MendelsonKornblum
Physical Therapy & Rehabilitation

Physical Therapy
Occupational Therapy
Functional Capacity Evaluations
Lymphedema Management
Vestibular Rehabilitation
Lumbar Stabilization
Manual Therapy
Sports Medicine
Massage Therapy
Mulligan Concept
McKenzie Method
Kinesio Taping

Patient History

Name ______________________________________**Age**_________ **Date**______________

1. Describe the current problem that brought you here?___________________________
____

2. When did your problem first begin?
   a. _____ months ago
   b. _____ years ago

3. Was your first episode of the problem related to a specific incident? Yes No
Please describe and specify date ____
____

4. Since that, time is it:
   a. _____ staying the same
   b. _____ getting worse
   c. _____ getting better

5. Circle your pain on a 0-10 scale with 0 being no pain 10 being the worst pain.

0 1 2 3 4 5 6 7 8 9 10

Describe the nature of the pain (i.e. constant burning, intermittent ache)_____________
____
____

6. Describe any previous treatment/exercises to treat this condition:________________
____
____

7. Activities/events that cause or aggravate your symptoms. Check all that apply

___ Sitting greater than _____ minutes
___ Walking greater than _____ minutes
___ Standing greater than _____ minutes
___ Changing positions (ie. - sit to stand)
___ Light activity (light housework)
___ Vigorous activity/exercise (run/weight lift/jump)
___ Sexual activity
___ Other, please list

_____ With cough/sneeze/straining
_____ With laughing/yelling
_____ With lifting/bending
_____ With cold weather
_____ With triggers -running water
_____ With nervousness/anxiety
_____ No activity affects the problem

____
____

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8. What relieves your symptoms?____
____

9. How has your lifestyle/quality of life been altered/changed because of this problem?
Social activities (exclude physical activities), specify__________________________
Diet /Fluid intake, specify ____
Physical activity, specify ____
Work, specify ____
Other____

10. Rate the severity of this problem from 0 -10 with 0 being no problem and 10 being the worst

0 1 2 3 4 5 6 7 8 9 10

Since the onset of your current symptoms have you had:

_____ Fever/Chills
_____ Unexplained weight change
_____ Dizziness or fainting
_____ Change in bowel or bladder functions
_____ Malaise (Unexplained tiredness)
_____ Unexplained muscle weakness
_____ Night pain/sweats
_____ Numbness / Tingling
_____ Other /describe____

Health History:

Date of Last Physical Exam____
Tests performed____
____

Overall Health:

_____ Excellent
_____Good
_____ Average
_____ Fair
_____ Poor

Occupation ____
Hours worked/week: __________
On disability or leave? Yes No
Activity Restrictions? Yes No
If yes, what are your restrictions?
____
____

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Mental Health:
Current level of stress:
_____High
_____ Medium
_____ Low

Are you currently in psych therapy? Yes No

Activity/Exercise:
_____None
_____ 1-2 days/week
_____ 3-4 days/week
_____ 5+ days/week
Describe type of exercise: ____
____

Have you ever had any of the following conditions or diagnoses? Check all that apply

_____ Cancer
_____ Chronic bronchitis
_____ Asthma
_____ Allergies-list below
_____ Latex sensitivity
_____ Hypothyroid
_____ Chronic Fatigue Syndrome
_____ Tailbone pain
_____ Alcoholism
_____ Childhood bladder problems
_____ Irritable Bowel Syndrome
_____ Rheumatoid Arthritis
_____ Anorexia/bulimia
_____ Sexually transmitted disease
_____ Hearing loss/problems
_____ Vision/eye problems
_____ Stroke
_____ Heart problems
_____High Blood Pressure
_____ Ankle swelling
_____ Anemia
_____ Hyperthyroid
_____Headaches
_____Fibromyalgia
_____ Drug Problem
_____ Kidney disease
_____ Depression
_____ Hepatitis
_____ Joint Replacement
_____ Smoking history
_____ Physical/Sexual abuse
_____ Sports Injuries
_____ Emphysema
_____ Epilepsy/seizures
_____ Multiple sclerosis
_____ Head Injury
_____ Osteoporosis
_____Low back pain
_____Sacroiliac pain
_____ Diabetes
_____Arthritic conditions
_____ Stress fracture
_____HIV/AIDS
_____Raynaud's Disease
_____Pelvic pain
_____ Neck pain
_____ Bone Fracture
_____TMJ

Other/Describe____

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Surgical /Procedure History

Y/N Surgery for your back/spine
Y/N Surgery for your prostate
Y/N Surgery for your brain
Y/N Surgery for your female organs
Y/N Surgery for your bladder
Y/N Surgery for your bones/joints
Y/N Surgery for your abdominal
Other/describe____

Ob/Gyn History (females only)

Y/N Childbirth vaginal deliveries #________
Y/N Episiotomy #________
Y/N C-Section #_________
Y/N Difficult childbirth #________
Y/N Prolapse or organ falling out
Y/N Vaginal dryness
Y/N Painful periods
Y/N Menopause - when? _
Y/N Painful vaginal penetration
Y/N Pelvic pain
Y/N Other /describe____________________________________

Males only

Y/N Prostate disorders
Y/N Shy bladder
Y/N Pelvic pain
Y/N Erectile dysfunction
Y/N Painful ejaculation
Y/N Other /describe____

Medications - pills, injection, patch   Start date   Reason for taking

____
____
____

Over the counter -vitamins etc   Start date   Reason for taking

____
____
____
____

Pelvic Symptom Questionnaire

Bladder / Bowel Habits / Problems

Y/N Trouble initiating urine stream
Y/N Urinary intermittent /slow stream
Y/N Trouble emptying bladder
Y/N Difficulty stopping the urine stream
Y/N Trouble emptying bladder completely
Y/N Straining or pushing to empty bladder
Y/N Dribbling after urination
Y/N Constant urine leakage
Y/N Blood in urine
Y/N Painful urination
Y/N Trouble feeling bladder urge
Y/N Current laxative use
Y/N Trouble feeling bowel urge
Y/N Constipation/straining
Y/N Trouble holding back gas/feces
Y/N Recurrent bladder infections
Y/N Other/describe____

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1. Frequency of urination:
    a. _____X’s per day
    b. ______X’s times per night

2. When you have a normal urge to urinate, how long can you delay before you have to go to the toilet?
    a. _____ minutes
    b. _____ hours
    c. _____ not at all

3. The usual amount of urine passed is:
    a. _____ small
    b. _____ medium
    c. _____ large
4. Frequency of bowel movements
    a. _____ X’s per day
    b. _____ X’s per week

5. When you have an urge to have a bowel movement, how long can you delay before you have to go to the toilet?
    a. _____ minutes
    b. _____ hours
    c. _____ not at all
6. If constipation is present, describe management techniques ________________
____

7. Average fluid intake (one glass is 8 oz. or one cup): ______ glasses/day
    a. Of this total how many glasses are caffeinated? _____ glasses/day

8. Rate a feeling of organ "falling out" / prolapse or pelvic heaviness/pressure:
    a. _____ None present
    b. _____ Times per month (specify if related to activity or your period)
    c. _____ With standing for ______ minutes or ______hours
    d. _____With exertion or straining
    e. _____Other

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Skip questions (9-13) if no leakage/incontinence of bowel or bladder

9. Bladder leakage - number of episodes
   a. _____ No Leakage
   b. _____ X's per day
   c. _____ X's per week
   d. _____X's per month
   e. _____ Only with physical exertion / cough

10. Bowel Leakage – number of episodes
    a. _____ No Leakage
    b. _____ X's per day
    c. _____ X's per week
    d. _____X's per month
    e. _____ Only with physical exertion / strong urge

11. On average, how much urine do you leak?
    a. _____ No Leakage
    b. _____ Just a few drops
    c. _____ Wets underwear
    d. _____ wets the floor

12. How much stool do you lose?
    a. _____ No Leakage
    b. _____ Stool staining
    c. _____ Small amount in underwear
    d. _____ Complete emptying

13. What form of protection do you wear? (Please complete only one)
    a. _____ None
    b. _____ Minimal protection (Tissue paper/paper towel/pantishields)
    c. _____ Moderate protection (absorbent product, maxipad)
    d. _____Maximum protection (Specialty product/diaper)
    e. _____ Other ____

14. On average, how many pad/protection changes are required in 24 hours?
    a. _____ # of pads

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Name: ____ **Date:** ____________________

Colorectal Functional Outcome Questionnaire

Please answer all of the questions in the following survey. These questions will ask if you have certain bowel symptoms and how much these symptoms bother you. Answer each question by circle the number in appropriate box or boxes. If you are unsure about how to answer, please give the best answer you can. While answering these questions, please consider your symptoms over the **last 3 months.**

Have you unintentionally passed wind?	0 No, Never	1 Yes, less than once per week	2 Yes, 1-2 days per week	4 Yes, 3-5 days per week	5 Yes, 6-7 days per week
Have you unintentionally passed liquid stools during the day?	0 No, Never	1 Yes, less than once per week	2 Yes, 1-2 days per week	4 Yes, 3-5 days per week	5 Yes, 6-7 days per week
Have you unintentionally passed liquid stools during the night?	0 No, Never	1 Yes, less than once per week	2 Yes, 1-2 days per week	4 Yes, 3-5 days per week	5 Yes, 6-7 days per week
Have you unintentionally passed solid stools during the day?	0 No, Never	1 Yes, less than once per week	2 Yes, 1-2 days per week	4 Yes, 3-5 days per week	5 Yes, 6-7 days per week
Have you had to smear of feces in your underwear, pajamas or nightgown at the end of the night?	0 No, Never	1 Yes, less than once per week	2 Yes, 1-2 days per week	4 Yes, 3-5 days per week	5 Yes, 6-7 days per week
Was it difficult to distinguish between passing wind and a bowel movement?	0 No, Never	1 Yes, less than once per week	2 Yes, 1-2 days per week	4 Yes, 3-5 days per week	5 Yes, 6-7 days per week

Have you used something to protect your underwear, such as sanitary towels, panty liners, or nappies?	0 No, Never	1 Yes, less than once per week	2 Yes, 1-2 days per week	4 Yes, 3-5 days per week	5 Yes, 6-7 days per week
If you needed to go urgently, did you have trouble stopping your bowel movement for longer than 15 minutes?	0 No, Never	1 Yes, less than once per week	2 Yes, 1-2 days per week	4 Yes, 3-5 days per week	5 Yes, 6-7 days per week
Have you had a false alarm? (i.e. a need to go without a bowel movement)	0 No, Never	1 Yes, less than once per week	2 Yes, 1-2 days per week	4 Yes, 3-5 days per week	5 Yes, 6-7 days per week
When you went to the toilet, did your bowel movement require more than 15 minutes?	0 No, Never	1 Yes, less than once per week	2 Yes, 1-2 days per week	4 Yes, 3-5 days per week	5 Yes, 6-7 days per week
Did you feel that your bowels were not empty after your bowel movement?	0 No, Never	1 Yes, less than once per week	2 Yes, 1-2 days per week	4 Yes, 3-5 days per week	5 Yes, 6-7 days per week
After your bowel movement, did you have to return to the toilet within 1 hour for a bowel movement?	0 No, Never	1 Yes, less than once per week	2 Yes, 1-2 days per week	4 Yes, 3-5 days per week	5 Yes, 6-7 days per week
Did you adjust your activities to the availability of a toilet?	0 No, Never	1 Yes, less than once per week	2 Yes, 1-2 days per week	4 Yes, 3-5 days per week	5 Yes, 6-7 days per week
Were you limited in your daily activities (i.e. work of housework) due to problems with your bowel movements?	0 No, Never	1 Yes, less than once per week	2 Yes, 1-2 days per week	4 Yes, 3-5 days per week	5 Yes, 6-7 days per week
Were you limited in your social activities (i.e. family visits, visits to the theater, or eating out) due to problems with your bowel movements?	0 No, Never	1 Yes, less than once per week	2 Yes, 1-2 days per week	4 Yes, 3-5 days per week	5 Yes, 6-7 days per week
Were you limited in your sexual activities (with or without sexual intercourse) due to problems with your bowel movements?	0 No, Never	1 Yes, less than once per week	2 Yes, 1-2 days per week	4 Yes, 3-5 days per week	5 Yes, 6-7 days per week

How many bowel movements have you had during the day?	0 No, Never	1 Yes, less than once per week	2 Yes, 1-2 days per week	4 Yes, 3-5 days per week	5 Yes, 6-7 days per week
How many bowel movements have you had during the night?	0 No, Never	1 Yes, less than once per week	2 Yes, 1-2 days per week	4 Yes, 3-5 days per week	5 Yes, 6-7 days per week
Have you had pain during your bowel movements?	0 No, Never	1 Yes, less than once per week	2 Yes, 1-2 days per week	4 Yes, 3-5 days per week	5 Yes, 6-7 days per week
Have you experienced blood loss during your bowel movements?	0 No, Never	1 Yes, less than once per week	2 Yes, 1-2 days per week	4 Yes, 3-5 days per week	5 Yes, 6-7 days per week
Have you had irritated skin round your anus?	0 No, Never	1 Yes, less than once per week	2 Yes, 1-2 days per week	4 Yes, 3-5 days per week	5 Yes, 6-7 days per week
Have you used medicine to thicken your stools?	0 No, Never	1 Yes, less than once per week	2 Yes, 1-2 days per week	4 Yes, 3-5 days per week	5 Yes, 6-7 days per week
Have you eaten certain foods on purpose to make your stools thicker or thinner?	0 No, Never	1 Yes, less than once per week	2 Yes, 1-2 days per week	4 Yes, 3-5 days per week	5 Yes, 6-7 days per week
Have you purposely avoided certain foods to prevent your stools from becoming loose or hard?	0 No, Never	1 Yes, less than once per week	2 Yes, 1-2 days per week	4 Yes, 3-5 days per week	5 Yes, 6-7 days per week

Total Score: ___________/130

Patient's signature: ______________________________ Date: ______________

Therapist's signature: ______________________________ Date: ______________

IEET

Name: ____

Birth date: ____

Home Address: ____

Phone Number:

Home: ____

Work: ____

Cell: ____

Emergency Contact:

Name: ____

Relationship: ____

Phone Number: ____

PHYSICAL THERAPY APPOINTMENT ATTENDANCE POLICY

Consistent attendance to physical therapy is an important component of your rehabilitation process. However, if you should need to cancel or reschedule an appointment, please call us at 586-439-6243.

- I have read the above information and am aware that if I miss three consecutive appointments without prior notification, I can be removed from the schedule, with all future appointments cancelled. __________Please Initial
- Please give us at least 48 hours notice before cancelling an appointment. __________Please Initial
- Please be aware that if you show up 10 minutes late for an appointment can lead to the cancellation of that appointment. _________Please Initial
- Please be aware that it is your responsibility to verify your insurance coverage including deductable, co-payments and total annual benefits. _______Please Initial

PATIENT SIGNATURE: ____**Date:**__________

MENDELSON
KORNBLUM
orthopedic & spine surgeons

General Consent to Outpatient Treatment

I request and authorize physician office, clinic, or outpatient care as my physician, his assistants or designees (collectively called "the physicians") may deem necessary or advisable. This care may include, but is not limited to, routine diagnostic radiology and laboratory procedures, administration of routine drugs, biologicals and other therapeutics, and routine medical and nursing care. I authorize my physician(s) to perform other additional or extended services in emergency situations if it may be necessary or advisable in order to preserve my life or health. I understand that my (the patient's) care is directed by my (the patient's) physicians, and that other personnel render care and services to me (the patient) according to the physicians' instructions.

I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees or promises have been made to me with respect to the results of such diagnostic procedure or treatment.

I understand that samples of body fluids and/or tissues may be withdrawn from me (the patient) during routine diagnostics procedures. I authorize the facility to perform other tests on these body fluids and/or tissues in order to further medical research and knowledge and/or to dispose of these fluids and tissues.

I have been informed and understand that HIV (human immunodeficiency virus)/AIDS and HBV (hepatitis B virus) test may be performed on me without my consent if a health professional, facility employee or First Responder sustains an exposure to my blood or other body fluid.

ASSIGNMENT OF INSURANCE BENEFITS
Medicare Certification: I certify that the information provided by me in applying for payment under Title XVII of the Social Security Act is correct and request payment on my behalf of all authorized benefits.

I hereby authorize and instruct my insurance carrier to make payment directly to the facility benefits otherwise payable to me. **I agree to personally pay for any facility or physician charges that are not covered by or collected from any applicable insurance program, including any deductibles and coinsurance amounts.**

PERSONAL VALUABLES
I understand that I (the patient) am responsible for any and all personal valuables that I bring with me to the facility, clinic or physician's office. I hereby release the facility, clinic or physician's office from any liability for the loss or damage of any and all personal possessions which I choose to keep with me during my care and treatment.

TEACHING INSTITUTION
I have been informed and understand that this facility is affiliated with a teaching institution and the procedures performed may require observation, cooperation, and services of multiple health care providers. I authorize residents and/or students to participate in my care.

I HAVE HAD THE OPPORTUNITY TO READ THIS FORM (OR HAVE IT READ TO ME), ASK QUESTIONS AND HAVE THESE QUESTIONS ANSWERED.

ACKNOWLEDGEMENT OF PRIVACY PRACTICES
The Mendelson/Kornblum Notice of Privacy Practices provides information about how protected health information about me (the patient) - including information about human immunodeficiency virus (HIV), AIDS-related complex (ARC); and acquired immunodeficiency syndrome (AIDS); and including substance abuse treatment records protected under the regulations in 42 Code of Federal Regulations, Part 2, if any; and psychological and social services records, including communications made by me to a social worker or psychologist (if any) - may be used and disclosed. I have been offered an opportunity to review the Notice before signing the consent. I understand that the terms of the Notice may change.

Dear Patient:

Hello and Welcome to Mendelson Kornblum Physical Therapy. The entire staff would like to *Thank You for choosing Us to be Your Therapy Team.* We assure you that we are dedicated to helping you achieve your goals.

To receive the best therapy experience and optimum results, please **Read** the following **Attendance Policies** and **Recommendations**.

Attendance Policies:

- Please arrive 15 minutes prior to your Initial Evaluation and Re-Evaluations in order to fill out proper documentations. Please have photo ID, insurance card and list of current medications.
- If you are unable to keep your scheduled appointment please call us 24 hours prior to the scheduled time so that arrangements can be made to reschedule your appointment. Our number is **586-439-6243.**
- *PLEASE NOTE* : 3 No Shows (No Shows are scheduled appointments that are not kept with no prior calls) can result in a discharge from therapy.
- Please arrive on time for your scheduled appointments. If you are going to be late for your scheduled appointment please call if needed your appointment can be rescheduled.

Clothing Recommendations:

- Please wear loose-fitting, comfortable clothing that are comfortable for exercise and that will allow us to access to the area of treatment.
- Please wear appropriate shoes for physical activity.

Your treatment may include some, or all of the following:

- Therapeutic exercise/activities: Performed for strengthening and/or improving mobility or gait
- Manual Therapy: Including joint mobilization techniques, soft tissue massage and myofascial release.
- Modalities: Which include but not limited to hot packs, cold packs, electric stimulation and ultrasound

We would again like to Thank You, and look forward to working with you to achieve your goals.

Sincerely,

The Staff of Mendelson Kornblum Physical Therapy

Mendelson Kornblum
Orthopedic & Spine Specialists

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- *PLEASE NOTE* : 3 No Shows in a row can result in a discharge from therapy. No Shows are considered scheduled appointments that are not kept without prior notification.
- Please arrive on time for your scheduled appointments. If you are going to be late for your scheduled appointment please call. We will do our best to accommodate you, but please keep in mind it may be with a different therapist.

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