THERAPEUTIC SOLUTIONS, INC. INTAKE SCREENING QUESTIONNAIRE

It is our goal to treat every patient with genuine care and compassion and with the highest quality evidence based rehabilitation. We appreciate you choosing TSI. Completing this detailed questionnaire will help us meet your personal goals of treatment.

Date: _____

Name: _____ **DOB:**_____ **SSN:** _____
Height: _____ **Weight:** _____ **Gender F / M** **Last date on Home Health (if ever)**_____

Address_____ **City** _____ **State**_____ **Zip**_____
Home# (___**)** _____**Work # (**___**)** _____ **Cell# (**___**)** _____

Email address: _____

How did you hear of us: ***Please circle all that apply***

Friend/ Face book/ TSI website/ Email Ad / Doctor referred / Computer search / Workshop/ Newsletter/ Insurance Provider list Other: (please list) _____

Emergency Contact:
Name: _____ **Relationship:** _____**Phone# (**___**)** _____

Primary Insurance:
Insurance Name: _____**ID:**_____ **Subscriber:** _____ **DOB**_____
Relationship: _____

Secondary Insurance:
Insurance Name: _____ **ID:**_____ **Subscriber:** _____ **DOB**_____
Relationship: _____

Please list all Doctors that are involved in your care

_____ _____

_____ _____

_____ _____

I authorize release of information requested by my insurance plan for payment
I understand that I am financially responsible for any balance due.
I agree to comply with the terms and conditions as outlined on the patient registration form.

(You have the right to refuse to sign this acknowledgement if you so choose to.)

Signature: _____ **Date:** _____

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MEDICAL AND ACTIVITY INFORMATION:

Name: _____ **Height:** _____ **Weight:** _____
Are you on any restriction from your doctor? ___ **Yes** ___ **No**
If yes, please explain _____
Leisure activities: _____
How often do you exercise: (day/mins) _____ **Intensity(high/low)** _____
Do you believe you eat healthy? ____ **Yes** _____ **No**

Occupation, including activities that comprise your workday: _____
Current work status: ___ **Full Time** ____ **Part Time** ____ **Unemployed** ____ **Medical Disability** ___ **Retired**

Do you smoke or use any tobacco products? ___ **Yes** ____ **No**
Do you have any implants in your body? _____ **Yes** ___ **No** **Comment** _____
FOR WOMEN: Are you currently pregnant or think you might be pregnant? ____ **Yes** _____ **No**
ALLERGIES: List any medication(s) you are allergic to: _____

Have you RECENTLY noted any of the following (check all that apply)?

- ❑ fatigue
- ❑ fever/chills/sweats
- ❑ nausea/ vomiting
- ❑ unexplained weight loss/gain
- ❑ difficulty maintaining balance while walking
- ❑ falls: How many falls in the past 6 mths? ___
- ❑ abdominal pulsating sensation
- ❑ swelling/edema/lymphedema
- ❑ changes in appetite
- ❑ numbness or tingling
- ❑ muscle weakness
- ❑ dizziness/lightheadedness
- ❑ heartburn/indigestion
- ❑ difficulty swallowing
- ❑ changes in bowel or bladder function
- ❑ long term use of steroids
- ❑ joint pain, warmth
- ❑ breast or genital changes (tenderness etc.)
- ❑ constipation
- ❑ diarrhea
- ❑ shortness of breath
- ❑ fainting
- ❑ cough
- ❑ headaches
- ❑ difficulty sleeping
- ❑ skin changes

Have you or anyone in your immediate family EVER been diagnosed with any of the following conditions (check all that apply)? Please indicate if question pertains to you OR add which family member.

- ❑ cancer
- ❑ heart problems
- ❑ chest pain/angina
- ❑ high blood pressure
- ❑ circulation problems
- ❑ blood clots/Are you on blood thinners? ___
- ❑ stroke
- ❑ anemia
- ❑ bone or joint infection
- ❑ chemical dependency (i.e., drug, alcoholism)
- ❑ depression
- ❑ lung problems
- ❑ tuberculosis
- ❑ asthma
- ❑ rheumatoid arthritis
- ❑ other arthritic condition
- ❑ bladder/urinary tract infection
- ❑ kidney problem/infection
- ❑ sexually transmitted disease/HIV
- ❑ pelvic inflammatory disease
- ❑ thyroid problems
- ❑ diabetes
- ❑ osteoporosis
- ❑ multiple sclerosis
- ❑ epilepsy
- ❑ eye problem/infection
- ❑ ulcers
- ❑ liver problems
- ❑ hepatitis
- ❑ pneumonia

Type of cancers (if any) _____
Date of cancers _____

Treatments (name of chemotherapies, radiation therapy, surgeries etc.)

_____

During the past month have you been bothered by feeling down, depressed or hopeless? ___Yes__ No
During the past month have you been bothered by little interest or pleasure in doing things? ___Yes__ No
Is this something with which you would like help? ___Yes ___ No ____Yes but not today

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Please list any medications you are currently taking (INCLUDING pills, injections, and/or skin patches):

I.e. analgesics, blood thinners, steroids, anti-anxiety/depression, antipsychotic, antibiotics, anticoagulant medications, blood pressure, beta blocker, corticosteroids, decongestants, hormones, muscle relaxants, NSAIDs, vitamins

1. _____ 2. _____ 3. _____

Please list any surgeries or other conditions for which you have been hospitalized, including dates:

1. _____ 2. _____ 3. _____

What date (roughly) did your present symptoms start? _____

What do you think caused your symptoms? _____

My symptoms are currently: ❑ **Getting Better** ❑ **Getting Worse** ❑ **Staying about the same**

I should not do physical activities that might make my pain worse: ❑ **Disagree** ❑ **Unsure** ❑ **Agree**

Treatment received so far for this problem (chiropractic, injections, etc) _____

Please list special tests performed for this problem (x-ray, MRI, labs, etc.) _____
(It will be helpful to bring any new blood work, lab tests, and scans results to subsequent PT visits)

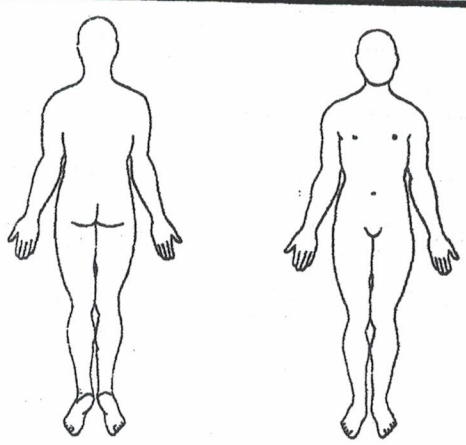
Have you ever had this problem before: ❑ **Yes** ❑ **No** **When**_____ **Treatment rec'd**_____

How long did it take for you to feel better? _____
What are goals from physical therapy? _____
List the top three usual daily activities you are now limited in doing, that you would like to improve?
1._____ 2._____ 3._____

Body Chart:

Please mark the areas where you
Feel symptoms on the chart to the right with
The following symbols to describe your symptoms:

↓ **Shooting/sharp pain**
O **Dull/aching pain**
||| **Numbness**
= **Tingling**
B **Burning**



My symptoms currently: ❑ Come and go ❑ Are Constant ❑ Are constant, but change with activity

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Aggravating Factors: Identify up to 3 important positions or activities that make your symptoms worse:

1. _____
2. _____
3. _____

Does bending, sitting, lifting or twisting your back aggravate your symptoms? ____Yes _____ No
Are your symptoms aggravated by coughing, sneezing or taking a deep breath? ____Yes _____ No
Does eating certain foods aggravate your symptoms? ____Yes _____ No
Has there been an unexplained weight change associated with your symptoms? ____ Yes _____ No
Have you noticed any changes in urination such as retention, frequency, urgency, incontinence, burning, unusual odor, change in color, blood in urine, interruption in urine stream, difficulty initiating urination,? ___ Yes ___ No
Are you experiencing loss of sensation over the buttocks, anus, front or backs of the thighs or urogenital region? ____ Yes ____ No

Easing Factors: Identify up to 3 important positions or activities that make your symptoms better:

1. _____
2. _____
3. _____
4. Does changing positions alter, ease or aggravate your pain? _____ Yes _____ No

How are you currently able to sleep at night due to your symptoms?
❑ No problem sleeping ❑ Difficulty falling asleep ❑ Awakened by pain ❑ Sleep only with medication

When are your symptoms worst? ❑ Morning ❑ Afternoon ❑ Evening ❑ Night ❑ After exercise
When are your symptoms the best? ❑ Morning ❑ Afternoon ❑ Evening ❑ Night ❑ After exercise

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Using the 0 to 10 the scale, with 0 being *"no pain"* and 10 being the *"worst pain imaginable"* please describe:

Your current level of pain while completing this survey: _____

The best your pain has been during the past 24 hours: _____

The worst your pain has been during the past 24 hours: _____

Using the 0 to 10 the scale, with 0 being *" no fatigue"* and 10 being *"so fatigued you couldn't get out of bed"* please describe:

Your current level of fatigue while completing this survey: _____

The best your fatigue has been during the past 24 hours: _____

The worst your fatigue has been during the past 24 hours: _____

Any additional comments: _____

THERAPEUTIC SOLUTIONS, INC. INTAKE SCREENING QUESTIONNAIRE

New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment or Health Care Operations.

I, _____, understand that as part of the healthcare, ***Therapeutic Solutions, Inc.*** originates and maintains paper and/ or electronic records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill,
- A means by which a third- party- payer can verify that services were actually provided, and
- A tool for routine healthcare operation such as assessing quality and reviewing the competence of health care professionals.

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that Therapeutic Solutions, Inc. is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the organization that has referred me. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Therapeutic Solutions, Inc. reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Therapeutic Solutions Inc. change their notice, they will send a copy of any revised notice

I wish to have the following restrictions to the use or disclosure of my health information:

None [ ]
Other: _____

I understand that this is part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept/decline the terms of this consent.
(Please circle one)

_____ _____

Patient's Signature (authorized representative signing for the patient) Date

THERAPEUTIC SOLUTIONS, INC. INTAKE SCREENING QUESTIONNAIRE

Thank you for selecting Therapeutic Solutions Inc. Physical Therapy! We strive to provide the highest quality of care with a very personalized, individualized approach. Listed are a few policies effective for all our clients.

• Cancellation Policy

•Reserved time slots are always provided for each patient. In light of that, canceling an appointment at the last minute eliminates the scheduling opportunities for other patients. As a result, **cancellation notice of 24 hours is needed in order to avoid a fee of $50.00.** This fee will be collected at your next appointment before treatment.

• Co pay/ Co-insurance

• If the contract with your insurance requires you to pay a co-pay or co- insurance, it is due at time of service, before treatment.

• Scheduling

• In order to provide the highest quality of care while attempting to accommodate each patient's schedule, we try to reserve time slots as early in advance as possible. After initial visit with the therapist, please schedule as many visits as you can with the front office in order to get the appointment times you prefer.

•Exercise attire

• Your physical therapy treatment plan will likely involve stretching, strengthening, cardiovascular endurance training, massage, mobilizations as well as modalities. It is requested that you be dressed in exercise attire, which will be comfortable and suitable for your treatment. If you have questions about what to wear, please ask the therapist.

We look forward to meeting your needs and achieving your goals with you. We will do our best to make this a meaningful and rewarding experience for you.

_____ _____

Patient Signature Date