Preparing for Your First Appointment

Documents to Bring:

- ☐ Intake Forms
- ☐ Driver's license or ID
- ☐ Accident Photos – can be emailed to: Info@prorehabwellness.com
- ☐ Accident Report – if available
- ☐ Estimates of damage – if available
- ☐ X-Rays / MRI / Medical Records
- ☐ Med-Pay verification
- ○ Auto Insurance Declaration Statement
- ○ Auto Adjuster's Phone # and Claim #
- ☐ Attorney Information – if applicable
- ☐ Third Party Insurance Info.

About your Appointment:

- Allow up to 60 - 90 minutes for your first appointment. Please arrive 45-60 minutes early if you have not already completed your initial paperwork.
- Comfortable athletic clothing is highly recommended. This allows the doctor to properly evaluate injured areas.
- Failure to bring in above documents may delay the initiation of treatment.

Thank you for trusting SD Elite Physical Therapy with your health.

We look forward to meeting you soon!

INSTRUCTIONS: Please use sections below to help you complete your forms.

[PAGE: 1]

Medical History Section

- ☐ Please include symptoms you are currently experiencing since the accident + before the accident.

[PAGE: 2]

It is HIGHLY important that you list all symptoms you are experiencing since your accident.

- ☐ Please write down symptoms on separate lines. Sections 1-3. Ex: if you are having back pain, please use section 1. Neck pain with Headaches can go together on section 2. Use section 3 to include pain areas: arms, wrists, hands, legs.

Remember use the sections 1, 2, & 3 in the order of most pain to least pain. Always provide a pain score 1-10, 10 means you are in the hospital. Please use the pain scale attached to help you score your pains. Include how often you experience each symptom.

ADL [activities of daily living]

- ☐ Mark one answer for each line, only if it applies. If it does not apply to you, you can skip that line.
- ☐ Sign this form when finished.

Upper Extremity

- ☐ Complete this form, ONLY if you are having pain in areas: arms, hands, wrists...

Lower Extremity

- ☐ Complete this form, ONLY if you are having pain in the legs, knees, or feet.

Release form for medical records

- ☐ Only a signature is required.
- ☐ Leave blank.

0	No Pain
1	Minimal Pain (Annoyance)
2	Constant Minimal to Intermittent Slight Pain
3	Constant Slight Pain (Some Handicap)
4	Constant Slight to Intermittent Moderate Pain
5	Constant Slight to Frequent Moderate Pain
6	Intermittent Moderate Pain (Marked Handicap)
7	Frequent Moderate Pain
8	Constant Moderate Pain
9	Constant Moderate to Intermittent Severe Pain
10	Constant Severe Pain (Incapacitated)

NEW PATIENT INFO. & MEDICAL HX-PI

First Name _____ Last Name _____ Middle Initial ____ Sex (M / F)

Address _____
(number) (street) (city) (state) (zip code)

Social Security# _____-_____-_____ Birth Date ____ / ____ / _____ Age _____

Phone # (_____) _____ - _____ Cell # (_____) _____ - _____Email_____

Married ( ) Single ( ) Other ( ) _____ Spouse's Name _____

Occupation _____ Employer _____ Work Address_____

IN CASE OF AN EMERGENCY, CONTACT_____
Name Relationship Phone #

Have you ever had physical therapy before? (YES / NO) If yes, when was your last treatment? _____

What are your health goals? (Check one of the following)

( ) Reduce symptoms only ( ) Reduce symptoms and show me how to prevent flair-ups ( ) Reduce symptoms, prevent flair-ups and maintenance care

Do you have any type of health insurance? (YES / NO) Primary Insurance _____ Secondary Insurance_____

Is this injury work related? (YES / NO) Is this injury due to a motor vehicle accident? (YES / NO)

*** IF YOU ANSWERED YES TO EITHER OF THE TWO PREVIOUS QUESTIONS, PLEASE NOTIFY THE FRONT DESK ***

MEDICAL HISTORY

Check any of the following symptoms you are currently experiencing or have experienced within the past 6 months.

Musculoskeletal
__Low Back Pain
__Pain Between Shoulders
__Neck Pain
__Headaches
__Arm Pain/Numb/Tingling
__Leg Pain/Numb/Tingling
__Joint Pain/Stiffness
__Walking Problems
__Difficulty Chewing
__Weakness

EENT
__Vision Problems
__Dental Problems
__Sore Throat
__Ear Pain/Ringing
__Hearing Difficulty

General
__Allergies
__Loss of Sleep
__Fever/Night Sweats
__Eczema (skin rash)
__Weight Loss/Gain

Genitourinary
__Bladder Trouble
__Painful Urination
__ Excessive Urination
__Discolored Urine

Male Specific
__Difficulty Urinating
__Impotence
__Sterility

C-V-R
__Chest Pain
__Short of Breath
__Blood Pressure
__Heart Problems
__Wheezing
__Lung Problems
__Varicose Veins
__Arm/Leg Swelling
__Asthma
__High Cholesterol
__Bruise Easily

Female Specific
__Menstrual Irregularity
__Menstrual Cramping
__Sterility
__Breast Pain

*****ARE YOU PREGNANT? (YES / NO)*****

Nervous
__Numbness
__Paralysis
__Dizziness
__Forgetfulness
__Confusion
__Depression
__Fainting
__Convulsions
__ADHD/Hyperactivity
__Anxious
__Tremor/Shaking

Gastrointestinal
__Gas/Bloating
__Heartburn
__Poor Appetite
__Excessive Appetite
__Excessive Thirst
__Decreased Appetite
__Colitis
__Vomiting
__Diarrhea
__Constipation
__Black/Bloody Stool
__Hemorrhoids
__Liver Problems
__Abdominal Pain
__Frequent Nausea

Name of your family physician _____Last appointment with your physician _____Phone # _____Fax # _____
Do you give us permission to send your medical doctor an updated report on your status? (YES / NO)
Have you been hospitalized in the past? (YES / NO) If yes when and why? _____
Please list any surgeries you have had and when.
_____
Please list any medications you are taking.
_____

PATIENT SIGNATURE _____ **DATE** _____

NEW PATIENT COMPLAINT(S)

Name _____ (Complete #1-10) Date _____

1. What is your **worst** complaint? _____

When and How did your condition begin? _____

Rate your pain/discomfort on the scale. (circle) (none) = **0 1 2 3 4 5 6 7 8 9 10** = (severe)

How often do you experience this complaint? (circle) Occasionally (0-25% of the day) Intermittently (26-50% of the day) Frequently (51-75% of the day) Constantly (76-100% of the day)

How are your symptoms changing? (circle) **Improving** **Not Changing** **Worsening**

2. What is your **second worst** complaint? _____

When and How did your condition begin? _____

Rate your pain/discomfort on the scale. (circle) (none) = **0 1 2 3 4 5 6 7 8 9 10** = (severe)

How often do you experience this complaint? (circle) Occasionally (0-25% of the day) Intermittently (26-50% of the day) Frequently (51-75% of the day) Constantly (76-100% of the day)

How are your symptoms changing? (circle) **Improving** **Not Changing** **Worsening**

3. Briefly describe any other complaints. _____

_____

4. How much have these symptoms interfered with the following activities? (check all that apply)

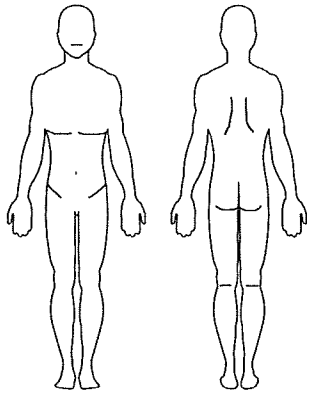
Work	Social Activities
___ Not at all	___ Not at all
___ A little bit	___ A little bit
___ Moderately	___ Moderately
___ Quite a bit	___ Quite a bit
___ Extremely	___ Extremely

5. Circle any other symptoms you are experiencing.

(Sharp Pain) (Dull Ache) (Shooting Pain) (Burning Pain) (Throbbing Pain) (Popping) (Weakness)

6. Please indicate on the diagram to the right where you experience your symptoms. (Use the key below)

Pain XXX Numbness OOO Tingling √ √ √
Stiffness / / / Burning + + +



7. Who have you seen for your symptoms?(check) ___No One ___Medical Doctor ___Chiropractor ___Physical Therapist ___Other

a. What treatment did you receive and when? _____

b. Circle any tests have you had for your symptoms? (X-Rays) date:____ (CT Scan) date:_____ (MRI) date:_____ (Other)

8. Have you had similar symptoms in the past? (YES / NO)

If yes, when was the last time you experienced those symptoms? _____ How long did your symptoms last? _____

9. What is your occupation? _____ Are you required a disability note for your employer / teacher? (YES / NO)

10. **Family History:** Does anyone in your immediate family (including your grandparents) have any of the conditions listed? (Circle all that apply)

Arthritis, Asthma, Birth Defects (i.e. heart defects), Cancer, Diabetes, Genetic Conditions (i.e. Cystic Fibrosis), Heart Disease, Mental Illnesses (i.e. Alzheimer's, Parkinson's), Obesity, Seizures

DOCTORS NOTES: _____

_____

SD Elite Physical Therapy—410 S Melrose Dr Suite 200, Vista, CA 92081—Ph/ Fax: 760.630.0683

SD Elite Physical Therapy
410 S. Melrose Drive Suite 200
Vista, CA 92081

Consent for treatment: I, as a patient, consent to physical therapy at SD Elite Physical Therapy as prescribed by my referring provider. I consent to maintain the confidentiality of other patients of the facility and not to disclose to anyone anything discussed at the facility by anyone other than myself.

Initials: _____

Authorized Release of Information: I hereby authorize SD Elite Physical Therapy to release medical records pertaining to my treatment to any entity that is responsible for payment of physical therapy charges. I understand that this authorizes my insurance company to pay any benefits directly to SD Elite Physical Therapy. In addition, I further understand that I am ultimately responsible for any remaining co-insurance or co-payment.

Initials: _____

HIPPA Patient Information Consent: I understand that SD Elite Physical Therapy may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand I have the right to restrict how my personal health information I used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand SD Elite Physical Therapy will consider requests for restrictions on a case by case basis but does not have to agree to requests for restrictions. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

Initials: _____

Signature: _____ Date: _____

OFFICE POLICIES / PROCEDURES AGREEMENT AND CUSTOMARY FEE SCHEDULE

FINANCIAL ARRANGMENTS

I understand and agree that health and accident policies are an arrangement between an insurance company carrier and myself. Furthermore, I understand that this office 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 this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

INSURANCE BILLING/PAYMENT

Patients are ultimately fully responsible for services provided by our office. For your convenience, our office will make an effort to verify your insurance benefits. However, please note that verification of benefits is not guaranteed. Your insurance company makes the final determination of insurance benefits when they consider the claim. Patients are fully responsible for payment of services not authorized or covered by their insurance company. Patients that are represented by an attorney in PI cases must notify our office the same day if changing or canceling representation.

PAYMENT ARRANGEMENTS

We understand that occasions arise when it may be necessary for you to request to be billed rather than pay at the time of service. This may include setting up a payment plan for those who may require extensive treatments. Payment is due within 30 days of the service rendered. If there are legitimate financial problems, please discuss them with our office manager prior to the 30 days so that we may find a workable solution. If an account is not paid within 30 days and no payment arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account. You will also be charged a monthly interest of 10% based off your principal balance until all fees are paid.

APPOINTMENT SCHEDULING

Canceling or rescheduling appointments requires a 24 hour notice otherwise you will be charged a fee for the missed scheduled service.

NOTICE OF PRIVACY POLICY

We are required by law to make sure your medical information is protected; give you notice describing our legal duties and privacy practices with respect to medical information about you; and follow the terms of the notice that is currently in effect. By signing below you are acknowledging that you have received our Notice of Privacy Policy.

NOTICE OF PRIVATE PRACTICES/ BUSINESSES AND PATIENT'S FREEDOM OF CHOICE

There are separate practices/ businesses within this office. Each entity is owned and operated as separate businesses and may have separate fee schedules and different treatment techniques. I understand that each service offered at this facility are owned and operated as separate businesses and hold each business harmless from any act or omission which may occur by any of the other businesses during the course of my treatment at this facility. Circumstances may arise such as emergencies, or doctor vacation or sick leave and you may request to be treated by another doctor within this office. If you are treated by another doctor you may be charged a different fee. Patients are free to choose any doctor or organization that may be recommended by our doctors. You do not have to use the facilities at our office for treatments and we can assist you on finding an alternative locations or sources.

CONSENT TO TREAT MINOR

I, _____ the parent or legal guardian, who has permission to make medical decisions for _____, a minor child, authorize any necessary treatment at SD Elite Physical Therapy for my minor child and fully agree to the above terms.

PRINT NAME	SIGNATURE	DATE
_____	_____	_____

SD Elite Physical Therapy

Acknowledgement of Receipt of Notice of Privacy Practices

This form will be retained in your medical record.

NOTICE TO PATIENT

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice.

Patient Name:_____ **Date of Birth:**_____

I acknowledge that I have **received and had the opportunity to review** the Notice of Privacy Practices on the date below on behalf of _____**SD Elite Physical Therapy.**

I understand that the Notice describes the uses and disclosures of my protected health information by **SD Elite Physical Therapy** and informs me of my rights with respect to my protected health information.

_____ _____

Patient's Signature or that of Legal Representative *Printed Name of Patient or that of Legal Representative*

_____ _____

Today's Date *If Legal Representative, Indicate Relationship*

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ Other (please specify):_____

_____

_____ _____

Employee Name *Today's Date*

ACCIDENT / INJURY QUESTIONS

Patient: _____ **Date:** _____

Date of Accident: ___ / ___ / ____ **Time of Accident:** ___: ____ **AM / PM** **Place (City/State):** _____

What was the cause of your Accident / Injury? **(Circle)** **Automobile Accident** **Work Injury** **Slip/Fall**

Describe in your own words what happened: _____

_____

_____

How did you feel immediately after the accident? (eg. Confused, dazed, dizzy, nervous, scared, nausea, etc…)

_____

Where did you immediately develop pain following the accident? _____

_____

Are there additional symptoms that developed hours, days or weeks after the accident? (eg. Headaches, tingling…)

_____

EMERGENCY CARE

Did you receive any medical care at the scene of the accident? (eg. Paramedics) **(YES / NO)**

Have you been to the hospital for this accident? **(YES / NO)** If yes, what hospital? _____ Date: _____

Were you taken to the hospital by ambulance? **(YES / NO)** Other: _____

Please list the areas of your body where **(X-Rays / CT / MRI)** were taken: _____

Have you been prescribed any medications for this accident? **(YES / NO)** List: _____

List ***any other Doctors' names and specialties with appointment dates*** you have seen for this accident?

_____

AUTOMOBILE ACCIDENT

What ***year and type*** of automobile were you driving? _____ Your approximate speed: ____ MPH

What parts of your vehicle were struck during the collision? _____

If struck by another vehicle, what type of vehicle was it? _____ Approximate speed: ____ MPH

What was the total damage estimate of your vehicle? **$**_____ Vehicle Totaled: **(YES / NO)**

Did the police arrive at the scene and was a report of the accident taken? **(YES / NO)**

Were you wearing your seatbelt? **(YES / NO)** Did the airbags deploy? **(YES / NO)**

Did you strike your head? **(YES / NO)** If yes, circle what your head hit: **Headrest, Airbag, Steering Wheel, Window, Other**

Did you strike any other body part? (eg. Knees against dashboard, etc…) **(YES / NO)** _____

Did you expect the vehicle was going to hit you? **(YES / NO)** Were you able to brace yourself? **(YES / NO)**

Was your head turned **(Right or Left)**, or looking **(Up or Down)** at the time of the impact? _____

Did you lose consciousness? **(YES / NO)** If yes, how long would you estimate you were out? _____

Patient Signature: _____ **Doctor Signature:** _____

BACK BOURNEMOUTH QUESTIONNAIRE

Patient Name _____ Date _____

Instructions: The following scales have been designed to find out about your back pain and how it is affecting you. Please answer ALL the scales, and mark the ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average, how would you rate your back pain?

No pain — Worst pain possible

0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your back pain interfered with your daily activities (housework, washing, dressing, walking, climbing stairs, getting in/out of bed/chair)?

No interference — Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your back pain interfered with your ability to take part in recreational, social, and family activities?

No interference — Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

Not at all anxious — Extremely anxious

0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed — Extremely depressed

0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your back pain?

Have made it no worse — Have made it much worse

0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce/help) your back pain on your own?

Completely control it — No control whatsoever

0 1 2 3 4 5 6 7 8 9 10

_____
Examiner

OTHER COMMENTS: _____

With Permission from: Bolton JE, Breen AC: The Bournemouth Questionnaire: A Short-form Comprehensive Outcome Measure. I. Psychometric Properties in Back Pain Patients. *JMPT* 1999; 22 (9): 503-510.

NECK BOURNEMOUTH QUESTIONNAIRE

Patient Name _____ Date _____

Instructions: The following scales have been designed to find out about your neck pain and how it is affecting you. Please answer ALL the scales, and mark the ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average, how would you rate your neck pain?

No pain Worst pain possible

0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your neck pain interfered with your daily activities (housework, washing, dressing, lifting, reading, driving)?

No interference Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your neck pain interfered with your ability to take part in recreational, social, and family activities?

No interference Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

Not at all anxious Extremely anxious

0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed Extremely depressed

0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your neck pain?

Have made it no worse Have made it much worse

0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce/help) your neck pain on your own?

Completely control it No control whatsoever

0 1 2 3 4 5 6 7 8 9 10

_____
Examiner

OTHER COMMENTS: _____

With Permission from: Bolton JE, Humphreys BK: The Bournemouth Questionnaire: A Short-form Comprehensive Outcome Measure. II. Psychometric Properties in Neck Pain Patients. *JMPT* 2002; 25 (3): 141-148.

HEADACHE DISABILITY INDEX

Patient Name _____ Date _____

INSTRUCTIONS: Please CIRCLE the correct response:

1. I have headache: (1) 1 per month (2) more than 1 but less than 4 per month (3) more than one per week
2. My headache is: (1) mild (2) moderate (3) severe

Please read carefully: The purpose of the scale is to identify difficulties that you may be experiencing because of your headache. Please check off "YES", "SOMETIMES", or "NO" to each item. Answer each question as it pertains to your headache only.

YES	SOMETIMES	NO		
_____	_____	_____	E1.	Because of my headaches I feel handicapped.
_____	_____	_____	F2.	Because of my headaches I feel restricted in performing my routine daily activities.
_____	_____	_____	E3.	No one understands the effect my headaches have on my life.
_____	_____	_____	F4.	I restrict my recreational activities (eg, sports, hobbies) because of my headaches.
_____	_____	_____	E5.	My headaches make me angry.
_____	_____	_____	E6.	Sometimes I feel that I am going to lose control because of my headaches.
_____	_____	_____	F7.	Because of my headaches I am less likely to socialize.
_____	_____	_____	E8.	My spouse (significant other), or family and friends have no idea what I am going through because of my headaches.
_____	_____	_____	E9.	My headaches are so bad that I feel that I am going to go insane.
_____	_____	_____	E10.	My outlook on the world is affected by my headaches.
_____	_____	_____	E11.	I am afraid to go outside when I feel that a headaches is starting.
_____	_____	_____	E12.	I feel desperate because of my headaches.
_____	_____	_____	F13.	I am concerned that I am paying penalties at work or at home because of my headaches.
_____	_____	_____	E14.	My headaches place stress on my relationships with family or friends.
_____	_____	_____	F15.	I avoid being around people when I have a headache.
_____	_____	_____	F16.	I believe my headaches are making it difficult for me to achieve my goals in life.
_____	_____	_____	F17.	I am unable to think clearly because of my headaches.
_____	_____	_____	F18.	I get tense (eg, muscle tension) because of my headaches.
_____	_____	_____	F19.	I do not enjoy social gatherings because of my headaches.
_____	_____	_____	E20.	I feel irritable because of my headaches.
_____	_____	_____	F21.	I avoid traveling because of my headaches.
_____	_____	_____	E22.	My headaches make me feel confused.
_____	_____	_____	E23.	My headaches make me feel frustrated.
_____	_____	_____	F24.	I find it difficult to read because of my headaches.
_____	_____	_____	F25.	I find it difficult to focus my attention away from my headaches and on other things.

OTHER COMMENTS: _____

_____
Examiner

With permission from: Jacobson GP, Ramadan NM, et al. *The Henry Ford Hospital headache disability inventory (HDI)*. Neurology 1994;44:837-842.

Upper Extremity Functional Scale

We are interested in knowing whether you are having any difficulty at all with the activities listed below <u>because of your upper limb</u> problem for which you are currently seeking attention. Please check (√) an answer for **each** activity.

Today, <u>do you</u> or <u>would you</u> have any difficulty at all with:

Activities	Extreme Difficulty Or Unable to Perform Activity	Quite a Bit of Difficulty	Moderate Difficulty	A Little Bit of Difficulty	No Difficulty
Any of your usual work, household, or school activities					
Your usual hobbies, recreational or sporting activities					
Lifting a bag of groceries to waist level					
Lifting a bag of groceries above your head					
Grooming your hair					
Pushing up on your hands (e.g., from bathtub or chair)					
Preparing food (e.g., peeling, cutting)					
Driving					
Vacuuming, sweeping, or raking					
Dressing					
Doing up buttons					
Using tools or appliances					
Opening doors					
Cleaning					
Tying or lacing shoes					
Sleeping					
Laundering clothes (e.g., washing, ironing, folding)					
Opening a jar					
Throwing a ball					
Carrying a small suitcase with your affected limb)					

Stratford P, Binkley JM, Stratford POW. Development and initial validation of the upper extremity functional index. Physiotherapy Canada Fall 2001;259-266, 281.

Patient name: _____ Signature: _____ Date: _____

Score _____/80 MDC (minimum detectable change) = 9 pts Error +/- 5 scale points

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 Circle an Answer for Each Activity

TODAY, do you or would you have any difficulty at all with:

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

SCORE: _____/80 = _____

NAME: _____ **DATE:** _____

FOR CLINICIAN: Lower Extremity Functional Scale Measurement Properties
LEFS is scored via summation of all responses (one answer per section) and compared to a total possible score of 80
Error +/- 5 points: an observed score is within 5 points of patients "true" score
Minimum detectable change (MDC); 9 points; change of more than 9 points on the LEFS represents a true change
Minimum clinically important difference (MCID): 9 points; Clinicians can be reasonably confident that a change of greater than 9 points is..a clinically meaningful functional change.

ADL (ACTIVITIES OF DAILY LIVING & FUNCTIONAL ASSESSMENT)

Patient Name: _____ **Date of Injury:** _____ **Date:** _____

Instructions: Please check the activities that currently bother you. Only check one box from each column.

ACTIVITY	ANNOYS ME ONLY	SLOWS ME DOWN	HARD TO PERFORM	UNABLE TO PERFORM
Bending head and neck				
Turning head and neck				
Bending waist – lower back				
Twisting waist – lower back				
Sitting				
Standing				
Walking				
Driving a car				
Riding a bicycle				
Reaching hands over head or shoulder level				
Household chores / cleaning / vacuuming etc.				
Combing / Brushing hair / Bathing				
Typing on a keyboard / Using home computer				
Carrying objects in hand				
Gripping objects or using wrists or hands				
Sleeping / Lying in bed				
Recreational or hobby activities				
Running or jogging				
Sports activities				
Yard work / Gardening etc.				
Using cell phone or tablet				
Crouching or squatting				
Kneeling				
Pushing or pulling with arms /hands				
Reading or Writing				
Dressing myself				
Playing with my children				
Going up or down stairs				
I have pain sitting and doing nothing				
Participating in sexual activity				
SCORE 30 Total Choices				
	(0-25%)	**(26-50%)**	**(51-75%)**	**(76-100%)**

Patient Signature: _____

Office Notes: ADL Total ____ **/ 30** _____

_____

_____ **Doctor Signature:** _____

Symptoms

Patient _____ Date _____ Date of Injury _____

Please fill in all symptoms you currently have <u>that you did not have</u> before the accident.

Orthopedic & Musculoskeletal Symptoms

- ☐ "Clunk" sound with neck movements
- ☐ Neck pain
- ☐ Upper back pain
- ☐ Low back pain
- ☐ Shoulder pain ☐ Left ☐ Right
- ☐ Upper arm pain ☐ Left ☐ Right
- ☐ Elbow pain ☐ Left ☐ Right
- ☐ Forearm pain ☐ Left ☐ Right
- ☐ Wrist pain ☐ Left ☐ Right
- ☐ Hand pain ☐ Left ☐ Right
- ☐ Hip pain ☐ Left ☐ Right
- ☐ Upper leg pain ☐ Left ☐ Right
- ☐ Knee pain ☐ Left ☐ Right
- ☐ Lower leg pain ☐ Left ☐ Right
- ☐ Ankle pain ☐ Left ☐ Right
- ☐ Foot pain ☐ Left ☐ Right
- ☐ Jaw pain
- ☐ Clicking in Jaw
- ☐ Pain when chewing
- ☐ Face pain
- ☐ Chest pain
- ☐ Stomach pain
- ☐ Bruise to _____
- ☐ Scrape/Cut to _____
- ☐ Other Symptom _____
- ☐ Other Symptom _____

Neurological Symptoms

- ☐ Numb/Tingling Arm / Hand L R
- ☐ Numb/Tingling Leg / Foot L R
- ☐ Weakness Arm / Hand L R
- ☐ Weakness Leg / Foot L R

Symptoms Associated with Injuries

- ☐ Stiffness or limited movement in joint(s)
- ☐ Headaches
- ☐ Muscle spasms/sore muscles
- ☐ Dizziness, lightheaded, woozy feeling
- ☐ Visual disturbances or vision change
- ☐ Sleep changes/disruption of patterns
- ☐ Pain radiates from one place to another
- ☐ Anxiety or nervous when driving
- ☐ Irregular Heartbeat or uneven pulse
- ☐ Feeling depressed about things
- ☐ I am taking the following medications _____

_____

Brain/Neuropsych/MTBI/PTSD Symptoms

- ☐ I prefer being alone now (not socializing)
- ☐ I am sleepy, tired during day or doze off easily
- ☐ Upset stomach, nausea, heartburn or vomiting
- ☐ Difficulty concentrating, mind wanders easily
- ☐ I get overwhelmed easily
- ☐ Mood swings, happy one moment then sad
- ☐ Agitation (can't sit still, need to move around)
- ☐ Sadness, tearful episodes, crying easily
- ☐ Blurry vision, had to get or change glasses
- ☐ Asking people to repeat things or hearing problem
- ☐ I make wrong turns driving or can't remember time
- ☐ I get confused easily or cannot multi-task anymore
- ☐ I have difficulty finding some words when talking
- ☐ Bright lights bother me
- ☐ I cannot pay attention as long as before
- ☐ I am eating more or less than normal
- ☐ Room spins, lightheaded or woozy feeling
- ☐ Balance problems
- ☐ I feel like my head is "Foggy"
- ☐ I have forgotten computer passwords or ATM PIN
- ☐ I have to re-read things to understand what I read
- ☐ My thinking is slowed down
- ☐ Difficulty with adding/subtracting numbers
- ☐ Fear I will never be the same again
- ☐ Difficulty learning new things
- ☐ Difficulty understanding what people say to me
- ☐ Difficulty remembering or memory problems
- ☐ Cannot take on any more responsibility
- ☐ I can't make decisions as quickly as before
- ☐ Loss of libido or lack of sexual desire
- ☐ I do not feel as confident of my abilities
- ☐ I get panic attacks, fast heartbeat, nervous
- ☐ I am more irritable than usual
- ☐ Some food or drink tastes "Funny" to me now
- ☐ I get frustrated very easily
- ☐ Difficulty planning my life or organizing my work
- ☐ Flashbacks or frightening thoughts about accident
- ☐ I have had bad dreams about the accident
- ☐ I avoid places & objects that remind me about it
- ☐ I feel emotionally numb-no interest in my hobbies
- ☐ I'm feeling strong guilt, worry or depression
- ☐ I am having trouble remembering the accident
- ☐ I am easily startled since the accident - "jumpy"
- ☐ I feel tense or "on edge" most of the time
- ☐ I am having difficulty sleeping
- ☐ I get angry easily or even yell at people now

SD Elite Physical Therapy
410 S. Melrose Drive Suite 200
Vista, CA 92081

NOTICE OF DOCTOR LIEN ON PERSONAL INJURY PROCEEDS

I hereby authorize **Dr. John Dawson, DPT** to furnish you, my attorney, with a full report of the examination, diagnosis, treatment, prognosis, etc. of me in regard to the accident on or about _____, for which you have been retained.

I understand that all bills incurred by me at **Dr. John Dawson, DPT 's** office are my responsibility to pay and I will either pay them in full at the time of service or make payment arrangements with **Dr. John Dawson, DPT** I also understand that, unlike my attorney, **Dr. John Dawson, DPT** does not work on a contingency fee and I must pay for his services at the time of his rendering of them and that this lien is only to protect his interests in case there is a balance owing when my case is resolved.

I irrevocably instruct my attorney to withhold from my settlement or judgment any amount that, at that time, is owed **Dr. John Dawson, DPT** for my healthcare in connection with this accident and pay it directly and promptly to **Dr. John Dawson, DPT** at:

SD Elite Physical Therapy
John Dawson, DPT
410 S. Melrose Dr. Suite 200
Vista, CA 92081

I am granting **Dr. John Dawson, DPT** an irrevocable lien on the proceeds of my legal case and it is my intent that this lien shall be binding on my present attorney and/or any subsequent attorney which either I might hire or to whom my present attorney may assign this case. In the event I have no attorney, I hereby instruct any insurance company from which I may receive a settlement in regard to this accident to add **Dr. John Dawson, DPT** as a payee on the settlement draft.

_____	_____	_____
Print Name	Patient's Signature	Date

I, the attorney of record for the above-named signatory in regard to the accident in question, hereby agree to abide by the terms of this lien.

_____	_____	_____
Attorney (Please Print)	Attorney's Signature	Date

Auto Insurance Information

Patient Name: _____
Date of Birth: _____

Your Auto Insurance Company

Name of Insurance Company: _____
Name of Insured: _____
Claim Number: _____
Insurance Adjuster's Name: _____
Insurance Adjuster's Phone Number: _____

Third Party Insurance Company (other driver)

Name of Insurance Company: _____
Name of Insured: _____
Claim Number: _____
Insurance Adjuster's Name: _____
Insurance Adjuster's Phone Number: _____

Attorney Information

Name of Attorney: _____
Phone Number: _____

AUTHORIZATION FOR RELEASE OF RECORDS FROM:

_____

_____

_____

_____

_____

I HEREBY REQUEST AND AUTHORIZE THE RELEASE OF RECORDS TO:

John Dawson, DPT
SD Elite Physical Therapy
410 S. Melrose Dr. Suite 200
Vista, CA 92081
PH/ Fax: 760-630-0683

☐ ALL RECORDS

☐ HEALTH RECORDS DATE(S):_____ TO _____

☐ X-RAY, MRI, CT REPORTS

☐ OTHER: _____

PATIENT'S NAME: _____

PATIENT'S SIGNATURE: _____

PATIENT'S DATE OF BIRTH: _____

DOCTOR'S SIGNATURE: _____