Eugene Physical Therapy

....Excellence as a Standard of Care

Attached you will find our new patient intake forms. Please fill out the appropriate sections and bring them with you to your first appointment.

- Make sure to arrive 10 minutes early **with your completed paperwork**. Our office staff will review your paperwork and answer any questions you may have.
- **If you are unable to complete your paperwork, please arrive 30 minutes prior to your scheduled appointment** time to complete them in the office. If you do not, your appointment may need to be rescheduled.

THINGS TO BRING TO YOUR APPOINTMENT:

- Completed paper work
- Physical Therapy referral
- Comfortable clothing/shoes
- Your insurance cards and a picture ID
- Reports you may have from your Physician

PAYMENT/INSURANCE:

- Payment is required at the time of service, so please make sure to contact your insurance company prior to your appointment so you are aware of your patient responsibility. If you have questions about this, you can ask our office staff in advance.
- MVA/Workman's comp - bring your claim number and the name and number of your adjuster. You must have an open claim to receive care.

CANCEL/NO SHOW POLICY

Physical Therapy is a commitment to improving your health and hinges on attending your appointments. ***This is critical to having a successful outcome.*** If you for some reason need to cancel, here is our policy.

- 1st CANCEL: Life happens, no fee.
- 2nd CANCEL: $25 fee which will be collected when you call or prior t your next appointment. You will not be seen by your PT until this fee is paid.
- 3rd CANCEL: $25 fee as above; your PT will speak to you about how future absences can be avoided, and a note sent to your referring physician. If you are unable to be reached, your therapy may be put on temporary hold, with appointments deleted.
- 4th CANCEL: $25 fee and case dismissed; physician informed.

NO SHOWS:

- 1st NO SHOW: Life happens, no fee.
- 2nd NO SHOW: $50 fee, if this is not paid in 24 hours with remaining appointments confirmed, your therapy will be put on hold, appointment deleted, physician informed.
- If you have 2 no shows in a row, your case is dismissed from our office.

ILLNESS CANCELs:

- If you call to cancel due to illness, your therapy will automatically be put on hold for 10 days
- If you feel you are 100% certain you are ready to return to therapy then you may contact us to restart your therapy and schedule accordingly.
- If you cancel 2 appointments in a row due to illness, therapy will be put on hold and your PT will follow up with you by phone/Email.

A fee of $25 can be avoided, but must have minimum 24 hours notice during business days M-F. This means if you call on Friday 1 PM to cancel Monday 9:00 AM appointment, this is not 24 hour notice. Although you may not be assessed a fee, cancels are still recorded, and the above cancel policy still applies.

If you have any questions, you may contact us by phone *541-687-7005* or email at *eugenept@eugenept.com*

Thank you for choosing our clinic! We look forward to meeting you!

LOCATION AND PARKING:

Please be aware we have 2 locations. If you are unclear at which location you are scheduled, contact our office.

Oakway Mall Location- parking lot map below (54 Oakway Center – Phone: 541-687-7005) Our office is located on the second level inside the courtyard, above Chico's clothing store.

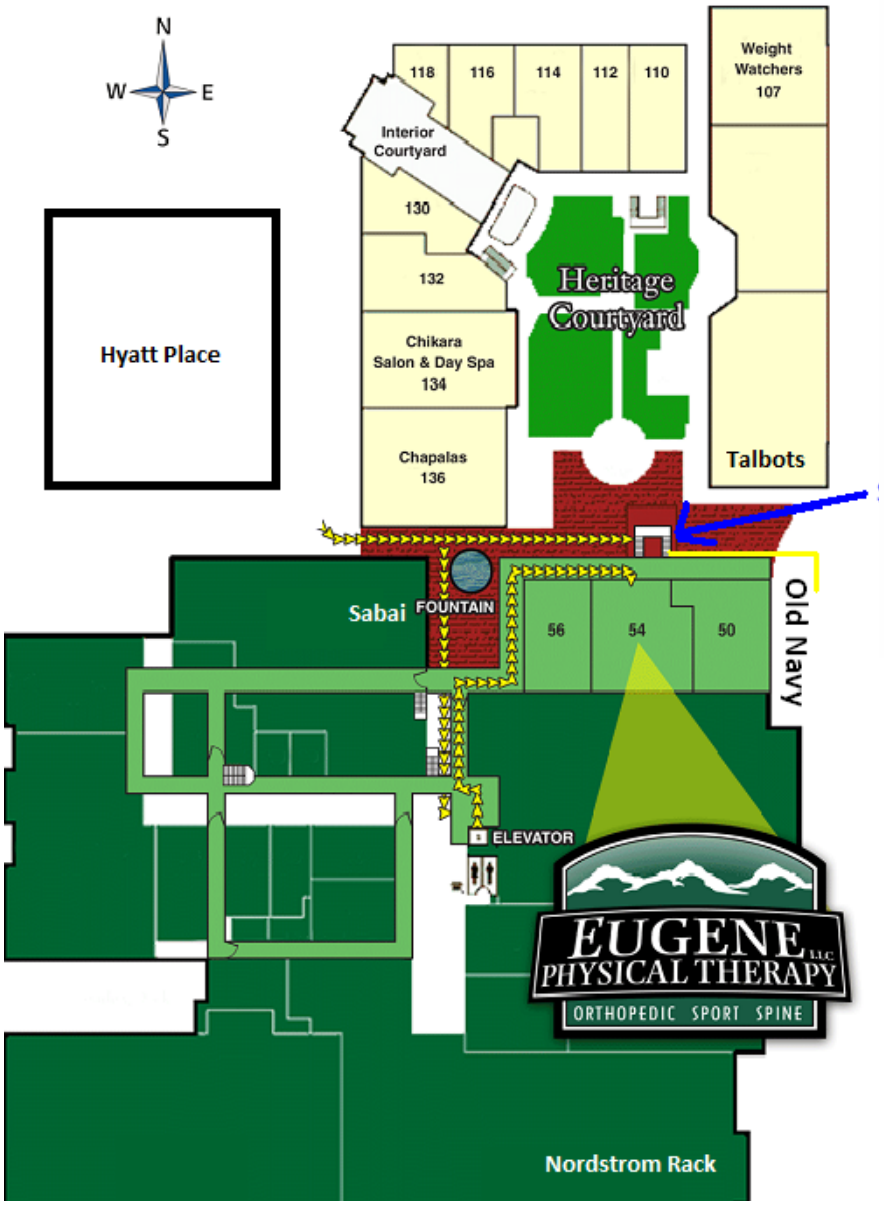
• Stairs: near Old Navy, you will see Chico's to the right of Old Navy; walk toward Chico's into the courtyard where there is a staircase. We are located at the top of those stairs.

• Elevator: this is located inside the Mall (enter the glass doors near the fountain/Sabai restaurant); take the elevator to the second floor. When you exit the elevator, there is a glass door 50ft ahead that will take you to the outside balcony, follow to the right and you will find our office at the end of the balcony on the right (at the top of the stairs).

• Parking Garage: The parking garage entrance is on the north side of Hyatt Place. Once inside the parking structure, the elevator/stairs to exit are located on the south east side of the garage. When you exit the parking garage walk toward the courtyard. You can access the elevator or the stairs as noted above.

Downtown Oak Street Location (1410 Oak Street Suite 100 – Phone: 541-345-2064) Our office is located on the SW corner of 14th and Oak Street, on the first floor of the Keiper Spine building. The entrance to our office is located on 14th Street.

• Parking – Our free parking lot can be accessed from either 14th or Oak Street. There is also metered parking available on the street.



Main Clinic - 54 Oakway Center

Oak Street Clinic - 1410 Oak St.

PATIENT DATA SHEET

Please complete this form in its entirety prior to your first visit. Also, please bring your insurance information and/or cards to our office at your first visit. **It is the patient's responsibility to notify our office of any changes to your information listed on this form.**

PATIENT INFORMATION

NAME: _____
LAST FIRST MIDDLE

ADDRESS: _____
STREET CITY STATE ZIP

PHONE: HOME ( ) _____ **WORK ( )** _____ **CELL ( )** _____

EMAIL: _____ **PREFERRED WAY TO CONTACT YOU: ☐ HOME ☐ WORK ☐ CELL** **SEX: ☐ MALE ☐ FEMALE**

DATE OF BIRTH: _____ **SOCIAL SECURITY NUMBER:** _____
☐ MARRIED ☐ SINGLE ☐ WIDOWED ☐ SEPARATED ☐ OTHER

REFERRING PHYSICIAN: _____ **PRIMARY CARE PHYSICIAN:** _____

EMPLOYER NAME/ADDRESS: _____
STREET CITY, STATE ZIP

EMERGENCY CONTACT: _____ **PHONE:** _____
NAME/RELATION

THE ABOVE INFORMATION PERTAINS TO THE PATIENT ONLY.
IF THE PATIENT IS A MINOR, THEN THE RESPONSIBLE PARTY COMPLETES THE NEXT SECTION. IF THE PATIENT IS NOT A MINOR, THEN SKIP THE NEXT SECTION.

RESPONSIBLE PARTY INFORMATION

RELATION TO PATIENT ☐ MOTHER ☐ FATHER ☐ OTHER

NAME: _____ **DATE OF BIRTH:** _____
LAST FIRST MIDDLE

ADDRESS: _____
STREET CITY STATE ZIP

PHONE: HOME ( ) _____ **WORK ( )** _____ **CELL ( )** _____

EMPLOYER: _____ **SOCIAL SECURITY NUMBER:** _____

EMPLOYER ADDRESS: _____
STREET CITY STATE ZIP

INSURANCE INFORMATION

ARE YOU AWARE OF YOUR BENEFITS FOR YOUR INSURANCE? ☐ YES ☐ NO

PRIMARY INSURANCE NAME: _____ INSURED NAME: _____

PRIMARY INSURANCE ADDRESS: _____ PHONE: _____

POLICY ID# _____ POLICY GROUP # _____ **☐ SEE COPY OF CARD**

SECONDARY INSURANCE NAME: _____ INSURED NAME: _____

SECONDARY INSURANCE ADDRESS: _____ PHONE: _____

POLICY ID# _____ POLICY GROUP # _____ **☐ SEE COPY OF CARD**

ACCIDENT INFORMATION: Was this injury the result of an accident? **☐ NO ☐ YES** DATE OF ACCIDENT/INJURY: _____
☐ MOTOR VEHICLE ACCIDENT ☐ WORK RELATED ☐ OTHER

HIPAA: By signing this form I acknowledge that I have received a copy of the HIPAA "Notice of Information Practices" from Eugene Physical Therapy, LLC and understand it completely.

CONSENT: By signing this form, I agree and give my consent for Eugene Physical Therapy Services, LLC to furnish physical therapy care and treatment considered necessary and proper in diagnosing and/or treating my physical condition.

_____ _____
Signature **Date**

Patient Financial Policy

This is an agreement between Eugene Physical Therapy, LLC (creditor) and the Patient (debtor) named on this form.

In this agreement the words "you", "your", and "yours" mean the Patient (debtor). The word "account" means the account that has been established in your name to which charges are made and payments are credited. The words "we", "us" and "our" refer to Eugene Physical Therapy, LLC.

By executing this agreement, you are agreeing to pay for all services and supplies that are received.

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, the finance charge, and any payments or credits applied to your account during the month. Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid by the end of the month.

Required Payments: Any co-payments or co-insurance required by an insurance company must be paid at the time of service. We shall have the right to cancel your privilege to make charges against your account at any time and require that visits must be paid at the time of service.

Contracted Insurance: If we are contracted with your insurance company, we must follow our contract and their requirements. If you have a co-pay, deductible or co-insurance, you must pay that at the time of service. As contracted providers with your insurance company, we agree to accept the allowable amount (usual and customary) established by your insurance company. Although we may estimate what your insurance company may pay and the patient responsibility portion, it is the insurance company that makes the final determination of payment and eligibility.

Non-Contracted Insurance: Insurance is a contract between you and your insurance company. It is the patient's responsibility to verify if our office is a contracted or non-contracted provider. As a non-contracted provider, there is no adjustment or write-off for the difference between what we charge and what the insurance allows. You agree to pay any portion of the charges not covered by your insurance.

INSURANCE BENEFITS:

Patient Responsibility

_____ Deductible

_____ Copay / Approximate CoInsurance

Primary Insurance: If possible, we will verify your insurance benefits and eligibility prior to your first appointment. It is the patient responsibility to be aware of your own benefits and eligibility. If your insurance company notifies us that they are waiting to receive the accident report form from you, the balance is automatically patient responsibility and we will begin collection procedures. As a courtesy to you, we will bill your primary insurance; however, if our office has not received payment after 120 days, the balance will become patient responsibility unless other arrangements are made with us.

Secondary Insurance: As a courtesy to you, we will bill your secondary insurance after your primary insurance has paid. If our office has not received payment from your secondary insurance after 120 days from the date first billed to your secondary insurance, the balance will become patient responsibility unless other arrangements are made.

Referrals/Prescription/Authorization: If your insurance company requires a referral, prescription or pre-authorization, you are responsible for obtaining it. Failure to obtain the referral, prescription and/or pre-authorization may result in a lower payment, or no payment from the insurance company.

Workers Compensation: If your claim is in deferred status, we will ask for private medical insurance to bill if your claim is denied. We require approval/authorization by worker's compensation carrier prior to your initial visit. If your claim is denied and you do not have private medical insurance, you will be responsible for payment in full. If your claim is in litigation, we do require verification of this from your attorney and/or worker's compensation carrier.

Personal Injury /Motor Vehicle Accidents (MVA): If you are being treated as part of a personal injury lawsuit or claim, we may require verification from your attorney. In addition to this verification, we require that you allow us to bill your health insurance. In the absence of insurance, other financial arrangements may be discussed. Payment of the bill remains the patient's responsibility. We cannot bill your attorney for charges incurred in a personal injury case. If you have Personal Injury Protection (PIP) through your motor vehicle insurance, we will bill them as primary insurance and will bill your private health insurance when your PIP benefits are used up.

The Financial Policy continues on PAGE 2

Benefit Assignment: You assign all medical benefits to us including health insurance, Medicare, auto insurance, worker's compensation or other insurance plans. You also authorize Eugene Physical Therapy, LLC to release all information necessary (including photocopies of medical records) to secure payment (see Notice of Privacy Practices). You agree that if insurance pays directly to you, this monetary amount is actually due us and is patient responsibility.

Billing Information: It is your responsibility to provide us with correct information including insurance, responsible party, date of injury, type of accident, policy and/or group numbers, etc. Should the information change, it is your responsibility to update it within a timely manner. If you supply us with incorrect information, the balance of the account at the last date of service will be entirely patient responsibility. We will not be responsible for rebilling, appealing or other dealings with newly provided insurance company.

Divorce: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Methods of Payment: We accept VISA, MasterCard, personal checks and cash. There is a fee of $25 for any checks returned by your bank.

Finance Charge: A finance charge will be imposed on each item of your account which has not been paid within thirty (30) days of the time the item was paid by your insurance company or due by you. The **FINANCE** CHARGE will be computed at the rate of one percent (1%) per month or an **ANNUAL PERCENTAGE RATE** of twelve (12) percent. The finance charge on your account is computed by applying the periodic rate (1%) to the "past due balance" of your account. The "past due" balance of your account is calculated by taking the balance owed thirty (30) days ago, and then subtracting any payments or credits applied to the account during that time. You understand that finance charges are not billable or payable by insurance.

Past Due Accounts: If your account becomes past due, we may need to take necessary steps to collect this debt. This may include contacting the person listed as the Emergency Contact on your patient data sheet. If we have to refer your account to a collection agency, you agree to pay all of the collection costs which are incurred. If we refer your account to a collection agency, we will add a surcharge of 30% to your balance. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyers' fees which we incur plus all court costs.

Missed Appointment Fee: A $25 fee may be charged for appointments cancelled with less than 24 hours notice. A $50 fee will be charged for no show or missed appointments. This fee must be paid before a new appointment is made. This fee is not billable or payable by insurance. Patients with more than two missed appointments will be discharged from therapy and referred back to their physician. We understand that emergencies do occur and will attempt to make reasonable accommodations for that.

Waiver of Confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

TYPE OF CLAIM

Is this injury due to an accident?

☐ Yes ☐ No Date of accident: _____

Was this injury due to a motor vehicle accident (either in the past or current)?

☐ Yes ☐ No

Date of injury: _____

Did this injury occur on the job?

☐ Yes ☐ No

Do you have an open worker's compensation claim? ☐ Yes ☐ No

Date of injury: _____

THIS INFORMATION MUST BE COMPLETELY FILLED OUT ON THE PATIENT DATA SHEET

I have been informed of my financial responsibility and Cancel/No Show Policy and agree to the terms and conditions as stated on this form.

Patient Name: _____ Responsible Party (if not the patient:): _____

Signature: _____ Date: _____

EUGENE PHYSICAL THERAPY
PATIENT HISTORY QUESTIONNAIRE

PLEASE FILL OUT THIS FORM AS COMPLETE AS POSSIBLE. IT WILL ASSIST YOUR THERAPIST IN DEVELOPING A PLAN OF CARE FOR YOU. IF YOU HAVE ANY QUESTIONS, PLEASE FEEL FREE TO ASK FOR ASSISTANCE. THIS INFORMATION WILL REMAIN CONFIDENTIAL UNLESS AUTHORIZED FOR RELEASE BY THE PATIENT.

NAME _____ DATE OF BIRTH: _____

OCCUPATION _____ HOBBIES: _____

PLEASE CIRCLE: ACUTE INJURY CHRONIC ISSUE DATE OF ONSET/INJURY:_____

HAS THIS INJURY PREVENTED YOU FROM WORKING? YES NO IF YES, HOW LONG OFF WORK_____

WORK STATUS: AT THE **PRESENT TIME** I AM ABLE TO:

_____ Work without restrictions
_____ Work the same job with restrictions
_____ Work a different job with restrictions
_____ Unable to work due to dysfunction
_____ Don't normally work outside the home
_____ Homemaker
_____ Retired
_____ Other

IS AN ATTORNEY INVOLVED WITH THE CASE? YES NO

IF YES, ATTORNEY NAME: _____ PHONE: _____

HAVE YOU SOUGHT PREVIOUS TREATMENT FOR THIS CONDITION?

_____ No other treatment _____ Massage Therapy _____ Chiropractor
_____ Physical/Occupational Therapy _____ Psychiatrist/Psychologist _____ Other: _____

LIST ALL PRESCRIPTION MEDICATION YOU ARE TAKING (Including injection and skin patches: _____

_____

_____

LIST ALL OVER-THE-COUNTER MEDICATIONS YOU ARE TAKING (Including vitamins and supplements):

_____

_____

PLEASE LIST ANY SURGERIES OR OTHER CONDITIONS FOR WHICH YOU HAVE BEEN HOSPITALIZED:

DATE	SURGERY/HOSPITALIZATION	REASON
_____	_____	_____
_____	_____	_____
_____	_____	_____

ARE YOU CURRENTLY HAVING OR HAVE EXPERIENCED ANY OF THESE SYMPTOMS IN THE PAST 3 MONTHS?

_____ Fever _____ Chills _____ Night Sweats _____ Shortness of Breath
_____ Pins/Needles _____ Numbness _____ Skin Rash _____ Headaches
_____ Vision Problems _____ Hearing Loss _____ Bowel/Bladder Problem

PLEASE CHECK ALL THE FOLLOWING CONDITIONS THAT APPLY TO YOU EITHER PRESENTLY OR IN THE PAST

_____ High Blood Pressure _____ Epilepsy/Seizures _____ Gout _____ Varicose Veins
_____ Chest Pain/Heart Attack _____ Kidney Disease _____ Hepatitis _____ Dizziness/Fainting
_____ Stroke _____ Asthma _____ Arthritis _____ Depression
_____ Heart Disease _____ Emphysema/Bronchitis _____ Tuberculosis _____ Lung Disease
_____ Cardiovascular Disease _____ Hearing Loss _____ Thyroid Issues _____ Diabetes
_____ Emotional/Psychological Problems _____ Chemical Dependency (alcohol/drugs)
_____ Allergies: _____
_____ Other: _____

HAS ANYONE IN YOUR IMMEDIATE FAMILY (Parents, Brothers, Sisters) EVER BEEN TREATED FOR ANY OF THE FOLLOWING?

_____ Cancer _____Heart Disease _____Diabetes _____ Tuberculosis _____ Mental Disorder
_____ Arthritis _____ High Blood Pressure _____ Kidney Disease _____ Stroke

HAVE YOU RECENTLY EXPERIENCED ANY SIGNIFICANT CHANGES IN:

_____ Mood _____ Energy level (restlessness, lethargy, or fatigue)
_____ Interest or pleasure in daily activities _____ Recurrent thoughts of death or harming yourself
_____ Loss/Gain of appetite or weight loss/gain _____Sleeping habits

How many packs of cigarettes do you smoke per day? _____

How many days per week do you drink alcohol?_____ How much do you drink at an average sitting?_____

Are there any other substances that you regularly use?_____

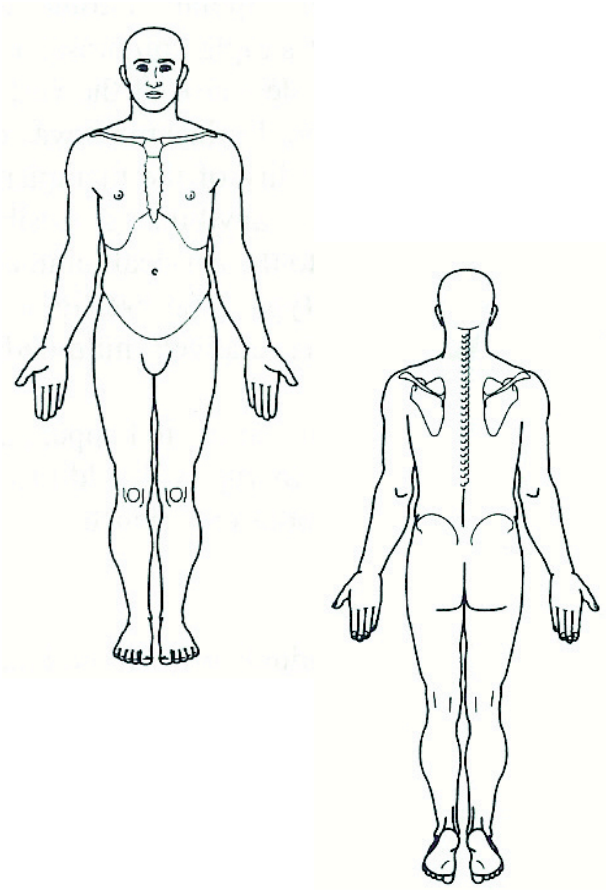
ARE YOU AWARE OF YOUR CURRENT DIAGNOSIS? YES NO

DO YOU HAVE QUESTIONS REGARDING YOUR DIAGNOSIS OR PROGNOSIS YES NO

RATE YOUR AVERAGE DISCOMFORT IN THE LAST 24HRS ON THE SCALE BELOW:

0 _____ 10
(no pain) (severe pain)

PLEASE MAP YOUR AREAS OF DISCOMFORT OR ALTERED SENSATION ON THE BODY MAP:
XXX = Pain 000 = Numb/Tingle *** = Weakness



PAIN BETTER WITH:_____
_____
_____

PAIN WORSE WITH:_____
_____
_____

DO YOU HAVE ANXIETY, INCREASED STRESS OR WORRY ABOUT YOUR SYMPTOMS: YES / NO

CONCERNS:_____
_____
_____

Form reviewed by therapist:
(PT initials)_____ Date _____

CARE CONNECTIONS

PATIENT WORKSHEET

NAME

DATE ❒ Initial Visit ❒ Discharge Visit

PROBLEM AREA *(Please check one):*

❒ Upper Extremity (A,D) ❒ Lower Extremity (B,F) ❒ Cervical/Thoracic (C,D) ❒ Lumbar (D,F) ❒ TMJ (C,E)

FUNCTIONAL INDEX

PART I: *Answer all five sections in Part 1. Choose the one answer in each section that best describes your condition.*

WALKING

❒ Symptoms do not prevent me walking any distance.
❒ Symptoms prevent me walking more than 1 mile.
❒ Symptoms prevent me walking more than 1/2 mile.
❒ Symptoms prevent me walking more than 1/4 mile.
❒ I can only walk using a stick or crutches.
❒ I am in bed most of the time and have to crawl to the toilet.

WORK

(Applies to work in home and outside)

❒ I can do as much work as I want to.
❒ I can only do my usual work, but no more.
❒ I can do most of my usual work, but no more.
❒ I cannot do my usual work.
❒ I can hardly do any work at all (only light duty).
❒ I cannot do any work at all.

PERSONAL CARE

(Washing, Dressing, etc.)

❒ I can manage all personal care without symptoms.
❒ I can manage all personal care with some increased symptoms.
❒ Personal care requires slow, concise movements due to increased symptoms.
❒ I need help to manage some personal care.
❒ I need help to manage all personal care.
❒ I cannot manage any personal care.

SLEEPING

❒ I have no trouble sleeping.
❒ My sleep is mildly disturbed (less than 1 hr. sleepless).
❒ My sleep is mildly disturbed (1-2 hrs. sleepless).
❒ My sleep is moderately disturbed (2-3 hrs. sleepless).
❒ My sleep is greatly disturbed (3-5 hrs. sleepless).
❒ My sleep is completely disturbed (5-7 hrs. sleepless).

RECREATION/SPORTS

(Indicate Sport if Appropriate _____)

❒ I am able to engage in all my recreational/sports activities without increased symptoms.
❒ I am able to engage in all my recreational/sports activities with some increased symptoms.
❒ I am able to engage in most, but not all of my usual recreational/sports activities because of increased symptoms.
❒ I am able to engage in a few of my usual recreational/sports activities because of my increased symptoms.
❒ I can hardly do any recreational/sports activities because of increased symptoms.
❒ I cannot do any recreational/sports activities at all.

ACUITY

(Answer on initial visit.)

How many days ago did onset/injury occur?

_____ days

PART II: *Choose the one answer that best describes your condition in the sections designated by your therapist.*

■ A. UPPER EXTREMITY

CARRYING

❒ I can carry heavy loads without increased symptoms.
❒ I can carry heavy loads with some increased symptoms.
❒ I cannot carry heavy loads overhead, but I can manage if they are positioned close to my trunk.
❒ I cannot carry heavy loads, but I can manage light to medium loads if they are positioned close to my trunk.
❒ I can carry very light weights with some increased symptoms.
❒ I cannot lift or carry anything at all.

DRESSING

❒ I can put on a shirt or blouse without symptoms.
❒ I can put on a shirt or blouse with some increased symptoms.
❒ It is painful to put on a shirt or blouse and I am slow and careful.
❒ I need some help but I manage most of my shirt or blouse dressing.
❒ I need help in most aspects of putting on my shirt or blouse.
❒ I cannot put on a shirt or blouse at all.

REACHING

❒ I can reach to a high shelf to place an empty cup without increased symptoms.
❒ I can reach to a high shelf to place an empty cup with some increased symptoms.
❒ I can reach to a high shelf to place an empty cup with a moderate increase in symptoms.
❒ I cannot reach to a high shelf to place an empty cup, but I can reach up to a lower shelf without increased symptoms.
❒ I cannot reach up to a lower shelf without increased symptoms, but I can reach counter height to place an empty cup.
❒ I cannot reach my hand above waist level without increased symptoms.

■ B. LOWER EXTREMITY

STAIRS

❒ I can walk stairs comfortably without a rail.
❒ I can walk stairs comfortably, but with a crutch, cane, or rail.
❒ I can walk more than 1 flight of stairs, but with increased symptoms.
❒ I can walk less than 1 flight of stairs.
❒ I can manage only a single step or curb.
❒ I am unable to manage even a step or curb.

UNEVEN GROUND

❒ I can walk normally on uneven ground without loss of balance or using a cane or crutches.
❒ I can walk on uneven ground, but with loss of balance or with the use of a cane or crutches.
❒ I have to walk very carefully on uneven ground without using a cane or crutches.
❒ I have to walk very carefully on uneven ground even when using a cane or crutches.
❒ I have to walk very carefully on uneven ground and require physical assistance to manage it.
❒ I am unable to walk on uneven ground.

■ C. CERVICAL/TMJ

CONCENTRATION

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

HEADACHES

- ❒ I have no headaches at all.
- ❒ I have slight headaches which come less than 3 per week.
- ❒ I have moderate headaches which come infrequently.
- ❒ I have moderate headaches which come 4 or more per week.
- ❒ I have severe headaches which come frequently.
- ❒ I have headaches almost all of the time.

READING

- ❒ I can read as much as I want without increased symptoms.
- ❒ I can read as much as I want with slight symptoms.
- ❒ I can read as much as I want with moderate symptoms.
- ❒ I cannot read as much as I want because of moderate symptoms.
- ❒ I can hardly read at all because of severe symptoms.
- ❒ I cannot read at all.

■ D. LUMBAR*/CERVICAL/UPPER EXTREMITY

DRIVING

- ❒ I can drive my car or travel without any extra symptoms.
- ❒ I can drive my car or travel as long as I want with slight symptoms.
- ❒ I can drive my car or travel as long as I want with moderate symptoms.
- ❒ I cannot drive my car or travel as long as I want because of moderate symptoms.
- ❒ I can hardly drive at all or travel because of severe symptoms.
- ❒ I cannot drive my car or travel at all.

LIFTING

- ❒ I can lift heavy weights without extra symptoms.
- ❒ I can lift heavy weights but it gives extra symptoms.
- ❒ My symptoms prevent me from lifting heavy weights but I manage if they are conveniently positioned. (e.g. on a table)
- ❒ My symptoms prevent me from lifting heavy weights but I 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.

■ E. TMJ

TALKING

- ❒ I can talk without any increased symptoms.
- ❒ I can talk as long as I want with slight symptoms in my jaws.
- ❒ I can talk as long as I want with moderate symptoms in my jaws.
- ❒ I cannot talk as long as I want because of moderate symptoms in my jaws.
- ❒ I can hardly talk at all because of severe symptoms in my jaws.
- ❒ I cannot talk at all.

EATING

- ❒ I can eat whatever I want without symptoms.
- ❒ I can eat whatever I want but it gives extra symptoms
- ❒ Symptoms prevent me from eating regular food, but I can manage if I avoid hard foods.
- ❒ Symptoms prevent me from chewing anything other than soft foods.
- ❒ I can chew soft foods occasionally, but primarily adhere to a liquid diet.
- ❒ I cannot chew at all and maintain a liquid diet.

■ F. LUMBAR*/LOWER EXTREMITY

STANDING

- ❒ I can stand as long as I want without increased symptoms.
- ❒ I can stand as long as I want, but it gives me extra symptoms.
- ❒ Symptoms prevent me from standing for more than 1 hour.
- ❒ Symptoms prevent me from standing for more than 30 minutes.
- ❒ Symptoms prevent me from standing for more than 10 minutes.
- ❒ Symptoms prevent me from standing at all.

SQUATTING

- ❒ I can squat fully without the use of my arms for support.
- ❒ I can squat fully, but with symptoms or using my arms for support.
- ❒ I can squat 3/4 of my normal depth, but less than fully.
- ❒ I can squat 1/2 of my normal depth, but less than 3/4.
- ❒ I can squat 1/4 of my normal depth, but less than 1/2.
- ❒ I am unable to squat any distance due to symptoms .

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.
- ❒ My symptoms prevent me sitting more than 1 hour.
- ❒ My symptoms prevent me sitting more than 1/2 hour.
- ❒ My symptoms prevent me sitting more than 10 minutes.
- ❒ My symptoms prevent me from sitting at all.

** Lumbar questions adapted from Oswestry.*

PAIN INDEX

Please indicate the worst your pain has been in the last 24 hours on the scale below

No Pain — Worst Pain Imaginable

PLEASE DO NOT COMPLETE THE FOLLOWING SECTIONS ON FIRST VISIT

IMPROVEMENT INDEX

Please indicate the amount of improvement you have made since the beginning of your physical therapy treatment on the scale below.

No Improvement — Complete Recovery

■ WORK STATUS *(check most appropriate)*

1. ❒ No lost work time
2. ❒ Return to work without restriction
3. ❒ Return to work with modification
4. ❒ Have not returned to work
5. ❒ Not employed outside the home

Work days lost due to condition: _____ days

I am aware that the information gathered on this form may be used anonymously for research or publication. Please initial: _____

