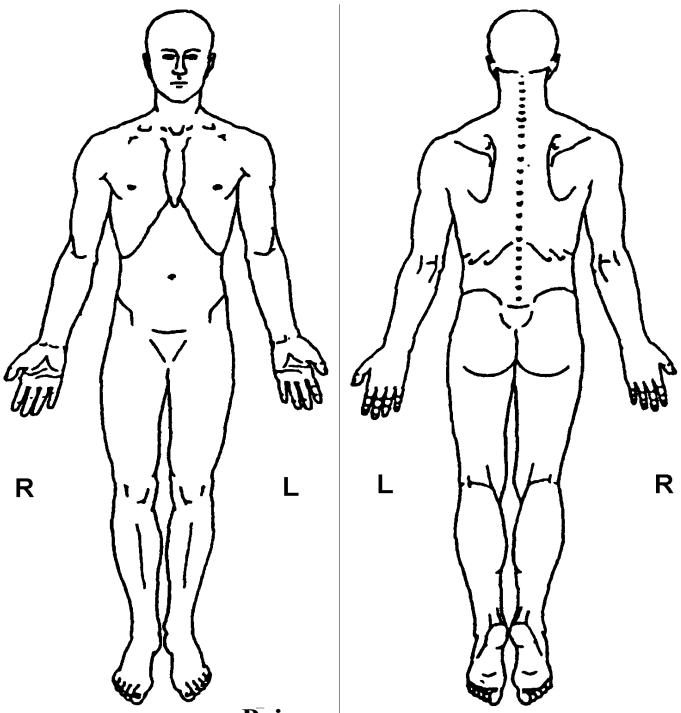
Please COMPLETE this page and BRING it with you

* * * * * * * * * * * * **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.

Please COMPLETE this page and BRING it with you

Patient Name_____ Page_____ of_____

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 your initials.

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 (pain, allergy, blood thinner, etc.)	Dosage (e.g.250mg)	Frequency (use the abbreviations provided above)	IE Date	Re Date	Re Date	Re Date	Re Date	Re Date	DC Date

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Read This Page Please

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

ALMOST DONE!

OUTCOMES

Following this page are the OUTCOMES forms. We are required to monitor these.
They also help us follow your progress. You do not need to do all of them.
We are happy if you do 2, but you may do as many as you wish. Choose ones that seem to apply most to you.
If you wonder if you should choose a certain one, then yes, go ahead and do it.
The more we know about you, the better
Several refer to "pain". Read that as "your symtoms/complaints". It can be tingling, weakness, weird feelings...etc.

Don't stress over them. The goal is to communicate what is bothering you.
Don't be a hero. We don't really want to know how tough you are, but rather what is bothering you.
This is your chance to be sure we "feel your pain". After all, you are coming in, something is wrong.
Especially, help us justify to your payor that there is something that needs help. They do look at these numbers.

Do not bother calculating the results. We will do it. You've spent enough time on paperwork!

Thank you for completing this packet, and doing your outcomes. We really appreciate it. It helps us help you best.

Quick DASH	anything to do with the shoulder and arm - we like you to do this if you also have a neck problem
Neck Disability Index (NDI)	for neck problems - we like you to do this if you also have a jaw, shoulder or arm problem
Back Disability Index (BDI)	for back problems - we like you to do this if you also have a hip or leg problem
LEFT Lower Extremity Functional Scale	for hip and leg problems - we like you to do this if you also have a back problem
Dizziness Handicap Inventory	for dizziness - if you do this one, be sure please to do the Neck Disability Index also
TMJ - Craniomandibular ADL Scale	for facial and jaw pain (TMJ) - if you do this one, be sure please to do the Neck Disability Index also

Thank you so much for having this packet complete when you arrive!

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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.

	TASK	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*

Office use only **SCORE: _____ / 100**

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Neck Disability Index (NDI)

Patient Name _____ Date _____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the ***ONE*** statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity
- ❍ I have no pain at the moment.
- ❍ The pain is very mild at the moment.
- ❍ The pain comes and goes and is moderate.
- ❍ The pain is fairly severe at the moment.
- ❍ The pain is very severe at the moment.
- ❍ The pain is the worst imaginable at the moment.

Sleeping
- ❍ I have no trouble sleeping.
- ❍ My sleep is slightly disturbed (less than 1 hour sleepless).
- ❍ My sleep is mildly disturbed (1-2 hours sleepless).
- ❍ My sleep is moderately disturbed (2-3 hours sleepless).
- ❍ My sleep is greatly disturbed (3-5 hours sleepless).
- ❍ My sleep is completely disturbed (5-7 hours sleepless).

Reading
- ❍ I can read as much as I want with no neck pain.
- ❍ I can read as much as I want with slight neck pain.
- ❍ I can read as much as I want with moderate neck pain.
- ❍ I cannot read as much as I want because of moderate neck pain.
- ❍ I can hardly read at all because of severe neck pain.
- ❍ I cannot read at all because of neck pain.

Concentration
- ❍ I can concentrate fully when I want with no difficulty.
- ❍ I can concentrate fully when I want with slight difficulty.
- ❍ I have a fair degree of difficulty concentrating when I want.
- ❍ I have a lot of difficulty concentrating when I want.
- ❍ I have a great deal of difficulty concentrating when I want.
- ❍ I cannot concentrate at all.

Work
- ❍ I can do as much work as I want.
- ❍ I can only do my usual work but no more.
- ❍ I can only do most of my usual work but no more.
- ❍ I cannot do my usual work.
- ❍ I can hardly do any work at all.
- ❍ I cannot do any work at all.

Personal Care
- ❍ I can look after myself normally without causing extra pain.
- ❍ I can look after myself normally but it causes extra pain.
- ❍ It is painful to look after myself and I am slow and careful.
- ❍ I need some help but I manage most of my personal care.
- ❍ I need help every day in most aspects of self care.
- ❍ I do not get dressed, I wash with difficulty and stay in bed.

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

Driving
- ❍ I can drive my car without any neck pain.
- ❍ I can drive my car as long as I want with slight neck pain.
- ❍ I can drive my car as long as I want with moderate neck pain.
- ❍ I cannot drive my car as long as I want because of moderate neck pain.
- ❍ I can hardly drive at all because of severe neck pain.
- ❍ I cannot drive my car at all because of neck pain.

Recreation
- ❍ I am able to engage in all my recreation activities without neck pain.
- ❍ I am able to engage in all my usual recreation activities with some neck pain.
- ❍ I am able to engage in most but not all my usual recreation activities because of neck pain.
- ❍ I am only able to engage in a few of my usual recreation activities because of neck pain.
- ❍ I can hardly do any recreation activities because of neck pain.
- ❍ I cannot do any recreation activities at all.

Headaches
- ❍ I have no headaches at all.
- ❍ I have slight headaches which come infrequently.
- ❍ I have moderate headaches which come infrequently.
- ❍ I have moderate headaches which come frequently.
- ❍ I have severe headaches which come frequently.
- ❍ I have headaches almost all the time.

Neck Index Score: _____

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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
- ❍ 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 with 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 effect on my pain.

2. 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.

3. 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 (e.g., 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 cannot lift or carry anything at all.

4. **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.

5. 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 more than 1 hour.
- ❍ Pain prevents me from sitting more than ½ hour.
- ❍ Pain prevents me from sitting more than 10 minutes.
- ❍ Pain prevents me from sitting at all.

6. Standing
- ❍ I can stand as long as I want without increased pain.
- ❍ I can stand as long as I want but, it increases my pain.
- ❍ Pain prevents me from standing more than 1 hour.
- ❍ Pain prevents me from standing more than a 1/2 hour.
- ❍ Pain prevents me from standing more than 10 minutes.
- ❍ Pain prevents me from standing at all.

7. 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.
- ❍ Even when I take pain medication, I sleep less than 2 hour
- ❍ Pain prevents me from sleeping at all.

8. 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 (e.g. sports, dancing).
- ❍ 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.

9. Traveling
- ❍ I can travel anywhere without increased pain.
- ❍ I can travel anywhere, but it increases my pain.
- ❍ My pain restricts my 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 physician/therapist or hospital.

10. 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 (eg, lift, vacuum).
- ❍ Pain prevents me from doing anything but light duties.
- ❍ Pain prevents me from doing even light duties.
- ❍ Pain prevents me from performing any job or homemaking chores.

Office use only **SCORE: _____%**

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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

Office use only **SCORE: _____ / 80**

Source: Binkley et al (1999): The Lower Extremity Functional Scale (LEFS): Scale development, measurement properties, and clinical application. Physical Therapy. 79:371-383

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

Office use only **SCORE:** _____

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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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