

COMPLIMENTARY CONSULTATION WORKSHEET



To help us assist you, please provide us with the information requested below.

Your Name: _____ Doctor's Name: _____
Visit Date: _____ Return To Dr. Date: _____

1. What health issue(s) are you being seen for today? Please provide a brief description below.

2. Have you undergone any testing for the problem for which you are being seen for today? (X-ray, MRI, EMG, CT Scan, etc) or treatments? Yes No. If you answered yes, please provide a brief description.

3. Are you currently taking any medications? Yes No If you answered yes, please list them below.

4. Do you have any other medical conditions for which you are currently being treated for? Yes No If you answered yes, please provide a brief description.

5. Please indicate any other pertinent information or difficulties you feel are relevant to your visit today.

System Review – Clinic Use Only

	<u>Not Impaired</u>	<u>Impaired</u>
Cardiovascular / Pulmonary System (HR, RR, BP, Edema) _____	<input type="checkbox"/>	<input type="checkbox"/>
Integumentary System (Integrity, Scar Formation, Color) _____	<input type="checkbox"/>	<input type="checkbox"/>
Musculoskeletal System (Gross Strength, ROM, Symmetry) _____	<input type="checkbox"/>	<input type="checkbox"/>
Neuromuscular System (Balance, Gait, Locomotion, Transfers, Motor Function) _____	<input type="checkbox"/>	<input type="checkbox"/>
Communication System (Affect, Cognition, Learning Style) _____	<input type="checkbox"/>	<input type="checkbox"/>
Other significant objective tests and measurable findings.		

Plan: <input type="checkbox"/> PT Eval <input type="checkbox"/> Referral: _____ <input type="checkbox"/> Other: _____	Staff Initials _____	Date _____

Name: _____ Referred By: _____ Date: _____

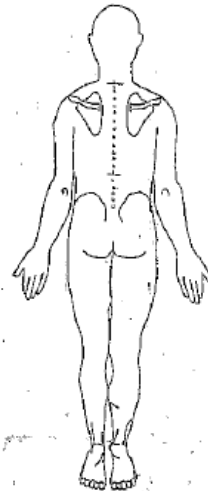
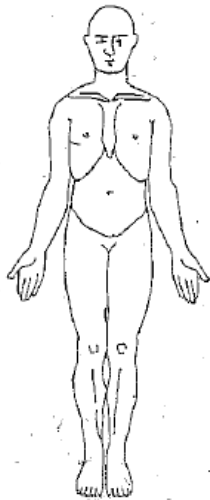
How did you hear about BODYWORKS? _____

Providing the requested information will help us understand your present condition and the impact it has had on your life. Your answers will help to guide our examination and will ensure that this evaluation is as accurate as possible. If you have any questions as you are completing this worksheet, please place a question mark there and your Clinician will discuss those areas.

HISTORY OF CURRENT CONDITION

1. What is your main physical complaint/problem? _____
2. When did your symptoms first begin? _____
3. How did your symptoms initially present themselves? _____
4. Was the onset of this episode... From injury* Disease Other: _____
5. How were you injured?* _____

Shade any areas of pain or abnormal sensation(s) on the body chart below.



6. Was the onset of this episode...? Gradual Delayed Sudden _____
7. Since the onset, are your symptoms...? Better Unchanged Worse _____
8. How is your pain? (Check all that apply.) Dull Aching Throbbing Sharp
 Constant Periodic Constant _____
9. Does the pain wake you at night? No Yes
10. If yes, it is present when you are... Lying still When changing position Both
11. In what position do you sleep? Left side Right Side On Stomach On Back
 In Recliner or Chair Other: _____
12. Do you have pain/stiffness upon getting out of bed? Yes No
13. As the day progresses, is your pain... Decreased The Same Increased

14. What aggravates your pain/symptoms? (Check all that apply.)

- | | | |
|---|--|---|
| <input type="checkbox"/> Sitting | <input type="checkbox"/> Reaching overhead | <input type="checkbox"/> Coughing/sneezing |
| <input type="checkbox"/> Going to/rising from sitting | <input type="checkbox"/> Reaching out from body | <input type="checkbox"/> Taking a deep breath |
| <input type="checkbox"/> Standing | <input type="checkbox"/> Reaching behind back | <input type="checkbox"/> Talking |
| <input type="checkbox"/> Squatting | <input type="checkbox"/> Reaching across body | <input type="checkbox"/> Yawning |
| <input type="checkbox"/> Lying down | <input type="checkbox"/> Doing repetitive activities | <input type="checkbox"/> Chewing |
| <input type="checkbox"/> Sleeping | like: _____ | <input type="checkbox"/> Swallowing |
| <input type="checkbox"/> Walking | <input type="checkbox"/> Playing sports, such as: | <input type="checkbox"/> Feeling stressed |
| <input type="checkbox"/> Going up/down stairs | _____ | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Bending (sustained) | <input type="checkbox"/> Doing household chores | _____ |
| <input type="checkbox"/> Looking up overhead | _____ | _____ |

Notes

15. What relieves your pain/symptoms? (Check all that apply.)

- | | | |
|---|---|--|
| <input type="checkbox"/> Sitting | <input type="checkbox"/> Playing Sports, such as: | <input type="checkbox"/> Alcohol |
| <input type="checkbox"/> Going to/rising from sitting | _____ | <input type="checkbox"/> Medication |
| <input type="checkbox"/> Standing | <input type="checkbox"/> Cold | <input type="checkbox"/> Rests |
| <input type="checkbox"/> Squatting | <input type="checkbox"/> Heat | <input type="checkbox"/> Elevating limbs |
| <input type="checkbox"/> Lying down | <input type="checkbox"/> Whirlpool | <input type="checkbox"/> Nothing |
| <input type="checkbox"/> Walking | <input type="checkbox"/> Massage | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Stretching | <input type="checkbox"/> Traction | _____ |
| <input type="checkbox"/> Exercising | <input type="checkbox"/> Wearing Splints/Orthosis | _____ |

HISTORY OF CURRENT CONDITION

16. How many times have you had symptoms similar to your current condition?

17. What previous treatment have you had for this condition? (Check all that apply.)

- | | | |
|--|--|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Bracing/taping | <input type="checkbox"/> Work conditioning |
| <input type="checkbox"/> Medication (oral) | <input type="checkbox"/> Casting | <input type="checkbox"/> Biofeedback |
| <input type="checkbox"/> Physical therapy | <input type="checkbox"/> Traction | <input type="checkbox"/> TENS unit |
| <input type="checkbox"/> Massage therapy | <input type="checkbox"/> Injection into the spine | <input type="checkbox"/> Acupuncture |
| <input type="checkbox"/> Exercise | <input type="checkbox"/> Injection into skin/muscles | <input type="checkbox"/> Bed rest |
| <input type="checkbox"/> Joint Manipulation by a | <input type="checkbox"/> Surgery (on the body area | <input type="checkbox"/> Overnight hospitalization |
| Chiropractor or Osteopath | Of your current problem) | Other |

18. Which health professionals are you currently seeing?

- | <u>Type</u> | <u>Name</u> | <u>Type</u> | <u>Name</u> |
|---|-------------|--|-------------|
| <input type="checkbox"/> Medical/Family Doctor | _____ | <input type="checkbox"/> Physical Therapist | _____ |
| <input type="checkbox"/> Chiropractor | _____ | <input type="checkbox"/> Massage Therapist | _____ |
| <input type="checkbox"/> Orthopedist | _____ | <input type="checkbox"/> Psychiatrist/Psychologist | _____ |
| <input type="checkbox"/> Neurologist/Neurosurgeon | _____ | <input type="checkbox"/> Other: | _____ |

19. Which of the following problems have you experienced? (Check all that apply.)

- | | | |
|--|--|--|
| <input type="checkbox"/> Weakness/tingling/numb
in both arms at same time | <input type="checkbox"/> Weakness/tingling/numb
in both legs at same time | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Unexplained weight loss | <input type="checkbox"/> Falling/balance problems | <input type="checkbox"/> Visual disturbances |
| <input type="checkbox"/> Numbness in genitals/anus | <input type="checkbox"/> Dizziness or fainting | <input type="checkbox"/> Ringing in the ears |
| | | Other: |

FUNCTIONAL LEVELS

For each of the questions below, read the question and answer it twice. First answer how it was for you were before the incident/accident/surgery (check the hollow box) AND then how things are now (check the gray box).

Living Situation	
<input type="checkbox"/> <input type="checkbox"/> Have stairs in the home/outside	<input type="checkbox"/> <input type="checkbox"/> Live alone
<input type="checkbox"/> <input type="checkbox"/> Live in a house	<input type="checkbox"/> <input type="checkbox"/> Live with your spouse or a relative
<input type="checkbox"/> <input type="checkbox"/> Live in an apartment	<input type="checkbox"/> <input type="checkbox"/> Other
<input type="checkbox"/> <input type="checkbox"/> Live in a mobile home	
<input type="checkbox"/> <input type="checkbox"/> Live in a facility that offers care	
Equipment Needed/Use	
<input type="checkbox"/> <input type="checkbox"/> Cane	<input type="checkbox"/> <input type="checkbox"/> Wheelchair
<input type="checkbox"/> <input type="checkbox"/> Walker	<input type="checkbox"/> <input type="checkbox"/> Grab Bars
<input type="checkbox"/> <input type="checkbox"/> Elevated/Bedside Commode	<input type="checkbox"/> <input type="checkbox"/> Hospital Bed
<input type="checkbox"/> <input type="checkbox"/> Other	<input type="checkbox"/> <input type="checkbox"/> Other

Occupational Situation	
<input type="checkbox"/> <input type="checkbox"/> Employed full-time	<u>Work Related Physical Activities</u>
<input type="checkbox"/> <input type="checkbox"/> Self-employed	<input type="checkbox"/> <input type="checkbox"/> Sitting
<input type="checkbox"/> <input type="checkbox"/> Full-time homemaker	<input type="checkbox"/> <input type="checkbox"/> Using a computer
<input type="checkbox"/> <input type="checkbox"/> Employed part-time	<input type="checkbox"/> <input type="checkbox"/> Talking on the phone
<input type="checkbox"/> <input type="checkbox"/> Retired	<input type="checkbox"/> <input type="checkbox"/> Driving
<input type="checkbox"/> <input type="checkbox"/> Disabled	<input type="checkbox"/> <input type="checkbox"/> Moving in a specific repetitive way
<input type="checkbox"/> <input type="checkbox"/> Unemployed	<input type="checkbox"/> <input type="checkbox"/> Lifting 50+ pounds
Time Taken Off From Work	<input type="checkbox"/> <input type="checkbox"/> Lifting repetitively
_____	<input type="checkbox"/> <input type="checkbox"/> Operating heavy equipment
	<input type="checkbox"/> <input type="checkbox"/> Other

General Activity	
<u>Daily Living / Self Care Activities</u>	<u>Activities Outside The Home</u>
<input type="checkbox"/> <input type="checkbox"/> Perform all activities alone	<input type="checkbox"/> <input type="checkbox"/> Often active with others outside home
<input type="checkbox"/> <input type="checkbox"/> Require some assistance	<input type="checkbox"/> <input type="checkbox"/> Occasionally active outside home
<input type="checkbox"/> <input type="checkbox"/> Need help for some activities	<input type="checkbox"/> <input type="checkbox"/> Rarely active outside the home
<input type="checkbox"/> <input type="checkbox"/> Need help for all activities	<input type="checkbox"/> <input type="checkbox"/> Need help for activities outside home

Exercise / Physical Activities	
<u>Frequency</u>	<u>Your Sports & Recreational Activities</u>
<input type="checkbox"/> <input type="checkbox"/> 5+ days per week	<input type="checkbox"/> <input type="checkbox"/> Walking
<input type="checkbox"/> <input type="checkbox"/> 3-4 days per week	<input type="checkbox"/> <input type="checkbox"/> Running
<input type="checkbox"/> <input type="checkbox"/> 1-2 days per week	<input type="checkbox"/> <input type="checkbox"/> Stationary Biking
<input type="checkbox"/> <input type="checkbox"/> Rarely	<input type="checkbox"/> <input type="checkbox"/> Biking
<input type="checkbox"/> <input type="checkbox"/> Never	<input type="checkbox"/> <input type="checkbox"/> Stretching/Yoga
	<input type="checkbox"/> <input type="checkbox"/> Swimming
	<input type="checkbox"/> <input type="checkbox"/> Weight Lifting
	<input type="checkbox"/> <input type="checkbox"/> Pilates
	<input type="checkbox"/> <input type="checkbox"/> _____

DIAGNOSTIC TESTS

Test	Where	When	Results
<input type="checkbox"/> X-Rays			
<input type="checkbox"/> MRI			
<input type="checkbox"/> CT Scan			
<input type="checkbox"/> Bone Scane			
<input type="checkbox"/> Arthrogram			
<input type="checkbox"/> EMG			
<input type="checkbox"/> Other:			

PRESCRIPTIONS & OVER THE COUNTER MEDICATIONS (Provide a list or write down any pills, injections, patches, herbs, etc.)

Prescription Medications	Over The Counter Medications/Treatments

ADDITIONAL INFORMATION

Please list any additional details you want us to know about.

SYSTEM REVIEW/CLINIC USE ONLY

Impression		Physical System
Not Impaired	Impaired	
<input type="checkbox"/>	<input type="checkbox"/>	Cardiovascular/Pulmonary System (HR, RR, BP, Edema)
<input type="checkbox"/>	<input type="checkbox"/>	Integumentary System (Integrity, Scar Formation, Color, Pliability)
<input type="checkbox"/>	<input type="checkbox"/>	Musculoskeletal System (Gross Strength, ROM, Symmetry) Height _____ Weight _____ BMI _____
<input type="checkbox"/>	<input type="checkbox"/>	Neuromuscular System (Balance, Gait, Location, Transfer, Transitions, and Motor Function)
<input type="checkbox"/>	<input type="checkbox"/>	Communication, Affect, Cognition, Learning Style System (Communication, Person/Place/Time Orientation Emotional/Behavioral Responses, Learning Barriers, Educational Needs)

CLINICIAN NOTES

Reviewing Clinician's Initials: _____ Date Reviewed: _____

CONSENT TO RECEIVE A COMPLIMENTARY CONSULTATION

I, the undersigned, consent to a Complimentary Consultation at BODYWORKS. I understand that this Consultation is not a substitute for an Evaluation and is provided to me as a professional courtesy. By initialing below, I acknowledge this fact and give the Physical Therapist permission to speak with me; perform a physical screening examination; and advise me on further treatment options. Neither I nor my insurance company will be billed for this service.

Initials: _____ Date: _____

CONSENT TO RECEIVE AN EVALUATION

I, the undersigned, consent to an Evaluation at BODYWORKS. I understand that the Evaluation will determine my diagnosis, prognosis, and outcome of treatment. By returning for subsequent appointments, I demonstrate my consent to receive and participate in a treatment program in accordance with the facility operating policies, of which I will be given a written copy.

Initials: _____ Date: _____

CONSENT TO RELEASE MEDICAL INFORMATION TO HEALTH CARE PROVIDERS INVOLVED IN YOUR TREATMENT

I, the undersigned, consent to the release of only pertinent medical records, X-rays, information regarding my medical condition, verbal reports, history, physical condition, and treatment rendered, to other health care professionals involved in my care. I will be provided with a written copy of PRAXIS Corporation’s policy of the Health Insurance Portability and Accountability Act of 1996 (HIPPA) with regard to Protected Health Information (PHI).

Initials: _____ Date: _____

CONSENT TO RELEASE OR RECEIVE MEDICAL INFORMATION VIA MAIL, ELECTRONIC MAIL (SUCH AS E-MAIL LOCAL INTRANETS, THE INTERNET AND “WORLD WIDE WEB” FOR NECESSARY MEDICAL CORRESPONDENCE)

I, the undersigned, hereby authorize BODYWORKS to release/receive only pertinent medical records and information regarding my medical condition, history, physical condition, prior authorizations, insurance billing and treatment rendered. I understand that the reason for Internet use is to allow more rapid action and decision-making to assist in my care. I will be provided with a written copy of PRAXIS Corporation’s policy of the Health Insurance Portability and Accountability Act of 1996 (HIPPA) with regard to Protected Health Information (PHI).

Initials: _____ Date: _____

CONSENT TO ASSIGNMENT OF BENEFITS AND ACCEPTANCE OF FINANCIAL RESPONSIBILITY

I, the undersigned, have medical insurance coverage and assign directly to BODYWORKS/PRAXIS CORPORATION medical benefits, if any, payable to me for services rendered. I will be provided with and read a copy of BODYWORKS’ financial policies. I understand that I am responsible for all charges whether paid for by my insurance or not. I authorize the release of only pertinent medical information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment. In addition, I understand that PRAXIS Corporation reserves the Right to Recover attorney fees and costs associated with the collection of my account in the event that my account is placed with a collection agency to recover the balance and principal due.

Initials: _____ Date: _____

Patient/Claimant Signature: _____ Date: _____

Legally Authorized Representative: _____ Date: _____

Signature of Witness: _____ Date: _____

Note: The above authorizations will be in effect unless revoked by written notification from the patient.

ACKNOWLEDGEMENT OF PRIVACY PRACTICES NOTICE



I understand that:

- In general, any information that is about your health, the health care you receive or payment for that care is considered confidential and protected by our practice.
- BODYWORKS need to use your protected health information to carry out a treatment, payment, health care operations, and/or other purposes.
- BODYWORKS' Notice of Privacy Practices provides a more complete description of permitted uses and disclosures.

I have received a copy of BODYWORKS' Notice of Privacy Practices.

Patient Name: (Please Print.) _____

Patient Signature: (OR, Below) _____

Date: _____

Patient Representative/Signature: _____

Date: _____

Relationship To Patient: _____

PRAXIS CORPORATION will accommodate all reasonable requests for confidential communications. All communications will be routed to you using the information you verified on your Patient Referral Form unless otherwise indicated below.

Are you requesting restricted communications? Yes No

If you answered yes, please complete the rest of the form.

----- ✂ -----

If yes, cut and attach to the front of the patient's medical records.

REQUEST FOR RESTRICTED COMMUNICATIONS

List any Health Care Providers that you DO NOT WANT your information sent to.

Indicate where we should contact you about information relating to your care (eg: appointment reminders/changes).

Contact me at any and all numbers available.

Contact me only at: _____

Indicate which address we can send correspondence to you at.

My home or place of residence as listed on my Patient Referral Form

Other, please specify: _____

Patient Initials and Date: _____

A good faith effort was made to obtain this written acknowledgement of receipt of our Notice of Privacy Practices & Request for Restricted Communications that was provided to the patient/patient's representative on...

BODYWORKS' Staff Signature: _____

Date: _____

Signature of Witness: _____

Date: _____