Date of initial evaluation:

Low back and hip *Questionnaire*

Date:	
Name:	Age:
Occupation:	□ Retired □ n.a.

Date of injury or date when your pain/condition started:
What happened ?

Date surgery (if indicated):
List any other surgeries you had and the approximate year:

Please list your current medications:	Please list prior hospitalizations:

Does your past medical history include?

			Physical therapist comments
Pace maker or other implanted electronics ?	Yes	No	
Diabetes ? □ Insuline □ Meds □ Diet	Yes	No	
Allergies (including latex allergies) ?	Yes	No	
Scoliosis ?	Yes	No	
Spinal surgery ?	Yes	No	When?
Hip replacement ?	Yes	No	When? Side: L R
Knee replacement ?	Yes	No	When? Side: L R
Low back pain or sciatica (pinched nerve) ?	Yes	No	
History of low back pain or sciatica ?	Yes	No	
Arthritis ?	Yes	No	
Any unexplained weight loss ?	Yes	No	
Any weight gain ?	Yes	No	
Bladder/bowel incontinence ?	Yes	No	
Do you smoke ?	Yes	No	
History of cancer in the family ?	Yes	No	
History of cancer ?	Yes	No	
Intestinal problems ?	Yes	No	
Blood clot / DVT/ Thrombosis ?	Yes	No	

Long term steroid use?	Yes	No	
Psychiatric illness ?	Yes	No	
Pregnancy ?	Yes	No	
Heart disease ?	Yes	No	
High/low blood pressure ?	Yes	No	
Lung disease ?	Yes	No	
Have you ever had Tuberculosis test that was positive ?	Yes	No	
Have you ever been exposed to someone with TB ?	Yes	No	
Have you ever been diagnoses with TB ?	Yes	No	
Coughing up blood ?	Yes	No	
Persistent cough longer than 3 weeks ?	Yes	No	
Osteoporosis ?	Yes	No	

Have you fallen in the last 3 months? ?	Yes	No	If yes; how many times? _____ X
Did your fall lead to any injuries?	Yes	No	

Who referred you to us?

- ☐ Hospital Program
- ☐ Insurance Referral
- ☐ Internet / Website
- ☐ Friend / Family Member
- ☐ Advertisement
- ☐ Physician referral by:
  - ☐ A Mendelson-Kornblum physician
  - ☐ An other physician.
    Please add name:_____

*Please check the circle that reflects the most you can currently **walk without pain**, weakness or limitation.*

- ◯ Unable
- ◯ Bed to chair
- ◯ Within the home
- ◯ Home to car
- ◯ For more than 10 minutes
- ◯ For more than 30 minutes
- ◯ For more than 60 minutes
- ◯ For more than 120 minutes

*Is your walking **distance limited due to** any of the reason listed below?*

Please check one or more circles.

- ◯ **Low back** or buttock pain
- ◯ Weakness/fatigue of the **legs**
- ◯ Numbness/tingling or burning of the **legs**
- ◯ Lack of balance (fear of falling)
- ◯ Stiffness
- ◯ Per Dr's orders
- ◯ Other:

*Are you **dependent on** any of the following items to improve your ability to walk? Please mark one or more circles.*

- ◯ Walker
- ◯ Cane
- ◯ Crutches
- ◯ Family member/friend
- ◯ Pain medication
- ◯ Brace/orthotic/ rehab boot
- ◯ I hold on to furniture and countertop
- ◯ Without assist

*How long can you **stand** without increased pain, discomfort or weakness?*

- ◯ Unable
- ◯ Brush teeth/comb hairs (2-5 min)
- ◯ Prepare sandwich (5-10 min)
- ◯ Washing dishes (10-20 min)
- ◯ Cooking dinner (20-40 min)
- ◯ For 60 minutes or more

*How long can you **sit** without increased pain, numbness, tingling or weakness?*

- ◯ 0-5 min
- ◯ 5-15 min
- ◯ 15-30 min
- ◯ 30-60 min
- ◯ 60 min or more

Information in regards to your daily functioning (please circle)

0 = Able without difficulty 3 = Able with some limitation 6 = Difficult 8 = Very difficult 10 = Unable

N.a. = Doesn't apply to me

ARE YOU ABLE TO?

Turn over in bed without pain or difficulty ?	0	1	2	3	4	5	6	7	8	9	10	N.a.
Get out of bed without pain or difficulty ?	0	1	2	3	4	5	6	7	8	9	10	N.a.
Get dressed without pain or difficulty?	0	1	2	3	4	5	6	7	8	9	10	N.a.
Put on socks and tie shoes without pain or difficulty ?	0	1	2	3	4	5	6	7	8	9	10	N.a.
Use the restroom without pain or difficulty ?	0	1	2	3	4	5	6	7	8	9	10	N.a.
Get up from a chair without assist of your arms ?	0	1	2	3	4	5	6	7	8	9	10	N.a.
Get up from a couch without assist of your arms ?	0	1	2	3	4	5	6	7	8	9	10	N.a.
Sit down and get up from the bath tub without pain or difficulty ?	0	1	2	3	4	5	6	7	8	9	10	N.a.
Return to work without limitations ?	0	1	2	3	4	5	6	7	8	9	10	N.a.
Do the laundry without pain or difficulty ?	0	1	2	3	4	5	6	7	8	9	10	N.a.
Do your own grocery shopping ?	0	1	2	3	4	5	6	7	8	9	10	N.a.
Make the bed without pain or difficulty ?	0	1	2	3	4	5	6	7	8	9	10	N.a.
Pick up objects from the floor with straight knees?	0	1	2	3	4	5	6	7	8	9	10	N.a.
Can you bend at the waist in order to wash your legs without pain or difficulty	0	1	2	3	4	5	6	7	8	9	10	N.a.
Can you load and unload the dishwasher without difficulty?	0	1	2	3	4	5	6	7	8	9	10	N.a.
Can you safely ambulate up and down steps with use of handrail and without assist from others?	0	1	2	3	4	5	6	7	8	9	10	N.a.
Can you safely carry a 10 pound grocery bag for 50 feet.	0	1	2	3	4	5	6	7	8	9	10	N.a.

Total score:_____/ 17 = _____

To be completed by PTT

Information in regards to your pain during the past week

Please circle the appropriate numbers

0 = pain free 2 = Discomfort 5 = Moderate 8 = Severe 10 = Excruciating

1. Please circle your ***worst*** pain this past week:	0	1	2	3	4	5	6	7	8	9	10
2. Please circle your ***current*** pain:	0	1	2	3	4	5	6	7	8	9	10
3. Rate your pain while ***standing****:*	0	1	2	3	4	5	6	7	8	9	10
4. Rate your pain while ***walking****:*	0	1	2	3	4	5	6	7	8	9	10
5. Rate your pain while ***lying****:*	0	1	2	3	4	5	6	7	8	9	10
6. Rate your pain while ***sitting****:*	0	1	2	3	4	5	6	7	8	9	10

Office use: total _____/6 =_____

7. What is the ***percentage*** of the day you have low back pain?:	0%	20%	40%	60%	80%	100%
8. What is the ***percentage*** of the day you have leg symptoms?:	0%	20%	40%	60%	80%	100%

9. Do you ***wake up*** due to pain?*:* 1 = Yes 2 = No If yes, how often?

10. Please circle your use of ***pain meds*** : 1 = None 2 = Occasional/ as needed 3 = Constant

a. Prescription

b. Over the counter

Information in regards to special tests

Did you undergo any of the following tests ?

1. M.R.I.	1 = Yes	2 = No	3 = Don't know
2. Cat Scan	1 = Yes	2 = No	3 = Don't know
3. X-ray	1 = Yes	2 = No	3 = Don't know
4. Bone Scan	1 = Yes	2 = No	3 = Don't know
5. E.M.G.	1 = Yes	2 = No	3 = Don't know

Patient Signature:_____ ***Date***:_____

Reviewed by therapist _____P.T. Date:_____

EET

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.

I understand that I have the right to request restrictions on how my protected health information is used or disclosed for treatment, payment or health care operations. My physicians and the facility are not required to agree to this restriction, but if they agree they will be bound by the agreement.

By signing this form, I acknowledge that I have been offered and/or received the Mendelson/Kornblum General Consent to Outpatient Treatment and Notice of Patient Rights and Responsibilities.

Name of Patient (print)_____

Signature of Patient_____

Date_____ Time_____

Signature of Spouse_____

Date_____ Time_____

Signature of Witness_____

Consent of Legal Guardian, Patient Advocate or Nearest Relative if Patient is Unable to Sign or is a Minor

Signature of Guardian, Patient Advocate or Nearest Relative_____

Date_____ Time_____

Relationship_____

Address_____

Phone_____

Signature of Witness_____

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 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.

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