Dublin Family Physical Therapy
9240 Dublin Rd
Powell, OH 43065-9643
(614) 379-1120 (P) (614) 573-0502 (F)
Tim@DublinFamilyPT.com

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

Patient Name: _____ **Date:** _____

TMD Disability Index Questionnaire

Please check the one statement that best pertains to you (not necessarily exactly) in each of the following categories.

Section 1 - Communication (Talking)

____ (0) I can talk as much as I want without pain, fatigue or discomfort.
____ (1) I talk as much as I want, but it causes some pain, fatigue and/or discomfort.
____ (2) I can't talk as much as I want because of pain, fatigue and/or discomfort.
____ (3) I can't talk much at all because of pain, fatigue and/or discomfort.
____ (4) Pain prevents me from talking at all.

Section 2 - Normal Living Activities (Brushing Teeth/Flossing)

____ (0) I am able to care for my teeth and gums in a normal fashion without restriction, and without pain, fatigue or discomfort.
____ (1) I am able to care for all my teeth and gums, but I must be slow and careful, otherwise pain/discomfort, jaw tiredness results.
____ (2) I do manage to care for my teeth and gums in a normal fashion, but it usually causes some pain/discomfort, jaw tiredness no matter how slow and careful I am.
____ (3) I am unable to properly clean all my teeth and gums because of restricted opening and/or pain.
____ (4) I am unable to care for most of my teeth and gums because of restricted opening and/or pain.

Section 3 - Normal Living Activities (Eating, Chewing)

____ (0) I can eat and chew as much of anything I want without pain/discomfort or jaw tiredness.
____ (1) I can eat and chew most anything I want, but it sometimes causes pain/discomfort and/or jaw tiredness.
____ (2) I can't eat much of anything I want, because it often causes pain/discomfort, jaw tiredness or because of restricted opening.
____ (3) I must eat only soft foods (consistency of scrambled eggs or less) because of pain/discomfort, jaw fatigue and/or restricted opening.
____ (4) I must stay on a liquid diet because of pain and/or restricted opening.

Section 4 - Social/Recreational Activities (Singing, Playing Musical Instruments, Cheering, Laughing, Social Activities, Playing Amateur Sports/Hobbies, and Recreation, etc)

____ (0) I am enjoying a normal social life and/or recreational activities without restriction.
____ (1) I participate in normal social life and/or recreational activities but pain/discomfort is increased.
____ (2) The presence of pain and/or fear of likely aggravation only limits the more energetic components of my social life (sports, exercising, dancing, playing musical instrument, singing).
____ (3) I have restrictions socially, as I can't even sing, shout, cheer, play and/or laugh expressively because of increased pain/discomfort.
____ (4) I have practically no social life because of pain.

Section 5 - Non-Specialized Jaw Activities (Yawning, Mouth Opening and Opening my Mouth Wide)

____ (0) I can yawn in a normal fashion, painlessly.
____ (1) I can yawn and open my mouth fully wide open, but sometimes there is discomfort.
____ (2) I can yawn and open my mouth wide in a normal fashion, but it almost always causes discomfort.
____ (3) Yawning and opening my mouth wide are somewhat restricted by pain.
____ (4) I cannot yawn or open my mouth more than two finger widths (2.8-3.2 cm) or, if I can, it always causes greater than moderate pain.

Page 1 Total: _____

Patient Signature: _____ **Date** _____

Therapist Signature: _____ **Date** _____

Patient Name: _____ **Date:** _____

TMD Disability Index Questionnaire

Section 6 - Sexual function (Including Kissing, Hugging and Any and All Sexual Activities to Which You Are Accustomed)

____ (0) I am able to engage in all my customary sexual activities and expressions without limitation and/or causing headache, face or jaw pain.
____ (1) I am able to engage in all my customary sexual activities and expression, but it sometimes causes some headache, face, or jaw pain, or jaw fatigue.
____ (2) I am able to engage in all my customary sexual activities and expression, but it usually causes enough headache, face or jaw pain to markedly interfere with my enjoyment, willingness and satisfaction.
____ (3) I must limit my customary sexual expression and activities because of headache, face or jaw pain or limited mouth opening.
____ (4) I abstain from almost all sexual activities and expression because of the head, face or jaw pain it causes.

Section 7 - Sleep (Restful, Nocturnal Sleep Pattern)

____ (0) I sleep well in a normal fashion without any pain medication, relaxants or sleeping pills.
____ (1) I sleep well with the use of pain pills, anti-inflammatory medication or medicinal sleeping aides.
____ (2) I fail to realize 6 hours restful sleep even with the use of pills.
____ (3) I fail to realize 4 hours restful sleep even with the use of pills.
____ (4) I fail to realize 2 hours restful sleep even with the use of pills.

Section 8 - Effects of Any Form of Treatment, Including, But Not Limited to, Medications, In-office Therapy, Treatment, Oral Orthotics (eg, Splints, Mouthpieces), Ice/Heat, etc.

____ (0) I do not need to use treatment of any type in order to control or tolerate headache, face or jaw pain and discomfort.
____ (1) I can completely control my pain with some form of treatment.
____ (2) I get partial, but significant, relief through some form of treatment.
____ (3) I don't get "a lot of" relief from any form of treatment.
____ (4) There is no form of treatment that helps enough to make me want to continue.

Section 9 - Tinnitus, or Ringing in the Ear(s)

____ (0) I do not experience ringing in my ear(s).
____ (1) I experience ringing in my ear(s) somewhat, but it does not interfere with my sleep and/or my ability to perform my daily activities.
____ (2) I experience ringing in my ear(s) and it interferes with my sleep and/or daily activities, but I can accomplish set goals and I can get an acceptable amount of sleep.
____ (3) I experience ringing in my ear(s) and it causes a marked impairment in the performance of my daily activities and/or results in an unacceptable loss of sleep.
____ (4) I experience ringing in my ear(s) and it is incapacitating and/or forces me to use a masking device to get any sleep.

Section 10 - Dizziness (Lightheaded, Spinning and/or Balance Disturbance)

____ (0) I do not experience dizziness.
____ (1) I experience dizziness, but it does not interfere with my daily activities.
____ (2) I experience dizziness which interferes somewhat with my daily activities, but I can accomplish my set goals.
____ (3) I experience dizziness, which causes a marked impairment in the performance of my daily activities.
____ (4) I experience dizziness, which is incapacitating.

Page 2 Total: _____

Total Score (Page 1 + Page 2): _____

$$\frac{\text{Total Score}}{\text{Total \# Possible}} = \text{\% Disability}$$

_____ **% Disability**

Patient Signature: _____ **Date** _____

Therapist Signature: _____ **Date** _____