



Caledonia  
Physical  
Therapy

# Welcome

*Thank you for choosing Caledonia Physical Therapy.  
If you have any questions or concerns, do not hesitate to ask for  
assistance, we will be happy to help.*

**Patient Information:**

Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_  
FIRST MIDDLE LAST

Address: \_\_\_\_\_ Apt#: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone#: \_\_\_\_\_ Work/Cell Phone#: \_\_\_\_\_

How did you hear about our office? \_\_\_\_\_

SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Email Address: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

Spouse/Parents Name: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone#: \_\_\_\_\_

Is this injury due to an automobile accident?  YES  NO

Is this injury due to a work related incident?  YES  NO

Do you have insurance?  YES (if yes, please fill out the information below)  NO

Policy Holders Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Relationship to patient:  spouse  parent/guardian  other: \_\_\_\_\_  
 Policy Holder SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Policy Holder Employer: \_\_\_\_\_  
 Insurance Company Name: \_\_\_\_\_  
 Policy/ID #: \_\_\_\_\_ Group #: \_\_\_\_\_  
(Please have your DL and insurance cards available for the patient coordinator to make a copy of)

Primary Care Physician: \_\_\_\_\_ Phone#: \_\_\_\_\_

May we contact them about your condition?  Yes  No Date last seen: \_\_\_\_\_

Have you been to a physical therapist before?  Yes  No If yes, who? \_\_\_\_\_

Do you understand what physical therapists do?  Yes  No

Are you pregnant?  No  Yes my due date is: \_\_\_\_\_

I have provided correct information in the questionnaire to the best of my knowledge.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

**AUTHORIZATION TO EXAMINE AND RENDER CARE:**

I hereby authorize the examination and rendering of care.

Initials: \_\_\_\_\_

**INFORMED CONSENT FOR MEDICAL CARE**

I understand that with any health care procedure, there are certain inherent risks, which may arise during the course of treatment. I do not expect the physical therapist to be able to anticipate all possible risks and complications and I wish to rely on the physical therapist to exercise judgment during the course of the procedure(s) which the physical therapist feels at the time, based on the facts known then, and are in my best interest.

Upon my initial visit with the physical therapist, I will take the opportunity to discuss with the physical therapist, the nature, purpose and risks associated with physical therapy and have all my questions answered to my satisfaction. I also understand that results are not guaranteed.

I have read, or have had read to me, the above explanation of physical therapy. By signing below, I state that I have weighed the risks involved in undergoing care and have decided that it is in my best interest to undergo the physical therapy. Having discussed and been informed of possible risks, I hereby give my consent to care. I intend this consent form to cover the entire course of treatment for my present and future conditions for which I may seek care.

Initials: \_\_\_\_\_

I have provided correct information in the questionnaire to the best of my knowledge and will provide the physical therapist with any updated information as it arises.

I agree to take responsibility in my health and work with Tim Ulrich, P.T. to optimize my recovery.

Initials: \_\_\_\_\_

**INSURANCE AND BILLING ARRANGEMENTS**

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that Caledonia Physical Therapy will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the physical therapist's office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and I am personally responsible for payment.

I understand and agree that it is my sole responsibility to inform Caledonia Physical Therapy of **any** changes in my insurance carrier as soon as such information is provided to me or if my insurance has been suspended or canceled.

If credit is necessary, such arrangements must be made prior to services performed. Payment is due within 30 days of treatment or the sale of a product. A 1% per month (12% per year) late payment will be assessed on any unpaid balance remaining after 30 days.

I have been informed of the same day discount option and I understand full payment for this discount is within three calendar days. I understand that if full payment is not made within three calendar days, I will be charged the normal clinic fees.

If it becomes necessary to use a collection agency for my account, I am responsible for the charges incurred by the clinic.

I understand that a 24 hour notice is required for cancellations of an appointment and should I fail to do such, a **\$35**

**missed appointment fee** will be charged to my account.

I have read and agree to the above.

I understand and authorize the billing arrangements as stated above.

Initials: \_\_\_\_\_

**Personal Injury and Workmen's Compensation Claims:**

I understand that I will notify the front office staff when I schedule my appointment that my medical condition involves a Personal Injury or Workmen's Compensation case and will bring all the necessary documentation at that time. Should I fail to do such or change the nature of my claim after my initial visit, a **\$35 clerical fee** will be charged to my account. This fee must be paid prior to any additional treatment.

I have read and agree to the above.

I understand and authorize the billing arrangements as stated above.

Initials: \_\_\_\_\_

**DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE INFORMATION CONTAINED IN THIS AGREEMENT.**

\_\_\_\_\_  
Printed Name of Patient

\_\_\_\_\_  
Signature of Patient or Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness to Patient's Signature

\_\_\_\_\_  
Date

## **NOTICE OF PRIVACY PRACTICES**

THIS NOTICE DESCRIBES HOW PHYSICAL THERAPY AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

### **Uses and Disclosures**

Here are some examples of how we might have to use or disclose your health care information:

- 1) Your physical therapist or a staff member may have to disclose your health information including all of your clinical records to another health care provider or a hospital if it is necessary to refer you to them for diagnosis, assessment, or treatment of your health condition.
- 2) Our insurance and billing staff may have to disclose your examination and treatment records and your billing records to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are potentially responsible for the payment of your services.
- 3) Your physical therapist and members of the staff may need to use your health information, examination and treatment records and your billing records for quality control purposes or for other administrative purposes to efficiently and effectively run his/her practice.
- 4) Your physical therapist and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you to provide appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If you are not at home to receive an appointment reminder, a message will be left on your answering machine.

You have the right to refuse to give us authorization to contact you to provide appointment reminders, information about treatment alternatives, or other health related information. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time.

### **Permitted uses and disclosures without your consent or authorization**

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

- 1) We are permitted to use or disclose your health information to the extent that we are required to do so by applicable federal or state laws.
- 2) We are permitted to use or disclose your health information to a public health authority for a wide range of public health activities when the public health authority is authorized to collect or receive your health information under state or federal law.
- 3) We are permitted to use or disclose your health information to an appropriate government authority if we reasonably believe you are the victim of abuse, neglect or domestic violence.
- 4) We are permitted to use or disclose your health information for state and federal health oversight activities of the health care system and government benefit programs.

- 5) We are permitted to use or disclose your health information in response to a court order or, in response to a subpoena, discovery request, or other lawful purpose.
- 6) We are permitted to use or disclose your health information to a law enforcement official as required by laws that require us to report certain types of wounds or physical injuries or, to comply with court orders, a grand jury subpoena, or administrative requests authorized by the law.
- 7) We are permitted to use or disclose your health information to an appropriate law enforcement authority if the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.
- 8) We are permitted to use or disclose your health information to a correctional institution if we provide health care services to you as an inmate.
- 9) We are permitted to use or disclose your health information if we provide health care services to you in an emergency.
- 10) We are permitted to use or disclose your health information if we provide care to you that is related to a work place injury to the extent necessary to comply with Wisconsin's worker's compensation laws.

Other than the circumstances described in the preceding examples, any other use or disclosure of your health information will only be made with your written authorization.

#### **Your right to revoke your authorization**

You may revoke your authorization to us at any time; however, your revocation must be in writing. There are two circumstances under which we will not be able to honor your revocation request:

- 1) If we have already released your health information before we receive your request to revoke your authorization.
- 2) If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

#### **Your right to limit uses or disclosures**

If there are health care providers, hospitals, employers, insurers or other individuals or organizations to whom you do not want us to disclose your health information, please let us know, in writing, what individuals or organizations to whom you do not want us to disclose your health care information. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us. If we do not agree to your restrictions, you may drop your request or you are free to seek care from another health care provider.

#### **Your right to receive confidential communication regarding your health information**

We normally provide information about your health to you in person at the time you receive chiropractic services from us. We may also mail you information regarding your health or about the status of your account. We will do our best to accommodate any reasonable request if you would like to receive information about your health or the services that we provide at a place other than your home or, if you would like the information in a different form. To help us respond to your needs, please make any request in writing.

### **Your right to inspect and copy your health information**

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. We require your request to inspect and/or copy your health information to be in writing. We may refuse your request if the information is for use in a civil, criminal, or administrative action or proceeding

which is anticipated to occur in a time frame reasonable proximate to your request. There may be a cost associated with your request if we must copy information for you.

### **Your right to amend your health information**

You have the right to request that we amend your health information for seven years from the date that the record was created or as long as the information remains in our files. We require your request to amend your records to be in writing and for you to give us a reason to support the change you are requesting us to make.

### **Your right to receive an accounting of the disclosures we have made of your records**

You have the right to request that we give you an accounting of the disclosures we have made of your health information for the last six years before the date of your request. The accounting will include all disclosures except

1. those disclosures required for your treatment, to obtain payment for your services, or to run our practice.
2. those disclosures made to you.
3. those disclosures we are permitted to make without your consent or authorization as described above.
4. those disclosures made based on an authorization you signed.
5. those disclosures necessary to maintain a directory of the individuals in our facility or to individuals involved with your care.
6. those disclosures for national security or intelligence purposes.
7. those disclosures made to correctional officers or law enforcement officers.
8. those disclosures that were made prior to the effective date of the HIPAA privacy law.

We will provide the first accounting within any 12-month period without charge. There is a fee for any additional requests during the next 12 months. When you make your request we will tell you the amount of the fee and you will have the opportunity to withdraw or modify your request.

### **Your right to obtain a paper copy of this notice**

If you have agreed to receive privacy notices by e-mail, you may request a paper copy of this notice at any time.

### **Our duties**

We are required by law to maintain the privacy of your health information. We are also required to provide you with this notice of our legal duties and our privacy practices with respect to your health information.

We must abide by the terms of this notice while it is in effect. However, we reserve the right to change the terms of our privacy notices. If we make a change to the terms of our privacy agreement we will notify you in writing when you come in for treatment or by mail. If we make a change in our privacy terms the change will apply for all of your health information in our files.

**Re-disclosure**

Information that we use or disclose may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

**Your right to complain**

You may complain to us or to the Secretary of Health and Human Services if you feel that we have violated your privacy rights. We respect your right to file a complaint and will not take any action against you if you file a complaint. While you may make an oral complaint at any time, written comments should be sent to us at the address listed below.

**To contact us**

If you would like further information about our privacy policies and practices please contact:

Caledonia Physical Therapy

5401 Douglas Avenue, Suite A

Racine, Wisconsin 53402

(262) 681-8829

This notice is effective as of \_\_\_\_\_. This notice will expire seven years after the date upon which the record was created. By signing below, I acknowledge that I have received a copy of this notice.

\_\_\_\_\_  
Patient Name Printed

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Authorized Provider Representative

\_\_\_\_\_  
Personal Representative Printed

\_\_\_\_\_  
Personal Representative Signature

\_\_\_\_\_  
Description of personal representative's authority to act for the patient.

DOCUMENTATION TEMPLATE FOR PHYSICAL THERAPIST  
PATIENT/CLIENT MANAGEMENT  
Outpatient Form 1, Page 1

Today's Date: \_\_\_\_\_  
Patient ID#: \_\_\_\_\_

1 Name:

a Last \_\_\_\_\_  
b First \_\_\_\_\_ c MI \_\_\_\_\_ d Jr/Sr \_\_\_\_\_

2 Street Address:

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

3 Date of Birth: Month Day Year  
□□ □□ □□□□

4 Sex: a  Male b  Female

5 Are you: a  Right-handed b  Left-handed

6 Type of Insurance: a  Insurer \_\_\_\_\_  
b  Workers' Comp c  Medicare d  Self-pay e  Other \_\_\_\_\_

7 Race: a  American Indian or Alaska Native  
b  Asian  
c  Black or African American  
d  Hispanic or Latino  
e  Native Hawaiian or Other Pacific Islander  
f  White

8 Ethnicity: a  Hispanic or Latino  
b  Not Hispanic or Latino

9 Language: a  English understood  
b  Interpreter needed  
c  Language you speak most often: \_\_\_\_\_

10 Education: a Highest grade completed (Circle one): 1 2 3 4 5 6 7 8 9 10 11 12  
b  Some college / technical school  
c  College graduate  
d  Graduate school / advanced degree

SOCIAL HISTORY

11 Cultural/Religious: Any customs or religious beliefs or wishes that might affect care?  
\_\_\_\_\_

12 With whom do you live:

a  Alone  
b  Spouse only  
c  Spouse and other(s)  
d  Child (not spouse)  
e  Other relative(s) (not spouse or children)  
f  Group setting  
g  Personal care attendant  
h  Other: \_\_\_\_\_

13 Have you completed an advance directive? a  Yes b  No

14 Who referred you to the physical therapist?

\_\_\_\_\_

15 Employment/Work (Job/School/Play)

a  Working full-time outside of home  
b  Working part-time outside of home  
c  Working full-time from home  
d  Working part-time from home  
e  Homemaker f  Student g  Retired h  Unemployed

i Occupation: \_\_\_\_\_

LIVING ENVIRONMENT

16 Does your home have:

a  Stairs, no railing  
b  Stairs, railing  
c  Ramps  
d  Elevator  
e  Uneven terrain  
f  Assistive devices (eg, bathroom): \_\_\_\_\_  
g  Any obstacles: \_\_\_\_\_

17 Do you use:

a  Cane  
b  Walker or rollator  
c  Manual wheelchair  
d  Motorized wheelchair  
e  Glasses, hearing aids  
f  Other: \_\_\_\_\_

18 Where do you live:

a  Private home  
b  Private apartment  
c  Rented room  
d  Board and care / assisted living / group home  
e  Homeless (with or without shelter)  
f  Long-term care facility (nursing home)  
g  Hospice  
h  Other: \_\_\_\_\_

19 GENERAL HEALTH STATUS

a Please rate your health:  
(1)  Excellent (2)  Good (3)  Fair (4)  Poor  
b Have you had any major life changes during past year? (eg, new baby, job change, death of a family member) (1)  Yes (2)  No

20 SOCIAL/HEALTH HABITS

a Smoking  
(1) Currently smoke tobacco? (a)  Yes 1.  Cigarettes: # of packs per day \_\_\_\_  
2.  Cigars/Pipes: # per day \_\_\_\_  
(b)  No

(2) Smoked in past? (a)  Yes Year quit: □□□□ (b)  No

b Alcohol

(1) How many days per week do you drink beer, wine, or other alcoholic beverages, on average? \_\_\_\_  
(2) If one beer, one glass of wine, or one cocktail equals one drink, how many drinks do you have on an average day? \_\_\_\_

c Exercise

Do you exercise beyond normal daily activities and chores?  
(a)  Yes Describe the exercise: \_\_\_\_\_  
1. On average, how many days per week do you exercise or do physical activity? \_\_\_\_  
2. For how many minutes, on an average day? \_\_\_\_  
(b)  No

21 FAMILY HISTORY (Indicate whether mother, father, brother/sister, aunt/uncle, or grandmother/grandfather, and age of onset if known)

a Heart disease: \_\_\_\_\_  
b Hypertension: \_\_\_\_\_  
c Stroke: \_\_\_\_\_  
d Diabetes: \_\_\_\_\_  
e Cancer: \_\_\_\_\_  
f Psychological: \_\_\_\_\_  
g Arthritis: \_\_\_\_\_  
h Osteoporosis: \_\_\_\_\_  
i Other: \_\_\_\_\_

**22 MEDICAL/SURGICAL HISTORY**

a Please check if you have ever had:

- |  |   |
|--|---|
| (1) <input type="checkbox"/> Arthritis                         | (13) <input type="checkbox"/> Multiple sclerosis                                  |
| (2) <input type="checkbox"/> Broken bones/<br>fractures        | (14) <input type="checkbox"/> Muscular dystrophy                                  |
| (3) <input type="checkbox"/> Osteoporosis                      | (15) <input type="checkbox"/> Parkinson disease                                   |
| (4) <input type="checkbox"/> Blood disorders                   | (16) <input type="checkbox"/> Seizures/epilepsy                                   |
| (5) <input type="checkbox"/> Circulation/vascular<br>problems  | (17) <input type="checkbox"/> Allergies   |
| (6) <input type="checkbox"/> Heart problems                    | (18) <input type="checkbox"/> Developmental or growth<br>problems                 |
| (7) <input type="checkbox"/> High blood<br>pressure            | (19) <input type="checkbox"/> Thyroid problems                                    |
| (8) <input type="checkbox"/> Lung problems                     | (20) <input type="checkbox"/> Cancer  |
| (9) <input type="checkbox"/> Stroke                            | (21) <input type="checkbox"/> Infectious disease<br>(eg, tuberculosis, hepatitis) |
| (10) <input type="checkbox"/> Diabetes/<br>high blood sugar    | (22) <input type="checkbox"/> Kidney problems                                     |
| (11) <input type="checkbox"/> Low blood sugar/<br>hypoglycemia | (23) <input type="checkbox"/> Repeated infections                                 |
| (12) <input type="checkbox"/> Head injury                      | (24) <input type="checkbox"/> Ulcers/stomach problems                             |
|  | (25) <input type="checkbox"/> Skin diseases                                       |
|  | (26) <input type="checkbox"/> Depression  |
|  | (27) <input type="checkbox"/> Other: _____  |

b Within the past year, have you had any of the following symptoms? (Check all that apply)

- |   |   |
|---|---|
| (1) <input type="checkbox"/> Chest pain               | (13) <input type="checkbox"/> Difficulty sleeping   |
| (2) <input type="checkbox"/> Heart palpitations       | (14) <input type="checkbox"/> Loss of appetite      |
| (3) <input type="checkbox"/> Cough                    | (15) <input type="checkbox"/> Nausea/vomiting       |
| (4) <input type="checkbox"/> Hoarseness               | (16) <input type="checkbox"/> Difficulty swallowing |
| (5) <input type="checkbox"/> Shortness of breath      | (17) <input type="checkbox"/> Bowel problems        |
| (6) <input type="checkbox"/> Dizziness or blackouts   | (18) <input type="checkbox"/> Weight loss/gain      |
| (7) <input type="checkbox"/> Coordination problems    | (19) <input type="checkbox"/> Urinary problems      |
| (8) <input type="checkbox"/> Weakness in arms or legs | (20) <input type="checkbox"/> Fever/chills/sweats   |
| (9) <input type="checkbox"/> Loss of balance          | (21) <input type="checkbox"/> Headaches             |
| (10) <input type="checkbox"/> Difficulty walking      | (22) <input type="checkbox"/> Hearing problems      |
| (11) <input type="checkbox"/> Joint pain or swelling  | (23) <input type="checkbox"/> Vision problems       |
| (12) <input type="checkbox"/> Pain at night           | (24) <input type="checkbox"/> Other: _____          |

c Have you ever had surgery? (1)  Yes (2)  No  
 If yes, please describe, and include dates:

_____	Month	Year
_____	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
_____	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
_____	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

**For men only:** d Have you been diagnosed with prostate disease?  
 (1)  Yes (2)  No

**For women only:**

Have you been diagnosed with:

- |                                   |  |   |  |
|-----------------------------------|--|---|--|
| e Pelvic inflammatory<br>disease? | (1) <input type="checkbox"/> Yes (2) <input type="checkbox"/> No | h Complicated pregnancies<br>or deliveries?           | (1) <input type="checkbox"/> Yes (2) <input type="checkbox"/> No |
| f Endometriosis?                  | (1) <input type="checkbox"/> Yes (2) <input type="checkbox"/> No | i Pregnant, or think you<br>might be pregnant?        | (1) <input type="checkbox"/> Yes (2) <input type="checkbox"/> No |
| g Trouble with your period?       | (1) <input type="checkbox"/> Yes (2) <input type="checkbox"/> No | j Other gynecological or<br>obstetrical difficulties? | (1) <input type="checkbox"/> Yes (2) <input type="checkbox"/> No |
- If yes, please describe: \_\_\_\_\_

**23 CURRENT CONDITION(S)/CHIEF COMPLAINT(S)**

a Describe the problem(s) for which you seek physical therapy:

\_\_\_\_\_

\_\_\_\_\_

b When did the problem(s) begin (date)?

c What happened? \_\_\_\_\_

d Have you ever had the problem(s) before?

- (1)  Yes
- (a) What did you do for the problem(s)? \_\_\_\_\_
- (b) Did the problem(s) get better?
1.  Yes 2.  No
- (c) About how long did the problem(s) last? \_\_\_\_\_
- (2)  No

**23 Current Condition(s)/Chief Complaint(s) (continued)**

e How are you taking care of the problem(s) now? \_\_\_\_\_

f What makes the problem(s) better? \_\_\_\_\_

g What makes the problem(s) worse? \_\_\_\_\_

h What are your goals for physical therapy? \_\_\_\_\_

i Are you seeing anyone else for the problem(s)? (Check all that apply)

- |  |  |
|--|--|
| (1) <input type="checkbox"/> Acupuncturist             | (10) <input type="checkbox"/> Occupational therapist |
| (2) <input type="checkbox"/> Cardiologist              | (11) <input type="checkbox"/> Orthopedist            |
| (3) <input type="checkbox"/> Chiropractor              | (12) <input type="checkbox"/> Osteopath              |
| (4) <input type="checkbox"/> Dentist                   | (13) <input type="checkbox"/> Pediatrician           |
| (5) <input type="checkbox"/> Family practitioner       | (14) <input type="checkbox"/> Podiatrist             |
| (6) <input type="checkbox"/> Internist                 | (15) <input type="checkbox"/> Primary care physician |
| (7) <input type="checkbox"/> Massage therapist         | (16) <input type="checkbox"/> Rheumatologist         |
| (8) <input type="checkbox"/> Neurologist               | Other: _____   |
| (9) <input type="checkbox"/> Obstetrician/gynecologist |  |

**24 FUNCTIONAL STATUS/ACTIVITY LEVEL (Check all that apply)**

a  Difficulty with locomotion/movement:

- (1)  Bed mobility
- (2)  Transfers (such as moving from bed to chair, from  
bed to commode)
- (3)  Gait (walking)
- (a)  On level (c)  On ramps
- (b)  On stairs (d)  On uneven terrain

b  Difficulty with self-care (such as bathing, dressing, eating,  
toileting)

c  Difficulty with home management (such as household  
chores, shopping, driving/transportation, care of dependents)

d  Difficulty with community and work activities/integration

(1)  Work/school

(2)  Recreation or play activity

**25 MEDICATIONS**

a Do you take any prescription medications? (1)  Yes (2)  No  
 If yes, please list: \_\_\_\_\_

b Do you take any nonprescription medications?  
 (Check all that apply)

- |   |   |
|---|---|
| (1) <input type="checkbox"/> Advil/Aleve            | (6) <input type="checkbox"/> Decongestants      |
| (2) <input type="checkbox"/> Antacids               | (7) <input type="checkbox"/> Herbal supplements |
| (3) <input type="checkbox"/> Ibuprofen/<br>Naproxen | (8) <input type="checkbox"/> Tylenol            |
| (4) <input type="checkbox"/> Antihistamines         | (9) <input type="checkbox"/> Other: _____       |
| (5) <input type="checkbox"/> Aspirin                |   |

c Have you taken any medications previously for the  
 condition for which you are seeing the physical therapist?  
 (1)  Yes (2)  No If yes, please list: \_\_\_\_\_

**26 OTHER CLINICAL TESTS** Within the past year, have you had any  
 of the following tests? (Check all that apply)

- |   |   |
|---|---|
| a <input type="checkbox"/> Angiogram                  | m <input type="checkbox"/> Mammogram                            |
| b <input type="checkbox"/> Arthroscopy                | n <input type="checkbox"/> MRI                                  |
| c <input type="checkbox"/> Biopsy                     | o <input type="checkbox"/> Myelogram                            |
| d <input type="checkbox"/> Blood tests                | p <input type="checkbox"/> NCV (nerve conduction velocity)      |
| e <input type="checkbox"/> Bone scan                  | q <input type="checkbox"/> Pap smear                            |
| f <input type="checkbox"/> Bronchoscopy               | r <input type="checkbox"/> Pulmonary function test              |
| g <input type="checkbox"/> CT scan                    | s <input type="checkbox"/> Spinal tap                           |
| h <input type="checkbox"/> Doppler ultrasound         | t <input type="checkbox"/> Stool tests                          |
| i <input type="checkbox"/> Echocardiogram             | u <input type="checkbox"/> Stress test (eg, treadmill, bicycle) |
| j <input type="checkbox"/> EEG (electroencephalogram) | v <input type="checkbox"/> Urine tests                          |
| k <input type="checkbox"/> EKG (electrocardiogram)    | w <input type="checkbox"/> X-rays                               |
| l <input type="checkbox"/> EMG (electromyogram)       | x <input type="checkbox"/> Other: _____                         |