Date of initial evaluation:

Shoulder 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:	Prior hospitalization:

Does your past medical history include any of the following ?

			Physical therapist comments
Pace maker or other implanted electronics ?	Yes	No	
Diabetes ? □ Insuline □ Meds □ Diet	Yes	No	
Heart disease?	Yes	No	
Lung disease?	Yes	No	
Pinched nerve/ neck pain ?	Yes	No	
Circulatory disease?	Yes	No	
Breast cancer?	Yes	No	
Allergies (including latex allergies) ?	Yes	No	
Lower extremity weakness?	Yes	No	
Arthritis ?	Yes	No	
Any unexplained weight loss ?	Yes	No	
Any weight gain ?	Yes	No	
RSD ?	Yes	No	
Do you smoke ?	Yes	No	
History of cancer in the family ?	Yes	No	
History of cancer ?	Yes	No	
Dislocated shoulder ?	Yes	No	
History of spinal surgery ?	Yes	No	

			Physical therapist comments
Long term steroid use?	Yes	No	
Psychiatric illness ?	Yes	No	
Pregnancy ?	Yes	No	
Heart surgery ?	Yes	No	
High/low blood pressure ?	Yes	No	
Carpal tunnel syndrome ?	Yes	No	
Have you 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 Mem-
- ☐ Advertisement

Physician referral by:

- ☐ A Mendelson-Kornblum physician
- ☐ An other physician.

Please add name:_____

Other?

✓ *Ability to raise the involved arm without increased pain.*

The question pertains to your current ability not your ability before the injury , surgery or onset of pain. Please check the circles that tell us what you can do without increased pain:

- ◯ I can point ***straight up*** at the ceiling without bending the elbow
- ◯ I can change a ***light bulb*** *in the ceiling*
- ◯ I can reach for ***top shelve*** of top cupboard
- ◯ I can reach for the ***bottom shelve*** of top cupboard
- ◯ I can reach for the top of a ***steering wheel***
- ◯ I can reach for the ***doorknob***
- ◯ I can put my hand ***on the table***
- ◯ I can put my hand ***on my knee***
- ◯ I am **unable** to raise my arm at all

✓ *Raising limitations are due to?*

- ◯ Pain
- ◯ Stiffness
- ◯ Weakness
- ◯ Swelling
- ◯ Numbess or tingling
- ◯ Fatigue
- ◯ Per Dr's orders
- ◯ I have no limitations in raising the arm

✓ *Maximum tolerated raising time without increased pain?*

- ◯ As long as needed for most activities
- ◯ (20-40 min)
- ◯ (10-20 min)
- ◯ (5-10 min)
- ◯ (2-5 min)
- ◯ Unable

Questions in regards to your daily functioning.

With the following questions we evaluate what your limitations are before you start the physical therapy treatments. We will refer back to this questionnaire later to evaluate your progress. Please make sure to circle the number that reflects your disability and/or your lack of function.

What do the numbers mean?:

0 = Normal
2 = Some limitations
6 = With difficulty and limitation
8 = Very difficult and severely limited
10 = Completely unable to perform the activity.

N.a = if the question does not apply to your situation.

With the involved (or injured) arm are you able to?

Hang a shirt or pants in closet without limitations or difficulty?	0	1	2	3	4	5	6	7	8	9	10	N.a.
Hang a heavy coat above shoulder height without limitations or difficulty?	0	1	2	3	4	5	6	7	8	9	10	N.a.
Steer your car around a sharp corner without limitations or difficulty?	0	1	2	3	4	5	6	7	8	9	10	N.a.
Reach behind you for a seatbelt without limitations or difficulty?	0	1	2	3	4	5	6	7	8	9	10	N.a.
Fasten seatbelt?	0	1	2	3	4	5	6	7	8	9	10	N.a.
Reach for back seat of car/truck?	0	1	2	3	4	5	6	7	8	9	10	N.a.
Comb hairs with use of both hands?	0	1	2	3	4	5	6	7	8	9	10	N.a.
Wash opposite arm pit?	0	1	2	3	4	5	6	7	8	9	10	N.a.

Reach into your back pocket and reach behind your back for dressing and grooming ?	0	1	2	3	4	5	6	7	8	9	10	N.a.
Bring fork/spoon to mouth?	0	1	2	3	4	5	6	7	8	9	10	N.a.
Brush teeth?	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.
Carry a 10 Lbs. bag 50 feet with involved arm?	0	1	2	3	4	5	6	7	8	9	10	N.a.
Prepare 30 min meal without difficulty?	0	1	2	3	4	5	6	7	8	9	10	N.a.
Can you type for more than 15– 20 minutes?	0	1	2	3	4	5	6	7	8	9	10	N.a.

Office use: Total score from page 3-4 _____/15= _____

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 ***during movement*** of the arm:	0	1	2	3	4	5	6	7	8	9	10
4. Rate your pain while ***resting****:*	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

Office use: total _____/5 =_____

What is the ***percentage*** of the day you have pain?: 0% 20% 40% 60% 80% 100%

Do you ***wake up*** due to pain?: *yes* *no* If yes: **how many** times a night?_____

Please circle your use of ***pain meds*** : 1 = None 2 = Occasional/ as needed 3 = Constant
a. Prescription
b. Over the counter

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