REHAB Resource Inc.
PHYSICAL THERAPY

Patient Information

Last Name	First Name	MI	Date of Appointment
Address	City	State	Zip
Birth Sex	Social Security Number	Date of Birth	Age
Contact Number	Weight / Height	Pregnant Yes or No	Nursing Yes or No
Email	Employment status (Circle all that apply)		
	Part time Full Time Unemployed Disabled Retired Student		
Marital Status (Circle all that Apply)			
Single Married Widowed Seperated Divorced			
Referring Physician	Physician's Contact Number		
Date of last visit to your Physician	Surgery Date	Injury Date	
Sponsor's Name	Sponsor's Date of Birth	Sponsor's Social Security Number	
Patient's Employer	Spouse's Employer		

Primary Insurance Information			
(Circle All That Apply)			Date of Accident
Health Insurance Auto Insurance Worker's Comp Attorney Self Pay			
Primary Insurance Company Name	Policy Number		
Group Number	Claim Number	Adjuster's Name	
Deductible $	Copay $	Total Amount to be paid $	
Any Therapy in the last 6 months? If Yes, Where?			
Secondary Insurance Information			
Secondary Insurance Company's Name	Policy Number		
Group Number	Claim Number	Adjuster's Name	
Deductible $	Copay $	Total Amount to be paid $	

Social Worker Services	
Are You Interested in Speaking to a Social Worker?	Yes or No

Emergency Contact Information		
Name	Relationship	Phone

I acknowledge that all the information that i have supplied on these forms is true, accurate, current, and complete.

Signature Printed Name Date

Financial Agreement

We are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benifits. In order to achieve these goals, we need your assistance, and understanding of our payment policy.

Reguarding Insurance

We will be happy to process your insurance claim-form for payment to us; however, if your insurance company does not pay 100% benifits, we will expect you to pay the properamount due. Physical therapy, Occupational and Speech therapy coverage varies depending on your policy. **IT IS TO YOUR BENEFIT TO CALL YOUR INSURANCE COMPANY AND CONFIRM YOUR THERAPY COVERAGE AND ITS LIMITS**. If your deductible has not been met, this is to be paid at time services rendered.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance.
You must realize, however, that:

1. Your insurance is a contract between you, your employer, and the insurance company
   We are not a party to that contract.
2. Our fees are considered to fall within the usual, customary and reasonable range for this area.
   However, there are companies, who reimburse based on an arbitary "schedule" of fees, which bears no relationship to the current standard and cost of care in this area. **YOU WILL BE RESPONSIBLE FOR ANY CHARGES THAT YOUR INSURANCE COMPANY DOES NOT COVER**.
3. CONSENT TO TREATMENT: Your signature authorizes us to perform appropriate treatment and procedures prescribed by your physician.
4. Your signature authorizes your insurance company to pay directly to our clinic, and for our clinic to release information to your insurance company, Attorney, and medical provider as needed.

MISSED APPOINTMENTS

A charge of $35.00 will be automatically CHARGED TO YOU PERSONALLY IF YOU DO NOT CALL and cancel your appointment within a 24-hour advanced notice. INSURANCE DOES NOT COVER NO-SHOW CHARGES.

THIRD PARTY BILLING

We do not handle third party billing. Occasionally an Auto insurance cxlaim will exceed the coverage OR will be denied pending litigation. We will be happy to bill your health insurance company in this instance. However, you will need to contact the carrier for necessary authorization. If you have no coverage we offer an extended payment plan-provided regular monthly payments are received as per our financial agreement.

WORKER'S COMPENSATION CLAIMS

We accept assignment on Worker's compensation claims provided the insurance carrier has authorized treatment. If a claim becomes contested or controverted during the treatment program you are responsible for the charges.

MINOR PATIENTS

The parents or guardians of the minor patient must be present during therapy and are responsible for full payment.

SECURITY CAMERAS

Rehab Resource Inc. has installed security cameras in strategic locations throughout its premises to monitor activities for the safety and security of patients and staff members. Your signature acknowledges that security cameras are in operation and consents to being recorded while on Provider's premises.

For Your Privacy (HIPPA)

We do not release information unless we have a signed release authorized by the patient.

Please allow 3 working days for any records you need copied/Faxed/Mailed/and or Emailed.

We must emphasize that as Therapy providers, our relationship is with you, not your insurance company. While the filing of insuranceclaims is a courtesy, all charges are your responsibility. We realize that temporary financial problems may affect timely payment of ypour account. If such problems do arise, we encourage you to contact us immediately. Filing insurance claims is a service provided without charge and in no way relieves you of the responsibility for your bill.

Signature Date

REHAB Resource Inc. PHYSICAL THERAPY

MEDICATION LIST

NAME **DATE**

PRESCRIBED MEDICATIONS

NON-PRESCRIBED MEDICATION

Back Index

Patient Name: **Date:** **ACN Group, Inc. Form BI-100**

This questionaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statment that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

PAIN INTENSITY

0 The pain comes and goes and is very mild.
1 The pain is mild and does not vary much.
2 The pain comes and goes and is moderate.
3 The pain is moderate and does not vary much.
4 The pain comes and goes and is very severe.
5 The pain is very severe and does not vary much.

SLEEPING

0 I get no pain in bed.
1 I get pain in bed but it does not prevent me from sleeping well.
2 Because of pain my normal sleep is reduced by less than 25%.
3 Because of pain my normal sleep is reduced by less than 50%.
4 Because of pain my normal sleep is reduced by less than 75%.
5 Pain prevents me from sleeping at all.

SITTING

0 I can sit in any chair as long as i like.
1 I can only sit in my favorite chair as long as i like.
2 Pain prevents me from sitting more than 1 hour.
3 Pain prevents me from sitting more than 1/2 hour.
4 Pain prevents me from sitting more than 10 minutes.
5 I avoid sitting because it increases pain immediately.

STANDING

0 I can stand as long as I want without pain.
1 I have some pain while standing but it does not increase with time.
2 I cannot stand for longer than 1 hour without increasing pain.
3 I cannot stand for longer than 1/2 hour without increasing pain.
4 I cannot stand for longer than 10 minutes without increasing pain.
5 I avoid standing because it increases pain immediately.

WALKING

0 I have no pain while walking..
1 I have some pain while walking but it doesn't increase with distance.
2 I cannot walk more than 1 mile without increasing pain.
3 I cannot walk more than 1/2 mile without increasing pain.
4 I cannot walk more than 1/4 mile without increasing pain.
5 I cannot walk at all without increasing pain.

PERSONAL CARE

0 I do not have to change my way of washing / dressing in order to avoid pain.
1 I do not normally change my way of washing / dressing even though it causes some pain.
2 Washing / dressing increases the pain but I manage not to change my way of doing it.
3 Washing / dressing increases the pain and I find it necessary to change my way of doing it.
4 Because of the pain I am unable to do some washing /dressing without help.
5 Because of the pain I am unable to do any washing / dressing without help.

LIFTING

0 I can lift heavy weights without extra pain.
1 I can lift heavy weights but it causes extra pain.
2 Pain prevents me from lifting heavy weights off the floor.
3 Pain prevents me from lifting heavy weights off the floor, but i can manage if they are conveniently positioned.
4 Pain prevents me from lifting heavy weights off the floor, but i can manage light to medium weights if conveniently positioned.
5 I can only lift very light weights.

TRAVELING

0 I get no pain while traveling.
1 I get some pain while traveling but none of my usual forms of travel.
2 I get extra pain while traveling but it does not cause me to seek.
3 I get extra pain while traveling which causes me to seek alternate forms.
4 Pain restricts all forms of travel except travel done while lying down.
5 Pain restricts all forms of travel.

SOCIAL LIFE

0 My social life is normal and gives me no extra pain.
1 My social life is normal but increases the degree of pain.
2 Pain has no significant affect on my social life apart from limiting more.
3 Pain has restricted my social life and I do not go out very often.
4 Pain has restricted my social life to my home.
5 I have hardly any social life because of pain.

CHANGING DEGREE OF PAIN

0 My pain is rapidly getting better.
1 My pain fluctuates but overall is definetly getting better.
2 My pain seems to be getting better but improvemnet is slow.
3 My pain is neither getting better or worse.
4 My pain is gradually worsening.
5 My pain is rapidly worsening.

SUBMIT

Back Index Score

Index Score = [Sum of all staments selected / (# of sections with a statment selected x 5)] x 100

Neck Disability Index

This questionnaire is designed to help us better understand how your neck pain affects your ability to manage everyday life activities. Please circle in each section the one number that applies to you. Although you may consider that two of the statements relate to you, please circle the number that most closely describes your situation this past month.

Section 1: Pain Intensity

(0) I have no pain at the moment
(1) The pain is very mild at the moment
(2) The pain is moderate at the moment
(3) The pain is fairly severe at the moment
(4) The pain is very severe at the moment
(5) The pain is the worst imaginable at the moment

Section 2: Personal Care

(0) I can look after myself normally without causing extra pain.
(1) I can look after myself normally but it causes extra pain.
(2) It is painful to look after myself and I am slow and careful.
(3) I need some help but can manage most of my personal care.
(4) I need help everyday in most aspects of self-care.
(5) I do not get dressed, wash with difficulty and stay in bed.

Section 3: Lifting

(0) I can lift heavy weights without extra pain.
(1) I can lift heavy weights but it gives me extra pain.
(2) Pain prevents me lifting heavy weights off the floor but I can manage if they are conveniently placed (eg. on a table).
(3) Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
(4) I can only lift very light weights.
(5) I cannot lift or carry anything.

Section 4: Work

(0) I can do as much work as i want.
(1) I can only do my usual work, but no more.
(2) I can do most of my usual work, but no more.
(3) I can't do my usual work.
(4) I can hardly do any work at all.
(5) I can't do any work at all.

Section 5: Headaches

(0) I have no headaches at all.
(1) I have slight headaches that come infrequently.
(2) I have moderate headaches that come infrequently.
(3) I have moderate headaches that come frequently.
(4) I have severe headaches that come frequently.
(5) I have headaches almost all of the time.

Section 6: Concentration

(0) I can concentrate fully without difficulty.
(1) I can concentrate fully with slight difficulty.
(2) I have a fair degree of difficulty concentrating.
(3) I have a lot of difficulty concentrating.
(4) I have a great deal of difficulty concentrating.
(5) I can't concentrate at all

Section 7: Sleeping

(0) I have no trouble sleeping.
(1) My sleep is slightly disturbed for less than 1 hour.
(2) My sleep is mildly disturbed for up to 1-2 hours.
(3) My sleep is moderately disturbed for up to 2-3. hours.
(4) My sleep is greatly disturbed for 3-5 hours.
(5) My sleep is completely disturbed for up to 5-7 hours

Section 8: Driving

(0) I can drive my car without neck pain.
(1) I can drive as long as I want with slight neck pain.
(2) I can drive as long as i want with moderate neck pain.
(3) I can't drive as long as I want because of moderate neck pain.
(4) I can hardly drive at all because of severe neck pain.
(5) I can't drive my car at all because of neck pain.

Section 9: Reading

(0) I can read as much as i want with no neck pain.
(1) I can read as much as i want with slight neck pain.
(2) I can read as much as I want with moderate neck pain.
(3) I can't read as much as I want because of moderate neck pain.
(4) I can't read as much as I want because of severe neck pain.
(5) I can't read at all.

Section 10: Recreation

(0) I have no neck pain during all recreational activites.
(1) I have some neck pain with a few recreational activities.
(2) I have neck pain with most recreational activites.
(3) I have some neck pain with all recreational activites.
(4) I can hardly do recreational activites due to neck pain.
(5) I can't do any recreational activites due to neck pain.

Name: _____ **Date:** _____

Score: _____ **[100]** **Benchmark: -5 =** _____

Oswestry Low Back Pain Index

REHAB Resource Inc. PHYSICAL THERAPY

Name: **Date:**

Please rate the severity of your pain by circling a number below:

No pain	1	2	3	4	5	6	7	8	9	10	Unbearable pain

Instructions: Please circle the **ONE NUMBER** in each section which most closely describes your problem.

Section 1: Pain Intensity

0 - The pain comes and goes and is very mild.
1 - The pain is mild and does not vary much.
2 - The pain comes and goes and is moderate.
3 - The pain is moderate and does not vary much.
4 - The pain comes and goes and is severe.
5 - The pain is severe and does not vary much.

Section 2 : Personal Care (Washing, Dressing, etc.)

0 - I would not have to change my way of washing or dressing in order to avoid pain.
1 - I do not normally change my way of washing or dressing even though it causes some pain.
2 - Washing and dressing increase the pain but I manage not to change my way of doing it.
3 - Washing and dressing increase the pain and I find it necessary to change my way of doing it.
4 - Because of the pain I am unable to do some washing and dressing without help.
5 - Because of the pain I am unable to do any washing and dressing without help.

Section 3: Lifting

0 - I can lift heavy weights without extra pain.
1 - I can lift heavy weights but it gives extra pain.
2 - Pain prevents me lifting heavy weights off the floor.
3 - Pain prevents me lifting heavy weights off the floor, but i can manage if they are conveniently positioned, e.g., on table.
4 - Pain prevents me lifting heavy weights but i can manage light to medium weights if they are conveniently positioned.
5 - I can only lift very light weights at most.

Section 4: Walking

0 - I have no pain on walking.
1 - I have some pain on walking but it does not increase with distance.
2 - I cannot walk more than 1 mile without increasing pain.
3 - I cannot walk more than 1/2 mile without increasing pain.
4 - I cannot walk more than 1/4 mile without increasing pain.
5 - I cannot walk at all without increasing pain.

Section 5: Sitting

0 - I can sit in any chair as long as I like.
1 - I can sit only in my favorite chair as long as I like.
2 - Pain prevents me from sitting more than 1 hour.
3 - Pain prevents me from sitting more than 1/2 hour.
4 - Pain prevents me from sitting more than 10 minutes.
5 - I avoid sitting because it increases pain immediately.

Section 6: Standing

0 - I can stand as long as I want without pain.
1 - I have some pain when standing but it does not increase pain.
2 - I cannot stand for longer than 1 hour without increasing pain.
3 - I cannot stand for longer than 1/2 hour without increasing pain.
4 - I cannot stand for longer than 10 minutes without increasing pain.
5 - I avoid standing because it increases the pain immediately.

Section 7: Sleeping

0 - I have no pain in bed.
1 - I have pain in bed but it does not prevent me from sleeping well.
2 - Because of pain my normal nights sleep is reduced by less than 1/4.
3 - Because of pain my normal nights sleep is reduced by less than 1/2.
4 - Because of pain my normal nights sleep is reduced by less than 3/4.
5 - Pain prevents me from sleeping at all.

Section 8: Social Life

0 - My social life is normal and gives me no pain.
1 - My social life is normal but it increases the degree of pain.
2 - Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
3 - Pain has restricted my social life and I do not go out very often.
4 - Pain has restricted my social life to my home.
5 - I have hardly any social life because of the pain.

Section 9: Traveling

0 - I get no plain when traveling.
1 - I get some pain when traveling but none of my usual forms of travel make it any worse.
2 - I get extra pain while traveling but it does not compel me to seek alternate forms of travel.
3 - I get extra pain while traveling which compels to seek alternative forms of travel.
4 - Pain restricts me to short necessary journeys under 1/2 hour.
5 - Pain restricts all forms of travel.

Section 10: Changing degree of pain.

0 - My pain is rapidly getting better.
1 - My pain fluctuates but is definetlty getting better.
2 - My pain seems to be better but improvement is slow.
3 - My pain is niether getting better or worse.
4 - My pain is gradually worsening.
5 - My pain is rapidly worsening.

TOTAL _____

REHAB Resource Inc. PHYSICAL THERAPY

QuickDASH

Please rate your ability to do the following activities in the last week by circling the number below the appropriate response.

	No Difficulty	Mild Difficulty	Moderate Difficulty	Severe Difficulty	Unable
Open a tight or new jar	1	2	3	4	5
Do heavy household chores (e.g. wash walls, floors)	1	2	3	4	5
Carry a shopping bag or briefcase	1	2	3	4	5
Wash your back	1	2	3	4	5
Use a knife to cut food	1	2	3	4	5
Recreational activities in which you take some force or impact through your arm, shoulder or hand (e.g. golf, hammering, tennis, etc.)	1	2	3	4	5

	No Difficulty	Mild Difficulty	Moderate Difficulty	Severe Difficulty	Unable
During the past week, to what extent has your arm, shoulder or hand problem interfered with your normal social activities with family friends, neighbors or groups?	1	2	3	4	5

	No Difficulty	Mild Difficulty	Moderate Difficulty	Severe Difficulty	Unable
During the past week, were you limited in your work or other regular daily activites as a result of you arm, shoulder or hand problem?	1	2	3	4	5

	None	Mild	Moderate	Severe	Extreme
Arm, shoulder or hand pain	1	2	3	4	5
Tingling (pins and needles) in your arm, shoulder or hand	1	2	3	4	5

	No difficulty	Mild difficulty	Moderate difficulty	Severe difficulty	So much difficulty that I can't sleep
During the past week, how much difficulty have you had sleeping because of pain in your arm, shoulder or hand?	1	2	3	4	5

Quick Dash Diability / Sympton Score = **([**Sum of Responses/n**]**-1**)**x25

N is equal to the number of completed responses. A QuickDash score may NOT be calculated with greater than one missing item.

REHAB Resource Inc.
PHYSICAL THERAPY

The Lower Extremity Functional Scale

We are interested in knowing whether you are having any difficulty at all with the activities listed below because of your lower limb problem for which you are currently seeking attention. Please provide an answer for each activity. Today, do you or would you have any difficulty at all with:

	Activities	Extreme difficulty or unable to perform	Quite a bit of difficulty	Moderate difficulty	A little bit of difficulty	No difficulty
1	Any of your usual work, housework, or school activities.	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
2	Your usual hobbies, recreational or sporting activites.	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
3	Getting into or out of the bath.	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
4	Walking between rooms.	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
5	Putting on your shoes or socks.	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
6	Squatting.	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
7	Lifting an object, like a bag of groceries from the floor.	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
8	Performing light activites around your home.	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
9	Performing heavy activities around your home.	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
10	Getting into or out of car.	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
11	Walking 2 blocks.	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
12	Walking a mile.	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
13	Going up or down 10 stairs (about 1 flight of stairs)	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
14	Standing for 1 hour.	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
15	Sitting for 1 hour.	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
16	Running on even ground.	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
17	Running on uneven ground.	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
18	Making sharp turns while running fast.	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
19	Hopping.	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
20	Rolling over in bed.	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
	Column Totals:	☐	☐	☐	☐	☐

Minimum Level of Detectable Change (90% Confidence): 9 points Score___/80 (fill in blank with sum of your respopnses)

Source: Binkly et al (1999): The Lower Extremity Functional Scale (LEFS): Scale development, measurement properties, and clinical application. Physical Therapy. 79:371-383.

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