Dublin Family Physical Therapy
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Consent to Receive Electronic Communications

Patient Name: _____ Date: _____

Please check below:

- ☐ I Agree
- ☐ I Do Not Agree

That Dublin Family Physical Therapy, LLC may communicate at the email and/or mobile number listed below. I am aware that there is some level of risk that third parties may be able to read unencrypted emails. Dublin Family Physical Therapy, LLC will always provide HIPAA compliant encrypted emails for any communication that contains sensitive health or personal information. I further agree that I am responsible for updating Dublin Family Physical Therapy, LLC of any changes to my email address and/or mobile phone number.

My preferred method of electronic communication:

- ☐ Text Messaging
- ☐ Email
- ☐ Both

Email: _____

Mobile Phone Number: _____

I can withdraw my consent to electronic communication at any time by notifying Dublin Family Physical Therapy, LLC.

Patient Signature: _____ Date: _____

PATIENT INFORMATION

NAME: FIRST _____ LAST _____ DATE OF BIRTH _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHONE: ( ) _____ CELL: ( ) _____ HEIGHT: _____ WEIGHT: _____

EMERGENCY CONTACT NAME _____ PHONE _____

RELATIONSHIP _____

HAVE YOU HAD ANY PHYSICAL THERAPY TREATMENT THIS YEAR? Y N HOW MANY? _____

HAVE YOU HAD ANY CHIROPRACTIC TREATMENT THIS YEAR? Y N HOW MANY? _____

PHYSICIAN WHO REFERRED YOU TO PHYSICAL THERAPY _____

NEXT APPOINTMENT WITH PHYSICIAN WHO REFERRED YOU _____

PRIMARY CARE PHYSICIAN _____

EMPLOYMENT INFORMATION

EMPLOYER NAME _____ OCCUPATION _____

EMPLOYER ADDRESS _____ WORK PHONE _____

CITY, STATE, ZIP _____ DID INJURY OCCUR AT WORK? Y N

DID INJURY OCCUR IN AN AUTO ACCIDENT? Y N DATE OF ACCIDENT _____

STATE IN WHICH ACCIDENT OCCURRED _____

RESPONSIBLE PARTY

NAME _____

ADDRESS _____

DATE OF BIRTH _____ DAYTIME PHONE _____

PLACE OF EMPLOYMENT _____

INSURANCE

PRIMARY INSURANCE: _____ NAME OF INSURED: _____

INSURED DATE OF BIRTH: _____ RELATIONSHIP TO PATIENT: _____

ID NUMBER: _____ GROUP NUMBER: _____

SECONDARY INSURANCE: _____ NAME OF INSURED: _____

INSURED DATE OF BIRTH: _____ RELATIONSHIP TO PATIENT: _____

ID NUMBER: _____ GROUP NUMBER: _____

WORKERS COMPENSATION PATIENTS

CLAIM NUMBER _____ DATE OF INJURY _____

NAME OF EMPLOYER AT TIME OF INJURY? _____

ADDRESS OF EMPLOYER IF THEY ARE SELF INSURED _____

I agree to pay medical costs in the event of failure to prosecute the claim for Worker's Compensation or if the compensation claim is disallowed.

SIGNATURE OF INJURED WORKER _____ DATE _____

PATIENT MEDICAL HISTORY

Tell Us About You:

Name: _____

Why were you referred to physical therapy? Please describe how and when your injury occurred.

_____

_____

What do you want to accomplish from therapy? _____

In the last year, have you undergone any surgical procedures? ☐ YES ☐ NO

In the last year, have you been admitted to a hospital? ☐ YES ☐ NO

What was the condition/surgery? _____

Have you received any physical therapy treatment during the past year? ☐ YES ☐ NO

If yes, for what condition? _____ Where? _____

Have you fallen in the past 12 months? ☐ YES ☐ NO If yes, number of times: _____

If you have fallen in the past 12 months, how did you fall? _____

If you fell did you injure yourself and what was the injury? _____

Tell Us About Your Activities at Work and Home...

Occupation: _____

Hobbies/Sports & Exercise: _____

At the present time, what are the most difficult tasks for you to perform? _____

At WORK: _____

At HOME: _____

Have You Been Concerned With Any of the Following:

	YES	NO		YES	NO		YES	NO
High Blood Pressure	☐	☐	Pacemaker	☐	☐	Exposure/Treatment TB	☐	☐
Heart Condition	☐	☐	Seizures	☐	☐	Cough for > 2 weeks	☐	☐
Numbness	☐	☐	Cancer	☐	☐	Fever for > 2 weeks	☐	☐
Neurological	☐	☐	Skin	☐	☐	Unexplained Weight Loss	☐	☐
Diabetes	☐	☐	Weight	☐	☐	Pregnancy	☐	☐
Dizziness	☐	☐	Bladder Control	☐	☐	Digestion	☐	☐
Mental Health	☐	☐	Bowel Control	☐	☐	Immune System	☐	☐

Circle any special tests related to your injury/condition:

CT-scan EMG ECG MRI X-Rays Tilt Table VNG Bone Scan

Please list your medications (include dosage): _____

_____

Patient/Guardian Signature: _____ Date: _____

Reviewed with Patient: _____ Date: _____

Therapist Signature

Neck Index

Form N1-100

DOB:

rev 3/27/2003

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

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
③ The pain is fairly severe at the moment.
④ The pain is very severe at the moment.
⑤ The pain is the worst imaginable at the moment.

Sleeping

⓪ I have no trouble sleeping.
① My sleep is slightly disturbed (less than 1 hour sleepless).
② My sleep is mildly disturbed (1-2 hours sleepless).
③ My sleep is moderately disturbed (2-3 hours sleepless).
④ My sleep is greatly disturbed (3-5 hours sleepless).
⑤ My sleep is completely disturbed (5-7 hours sleepless).

Reading

⓪ I can read as much as I want with no neck pain.
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 cannot read as much as I want because of moderate neck pain.
④ I can hardly read at all because of severe neck pain.
⑤ I cannot read at all because of neck pain.

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 when I want.
③ I have a lot of difficulty concentrating when I want.
④ I have a great deal of difficulty concentrating when I want.
⑤ I cannot concentrate at all.

Work

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

Personal Care

⓪ I can look after myself normally without causing 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 I manage most of my personal care.
④ I need help every day in most aspects of self care.
⑤ I do not get dressed, I wash with difficulty and stay in bed.

Lifting

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

Driving

⓪ I can drive my car without any 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 cannot drive my car as long as I want because of moderate neck pain.
④ I can hardly drive at all because of severe neck pain.
⑤ I cannot drive my car at all because of neck pain.

Recreation

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

Headaches

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 frequently.
⑤ I have headaches almost all the time.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Neck Index Score

Name: _____ Date: _____ DOB: _____

HIT-6™ Headache Impact Test

HIT is a tool used to measure the impact headaches have on your ability to function on the job, at school, at home and in social situations. Your score shows you the effect that headaches have on normal daily life and your ability to function. This questionnaire was designed to help you describe and communicate the way you feel and what you cannot do because of headaches.

To complete, please circle one answer for each question.

When you have headaches, how often is the pain severe?

never rarely sometimes very often always

How often do headaches limit your ability to do usual daily activities including household work, work, school, or social activities?

never rarely sometimes very often always

When you have a headache, how often do you wish you could lie down?

never rarely sometimes very often always

In the past 4 weeks, how often have you felt too tired to do work or daily activities because of your headaches?

never rarely sometimes very often always

In the past 4 weeks, how often have you felt fed up or irritated because of your headaches?

never rarely sometimes very often always

In the past 4 weeks, how often did headaches limit your ability to concentrate on work or daily activities?

never rarely sometimes very often always

☐	☐	☐	☐	☐
COLUMN 1	COLUMN 2	COLUMN 3	COLUMN 4	COLUMN 5
6 points each	8 points each	10 points each	11 points each	13 points each

To score, add points for answers in each column.

If your HIT-6 is 50 or higher:

You should share your results with your doctor. Headaches that stop you from enjoying the important things in life, like family, work, school or social activities could be migraine.

☐ TOTAL SCORE

Dizziness Handicap Inventory

Date of Birth _____ Today's Date_____

Name _____ Height _____ ft. _____ in. Weight_____lbs.

Instructions: The purpose of this scale is to identify difficulties that you may be experiencing because of your dizziness. Please check "always", or "no" or "sometimes" to each question. Answer each question only as it pertains to your dizziness problem.

	Questions	Always	Sometimes	No
P1	Does looking up increase your problem?			
E2	Because of your problem, do you feel frustrated?			
F3	Because of your problem, do you restrict your travel for business or pleasure?			
P4	Does walking down the aisle of a supermarket increase your problem?			
F5	Because of your problem, do you have difficulty getting into or out of bed?			
F6	Does your problem significantly restrict your participation in social activities, such as going out to dinner, going to movies, dancing or to parties?			
F7	Because of your problem, do you have difficulty reading?			
F8	Does performing more ambitious activities like sports, dancing, and household chores, such as sweeping or putting dishes away; increase your problem?			
E9	Because of your problem, are you afraid to leave your home without having someone accompany you?			
E10	Because of your problem, have you been embarrassed in front of others?			
P11	Do quick movements of your head increase your problem?			
F12	Because of your problem, do you avoid heights?			
P13	Does turning over in bed increase your problem?			
F14	Because of your problem, is it difficult for you to do strenuous housework or yard work?			
E15	Because of your problem, are you afraid people may think that you are intoxicated?			
F16	Because of your problem, is it difficult for you to go for a walk by yourself?			
P17	Does walking down a sidewalk increase your problem?			
E18	Because of your problem, is it difficult for you to concentrate?			
F19	Because of your problem, is it difficult for you to walk around your house in the dark?			
E20	Because of your problem, are you afraid to stay home alone?			
E21	Because of your problem, do you feel handicapped?			
E22	Has your problem placed stress on your relationship with members of your family or friends?			
E23	Because of your problem, are you depressed?			
F24	Does your problem interfere with your job or household responsibilities?			
P25	Does bending over increase your problem?			