Initial Self-Evaluation Form - Flaming Physical Therapy

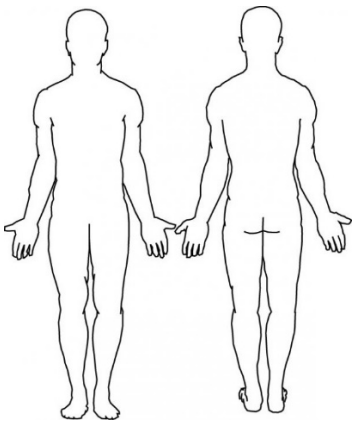
11 Elsinore Avenue, Bath 207-442-9810
68 Chapman Street, Damariscotta 207-563-7990

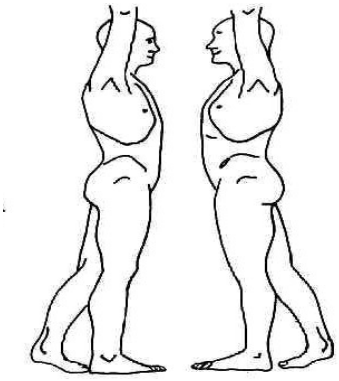
Patient's Name: _____ Date: _____

Date of Original Injury, symptoms or Pain: _____ Date of Birth: _____

PRESENT CONDITION / PAIN / SYMPTOMS:

1. Please Shade or make an "X" in area (or areas) where you are experiencing pain /symptoms.
   a. If the symptoms travel/radiate, use an "arrow" to follow the path of pain
   b. Feel free to use more than one symbol





   c. Current Injury/Symptom Descriptors: Circle any/all words that apply, add others

- Severe
- Moderate
- Numbness
- Tingling
- Weakness

- Dull
- Throbbing
- Aching
- Poor balance
- Stiffness

- Radiating
- Burning
- Stabbing
- Sharp/Searing
- _____

2. When and what initially caused you to seek Physical Therapy? _____
   _____
3. List symptom(s) that you "INITIALLY" experienced _____
   a. Severity Initially: 0 1 2 3 4 5 6 7 8 9 10
4. List Symptom(s) that you "CURRENTLY" experience _____
   a. Severity Currently: 0 1 2 3 4 5 6 7 8 9 10
5. Since Initiation, how has the pain changed? _____

Initial Self-Evaluation Form – Flaming Physical Therapy (Continued)

6. Since onset have your symptoms become:
    a. BETTER B. WORSE C. No CHANGE
7. How often do you experience the Symptoms? _____
8. What makes your symptoms Worse?

Sitting Standing Walking Bending Lifting Other

9. What eases your Symptoms

Sitting Standing Walking Bending Lifting Other

10. How much does your pain interfere with your activities?
    a. None (0%) Rarely (1-19%) Often (20-39%)
    b. Moderate (40-59%) Almost always (60-79%) Always (80-100)
11. Are you taking any Medications related to the reason you're in PT? YES NO
    a. If yes, What and how often? _____

PAST HISTORY OF SYMPTOMS

1. Have you ever had these kinds of symptoms before? YES NO

    If Yes, when was the previous episode? _____
2. How often have they reoccurred? _____

3. Has the frequency of severity of these symptoms increased since that former episode?

    a. FREQUENCY? YES NO B. SEVERITY? YES NO

PAST MEDICAL HISTORY

Accidents or injuries?	YES	NO	_____		
Surgeries?	YES	NO	_____		
Cancer?	YES	NO	COPD	YES	NO
Arthritis	YES	NO	Neurologic Disorders	YES	NO
Pregnancy?	YES	NO	Parkinson's	YES	NO
Immunosuppression?	YES	NO	Pacemaker	YES	NO

Have you had other related P.T. or Body work? _____

By signing, I certify that all information in this form is true and correct to the best of my knowledge.

Patient (or Guardian) Signature: _____ Date: _____

Therapy Treatment Agreement – Flaming Physical Therapy

11 Elsinore Avenue, Bath, Maine 207-442-9810
68 Chapman Street, Damariscotta, Maine 207-563-7990

This document is a treatment agreement in which the patient, or the responsible party for the patient, and Flaming Physical Therapy are identified below. The patient, or responsible party, consents to evaluations and treatments upon the provisions hereof, and patient, responsible party and Flaming Physical Therapy hereby agree with each other as follows:

PATIENT NAME; LAST _____ FIRST _____ MI ___

Date of Birth ____ / ____ / _____

ADDRESS: _____

CITY: _____ State: _____ Zip Code: _____

Billing Address _____ (If Different from above)

PHONE: Home: _____ Cell: _____ Other: _____

E-MAIL: _____

Gender: Male: _____ Female: _____

Marital Status: Married: _____ Single: _____ Other: _____

WORK STATUS: Employed: ____ Unemployed: ____ F/T Student: ____ Retired: ____

Employer: _____

RELATIONSHIP TO SUBSCRIBER: Self: ____ Spouse: ____ Child: ____ Other: ____

IF Someone other than the patient is the subscriber; Please fill out below:

Name of Subscriber _____ Subscriber Birth Date: ___ / ___ /___

Address (if different) _____ Phone: _____

Employer of Insured _____

EMERGENCY CONTACT _____ Phone _____

Is the Patient Condition related to (or results of) any of the Following?

Employment? YES ____ NO ____ If YES, is this Workers Compensation? _____

Auto Accident YES ____ NO ____ IF YES, who's Insurance is Responsible? _____

Other Accident YES ____ NO ____ If YES, Which Insurance is Responsible? _____

Use Space Below to Explain:

DIAGNOSIS of Injury / Illness / Surgery: _____

Date of Current Injury / Surgery / other: ____ / ____ / _____

Date P.T. Ordered: ____ / ____ / _____

Patient's Next Physician Follow up visit ____ / ____ / _____

PRIMARY PHYSICIAN: _____ Phone#: _____

Ordering Physician: _____ Phone#: _____

PRIMARY INSURANCE: _____ Plan Name: _____

ID Number: _____ Group#: _____

Claims Mailing Address: _____

Co-Payment Amount for Physical Therapy: _____ Deductible: _____

SECONDARY INSURANCE: _____ Plan Name: _____

ID Number: _____ Group#: _____

Claims Mailing Address: _____

CO-PAYMENTS ARE COLLECTED AT EACH VISIT. YOU WILL BE BILLED FOR ANY COINSURANCE BALANCE AS INDICATED BY YOUR INSURANCE PLAN. IT IS YOUR RESPONSIBILITY TO KNOW YOUR COINSURANCE.

AUTHORIZATION for RELEASE OF INFORMATION: The institution rendering services is hereby authorized to furnish and release, in accordance with facility policy, such professional and clinical information as may be necessary for the completion of my medical claims by valid third party, agents or agencies from the medical records compiled during treatment. The facility is hereby released from all legal liability that may arise from the release of said information.

TREATMENT CONSENT: I, the undersigned, so hereby agree and give my consent and authorization for Glenn Flaming Physical Therapy to provide examination, treatments and services to myself/designee. I realize and certify that no guarantee or assurance has been made as to the results that may be obtained for such examinations, treatments and services.

ASSIGNMENT AND AUTHORIZATION TO PAY INSURANCE BENEFITS: I hereby assign and authorize payment directly to this facility, herein specified and otherwise payable to me, but not to exceed the facility's regular charges for this period of treatment. I understand I am responsible to the facility for the charges NOT covered NOR paid by my Insurance, or through Worker's Compensation.

CANCELLATION / NO SHOW POLICY: Your well being is our highest concern. For you to benefit from your Physical Therapy treatment, we encourage you to keep each scheduled appointment. We realize that this is not always possible. Therefore, if you must cancel, we ask that you call the office at least 24 hours prior to the scheduled appointment time. Failure to cancel within the allotted time frame mentioned **will result in a $50.00 charge**, or the amount of your co-pay, **WHICH EVER IS THE GREATER AMOUNT**. This charge will be collected at the next scheduled appointment or will be billed to you upon Discharge. As always, we are glad to answer any questions and work with you if you have special circumstances. **Ongoing failure to keep your appointments may result in decision to terminate your therapy with us.**

PATIENT (or GUARDIAN) Signature: _____ Date:_____

HIPAA Notice of Privacy Practices – Flaming Physical Therapy

11 Elsinore Avenue, Bath, Maine 207-442-9810
68 Chapman Street, Damariscotta, Maine 207-563-7990

Flaming Physical Therapy (FPT) pledges to maintain the privacy and confidentiality of our patients at all times. The full written privacy policy is available upon request. Any complaints regarding privacy issues should be addressed with the management at Flaming Physical Therapy.

All employees at FPT pledge to keep your health information confidential; however, your conversations may, at times, be overheard by other parties. You may meet with your Therapist of other staff members in a private room if this is a concern.

HOW WE MAY USE AND DISCLOSE PROTECTED HEALTH INFORMATION ABOUT YOU

In accordance with government guidelines, we are herein asking for your consent in sharing necessary information about your care at FPT with other parties including but not limited to your Physician, Health Insurance Carrier, Lawyer, or Case Manager. Necessary information may include but is not limited to the following areas; For Treatment, For Payment of services, For Health Care Operations, Judicial and Administrative Proceedings, to avoid a serious threat to health or safety, Health Oversight Activities, Law Enforcement and Worker's Compensation.

YOUR RIGHTS REGARDING PROTECTED HEALTH INFORMATION ABOUT YOU.

You have the following rights regarding protected health information that we may obtain from you. You have the Right to inspect and copy any protected health information that may be used to make decisions about your care. You have the right to amend or supplement health information, if you feel that it is incorrect or incomplete. You have the right to request an "accounting of disclosures". You have the right to request restrictions or limitations on information we use or disclose about you. You have the right to a paper copy of this notice.

FLAMING PHYSICAL THERAPY IS ASKING FOR YOUR SPECIFIC DIRECTIVES IN THE FOLLOWING AREAS

Please initial <u>ONE</u> of the following options:

____ FPT has my consent to share necessary information regarding my Physical Therapy care as needed in accordance with the HIPAA Privacy Act.

____ FPT has my consent to share health information with ONLY THE FOLLOWING PARTIES:

In order to comply with federal regulations, we ask for your consent regarding TELEPHONE MESSAGES.

____ I authorize a telephone message may be left with any person or machine answering a phone call intended for me.

____ Telephone messages may be left ONLY WITH THE FOLLOWING: _____

I have read and understand the FPT privacy policy and consent to the sharing of necessary information about my care between appropriate parties in accordance with the HIPAA Privacy Act unless directed otherwise

PATIENT (or GUARDIAN) Signature: _____ DATE:_____

PRINTED PATIENT NAME AND BIRTH DATE: _____ DOB: ___/___/_____

PARENT OR GUARDIAN NAME (PRINTED): _____DATE: _____

Modified Oswestry Low Back Pain Disability Questionnaire[a]

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

Pain Intensity
- ❑ I can tolerate the pain I have without having to use pain medication.
- ❑ The pain is bad, but I can manage without having to take pain medication.
- ❑ Pain medication provides me 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.

Personal Care (e.g., Washing, Dressing)
- ❑ 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, I wash with difficulty, and I stay in bed.

Lifting
- ❑ I can lift heavy weights without increased pain.
- ❑ I can lift heavy weights, but it causes increased pain.
- ❑ Pain prevents me from lifting heavy weights off the floor, but I can manage if the weights are conveniently positioned (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.

Walking
- ❑ Pain does not prevent me from walking any distance.
- ❑ Pain prevents me from walking more than 1 mile. (1 mile = 1.6 km).
- ❑ Pain prevents me from walking more than 1/2 mile.
- ❑ Pain prevents me from walking more than 1/4 mile.
- ❑ I can walk only with crutches or a cane.
- ❑ I am in bed most of the time and have to crawl to the toilet.

Sitting
- ❑ I can sit in any chair as long as I like.
- ❑ I can only sit in my favorite chair as long as I like.
- ❑ Pain prevents me from sitting for more than 1 hour.
- ❑ Pain prevents me from sitting for more than 1/2 hour.
- ❑ Pain prevents me from sitting for more than 10 minutes.
- ❑ Pain prevents me from sitting at all.

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

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

Social Life
- ❑ My social life is normal and does not increase my pain.
- ❑ My social life is normal, but it increases my level of pain.
- ❑ Pain prevents me from participating in more energetic activities (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.

Please complete questionnaire on other side.

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 1/2 hour.
- ❑ My pain prevents all travel except for visits to the physician / therapist or hospital.

Employment / Homemaking

- ❑ My normal homemaking / job activities do not cause pain.
- ❑ My normal homemaking / job activities increase my pain, but I can still perform all that is required of me.
- ❑ I can perform most of my homemaking / job duties, but pain prevents me from performing more physically stressful activities (e.g., lifting, vacuuming).
- ❑ 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.

FOR OFFICE USE ONLY

Score: /50 x 100 = ____% points

Scoring: For each section the total possible score is 5: if the first statement is marked the section score = 0, if the last statement is marked it = 5. If all ten sections are completed the score is calculated as follows:

Example: 16 (total scored)
50 (total possible score) x 100 = 32%

If one section is missed or not applicable the score is calculated:

16 (total scored)
45 (total possible score) x 100 = 35.5%

Minimum Detectable Change (90% confidence): 10%points (Change of less than this amount may be attributed to error in the measurement.)

Name: _____ **Date: _____**

Source: Fritz JM, Irrgang JJ. A comparison of a modified Oswestry Low Back Pain Disability Questionnaire and the Quebec Back Pain Disability Scale. *Physical Therapy*. 2001;81:776-788.

[a]Modified by Fritz & Irrgang with permission of The Chartered Society of Physiotherapy, from Fairbanks JCT, Couper J, Davies JB, et al. The Oswestry Low Back Pain Disability Questionnaire. *Physiotherapy*. 1980;66:271-273.

Lower Extremity Functional Scale (LEFS)

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

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

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

Scoring instructions

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

Interpretation of scores

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

Performance:

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

Instructions

We are interested in knowing whether you are having any difficulty at all with the activities listed below **because of your lower limb problem** for which you are currently seeking attention. Please provide an answer for **each** activity.

Today, *do you* or *would you* have any difficulty at all with:

Activities	Extreme difficulty or unable to perform activity	Quite a bit of difficulty	Moderate difficulty	A little bit of difficulty	No difficulty
1. Any of your usual work, housework or school activities.	0	1	2	3	4
2. Your usual hobbies, recreational or sporting activities.	0	1	2	3	4
3. Getting into or out of the bath.	0	1	2	3	4
4. Walking between rooms.	0	1	2	3	4
5. Putting on your shoes or socks.	0	1	2	3	4
6. Squatting.	0	1	2	3	4
7. Lifting an object, like a bag of groceries from the floor.	0	1	2	3	4
8. Performing light activities around your home.	0	1	2	3	4
9. Performing heavy activities around your home.	0	1	2	3	4
10. Getting into or out of a car.	0	1	2	3	4
11. Walking 2 blocks.	0	1	2	3	4
12. Walking a mile.	0	1	2	3	4
13. Going up or down 10 stairs (about 1 flight of stairs).	0	1	2	3	4
14. Standing for 1 hour.	0	1	2	3	4
15. Sitting for 1 hour.	0	1	2	3	4
16. Running on even ground.	0	1	2	3	4
17. Running on uneven ground.	0	1	2	3	4
18. Making sharp turns while running fast.	0	1	2	3	4
19. Hopping.	0	1	2	3	4
20. Rolling over in bed.	0	1	2	3	4
Column Totals:	0	1	2	3	4