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

Name:_____ DATE:_____ DOB:_____

THE LOWER EXTREMITY FUNCTIONAL SCALE

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, re creational 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:					

Minimum Level of Detectable Change (90% Confidence): 9 points **SCORE: _____/ 80**

Please submit the sum of responses.

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