



BARROWS

TRAINING AND EDUCATION
PHYSICAL THERAPY

Where excellence and experience make a difference in your care.

Patient Name:	Date of Birth:	Age:
Address:	Social Security Number:	
City:	Marital Status: Married Single Widow Gender: Male Female	
State:	Emergency Contact:	
Zip Code:	Telephone number of Contact:	
Primary Telephone:	Relationship to Contact:	
Secondary Telephone:	Employer:	
Email Address:	Employment Status:	
How did you hear about us?	Referring Doctor:	

INSURANCE INFORMATION

PRIMARY INSURANCE

Insurance Name:	Subscriber Name: Subscriber Social Security Number:
Member ID:	Subscriber Employer:
Group Number:	Subscriber Date of Birth: Relationship to Subscriber: Self Spouse Child Other

SECONDARY INSURANCE (if applicable)

Insurance Name:	Subscriber Name: Subscriber Social Security Number:
Member ID:	Subscriber Employer:
Group Number:	Subscriber Date of Birth: Relationship to Subscriber: Self Spouse Child Other

WORKERS COMPENSATION (if work related)

Insurance Name:	Claim Number:
Claims Adjuster:	Date of Injury:
Adjuster Telephone:	Claims Address:

AUTO INSURANCE (if auto related)

Insurance Name:	Insured/Claim Number:
Claims Adjuster:	Date of Injury:
Adjuster Telephone:	Claims Address:

Patient Information

Patients Last name:	First:	Middle:	Date of Birth / /	Age
Employer: (currently working: <input type="checkbox"/> Y <input type="checkbox"/> N)		Occupation: (last day worked: _____)	Dominant Hand <input type="checkbox"/> R <input type="checkbox"/> L	Gender <input type="checkbox"/> M <input type="checkbox"/> F
Years at Job:		Hobbies/Activities:		

Injury Information

What body parts were <u>initially</u> injured?	
1. _____	2. _____
3. _____	4. _____
Describe how the injury happened:	

Date of injury: _____ **Your symptoms began:** Unknown Immediately Gradually

What treatments have you already received for this condition?

Surgery: _____ Physical Therapy: _____
 Date: _____ Chiropractic: _____

Injection: _____ Other: _____
 Date: _____

What diagnostic test have you received for this condition? (Please list approximate dates) None

X-Ray: _____ MRI: _____ CT Scan: _____
Bone Scan: _____ EMG/NCV: _____ Lab Test: _____

What body parts are <u>currently</u> painful?	
1. _____	2. _____
3. _____	4. _____

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

Since the injury/condition began your symptoms are: Increasing Decreasing Not changing

How much of the day do you feel your symptoms: Occasionally (10-25%) Intermittent (26-50%) Frequent (51-80%) Constant (80-100%)

Choose below what most accurately describes your symptoms:

Pain is annoying but able to perform all activities
 Pain is tolerant but may cause difficulty performing some activities
 Pain interferes with performance of all activities
 Pain is so severe that you are unable to perform any activities

Sleep: Good Moderate Difficult Only with meds **Position:** Back Side Stomach

What makes your injury/conditions feel better or worse? Use "O" for better, "X" for worse

___ Nothing ___ Sitting ___ Standing ___ Walking ___ Running ___ Stairs
 ___ Movement ___ Exercise ___ Stretching ___ Medication ___ Lying Down ___ Kneeling
 ___ Twisting ___ Bending ___ Lifting ___ Writing ___ Keying ___ Coughing
 Rest ___ Sneezing Repetitive Hand Motion ___ Other: _____

Symptoms are worst: AM Mid-day PM **Symptoms are best:** AM Mid-day PM

Medical History

Please list any prescription medications you are currently taking: (including pills, injections, &/or skin patches)

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____

Please list any over-the-counter medications you are currently taking:

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____

Do you smoke? Yes No

Do you have a pacemaker? Yes No

FOR WOMEN: Are you currently pregnant or think you might become pregnant? Yes No

Have you ever been diagnosed with having any of the following?

- | | | |
|--|---|---|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Circulatory problems | <input type="checkbox"/> Asthma | <input type="checkbox"/> Emphysema/Bronchitis |
| <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> Other arthritic conditions | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Anemia | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Chemical dependency (drugs) | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Other: |

Have you recently noted any of the following?

- | | | |
|--|---|---|
| <input type="checkbox"/> Weight loss/gain | <input type="checkbox"/> Nausea/vomiting | <input type="checkbox"/> Dizziness/lightheadedness |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Unusual weakness | <input type="checkbox"/> Fever/chills/sweats |
| <input type="checkbox"/> Numbness or tingling | <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Vision/eye problems | <input type="checkbox"/> Hearing problems |
| <input type="checkbox"/> Unusual joint/muscle swelling | <input type="checkbox"/> General arm/leg swelling | <input type="checkbox"/> Excessive bleeding/easy bruising |
| <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Regular/persistent cough | <input type="checkbox"/> Difficulty swallowing |
| <input type="checkbox"/> Problems sleeping | <input type="checkbox"/> Sexual difficulties | <input type="checkbox"/> Night sweats |
| <input type="checkbox"/> Heart racing in your chest | <input type="checkbox"/> Heartburn/indigestion | <input type="checkbox"/> Post menopause |
| <input type="checkbox"/> Constipation/diarrhea | <input type="checkbox"/> Blood in stool | <input type="checkbox"/> Blood in the urine |
| <input type="checkbox"/> Problems urination (difficulty) | <input type="checkbox"/> Urinary incontinence | <input type="checkbox"/> Pregnant (or think you might be) |
| <input type="checkbox"/> Stress at home or work | <input type="checkbox"/> Tremors | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Skin problems (ex: rash, redness) | <input type="checkbox"/> Neck/back pain | <input type="checkbox"/> Wheezing |
| <input type="checkbox"/> Pain with sweats | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Other: |

Please list any allergies we should know about:

Please list any surgeries or other conditions for which you have been hospitalized: (include approx. dates)

Please list any significant injuries for which you have been treated in the past: (include approx. dates)

During the past month have you been feeling down, depressed or hopeless? Yes No

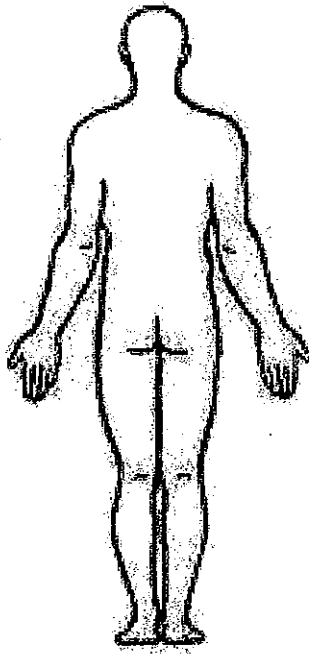
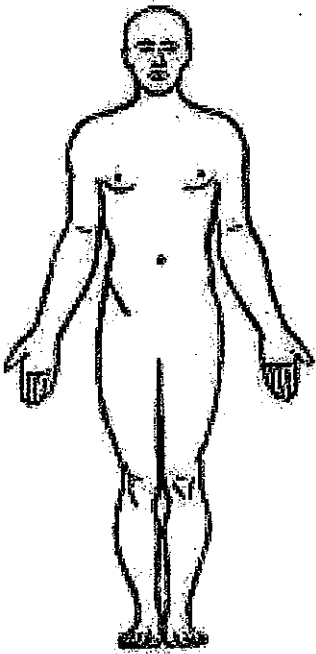
During the past month have you been often been bothered by little interest or pleasure in doing things that you enjoy? Yes No

Is this something with which you would like help? Yes Yes, but not today No

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
○ Dull/aching pain
+ Numbness
= Tingling



I would rate my pain **CURRENTLY** as:

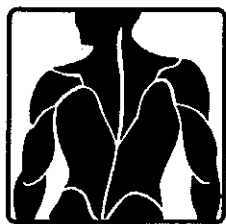
0 1 2 3 4 5 6 7 8 9 10
(none) (annoying) (uncomfortable) (horrible) (excruciating)

The **LEAST** pain I have had **IN THE LAST WEEK** is:

0 1 2 3 4 5 6 7 8 9 10
(none) (annoying) (uncomfortable) (horrible) (excruciating)

The **WORST** pain I have had **IN THE LAST WEEK** is:

0 1 2 3 4 5 6 7 8 9 10
(none) (annoying) (uncomfortable) (horrible) (excruciating)



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ACKNOWLEDGEMENT AND CONSENT OF PRIVACY PRACTICES ACT

I understand Barrows Physical Therapy may use or disclose my personal health information, for the purposes of carrying out treatment, obtaining payment or evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that Barrows Physical Therapy will consider requests for restrictions on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for the purposes as noted in the Barrows Physical Therapy Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the Practice in writing at any time.

I further acknowledge that a copy of the current notice will be available upon request.

Signature

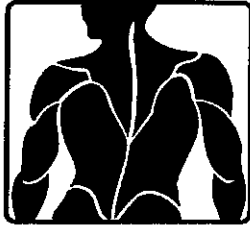
Date

If not signed by patient, please indicate relationship:

<input type="checkbox"/> Parent or guardian of minor	<input type="checkbox"/> Guardian or conservator	<input type="checkbox"/> Beneficiary or personal representative
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Please print below anyone you wish to release information on your behalf:

Name	Relationship
Name	Relationship
Name	Relationship



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MADERA: 500 E. ALMOND AVE., STE 5B 93637
(559) 674-7201 FAX (559) 674-1338

FRESNO: 6049 NORTH FIRST STREET, STE 104 93710
(559) 438-0355 FAX (559) 438-0359

OFFICE POLICIES

We would like to welcome you as a patient of Barrows Physical Therapy. We strive to provide you the best personal care available. To help us do this it is important for you to participate in your care and follow these important policies. Please read them carefully, initial ALL proper spaces, and indicate your agreement by signing the bottom.

Please Initial

_____ If you are ill and you know that you are contagious, please call our office ASAP to re-schedule your appointment and avoid your cancellation fee of \$35.00.

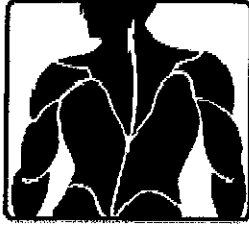
_____ **Medicare Patients:** To avoid a personal fee of \$60, please do not schedule X-rays and Physical therapy on the same day, as stated under Medicare guidelines.

_____ **Cellular Phone:** We ask that you turn your cell phone off or switch it to vibrate. Please refrain from answering your phone during treatment to prevent therapy distractions.

_____ Payment is expected at the time of your visit. It will include but not limited to any unmet deductible, co-insurance or co-payment amount. For your convenience Barrows Physical Therapy accepts Visa, Mastercard, Discover, Amex, Cash or personal check. Note: a \$25 fee will be placed on all returned checks payable by cash or money order prior to receiving additional services from our staff. At the conclusion of your care with us you may also be billed for any outstanding balances. If there is a credit, you will be provided a refund promptly

Signature of Patient/Responsible Party

Date



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ATTENDANCE/CANCELLATION POLICY

Good attendance is essential to receive the most benefit from your therapy program. Communication is extremely important to your care. Please make us aware of any concerns or questions you may have.

Please Initial Below

_____ "Late Policy 10 minutes" Being late by more than 10 minutes will require you to either reschedule or wait for the next available opening. Though we will make every effort to fit you in, there are no guarantees since openings due to cancellations are unpredictable.

_____ I understand that failure to keep my appointments may result in the therapist discussing this with my doctor and may result in discharge. Three or more "no-shows" will result in an automatic discharge and my doctor and insurance (if required) will be notified.

_____ If I wish to change or cancel an appointment Barrows Physical Therapy requires a minimum 24-hour advance notice. Anything less will result in a \$35 fee charged to my account. If I accumulate more than 1 of these charges I am aware that payment of at least 1 fee will have to be made before any other appointment can be scheduled. *****Your insurance carrier will not be held responsible for these charges (including Workers Compensation and HMO's)*****

Patient Signature

Date

PATIENT NAME: _____ ID#: _____ DATE: _____

Description: This survey is meant to help us obtain information from our patients regarding their current levels of discomfort and capability. **Please circle the answers below that best apply.**

LEFS – INITIAL VISIT

Please rate your pain level with activity: NO PAIN = 0 1 2 3 4 5 6 7 8 9 10 = VERY SEVERE PAIN

	Extreme Difficulty or Unable to Perform Activity	Quite a Bit of Difficulty	Moderate Difficulty	A Little Bit of Difficulty	No Difficulty
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1. Any of your usual work, housework or school activities	0	1	2	3	4
2. Your usual hobbies, recreational or sporting activities	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 activities 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 a 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

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

Patient Use Only		
Comorbidities:	<input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart Condition <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Multiple Treatment Areas	<input type="checkbox"/> Neurological Disorders (e.g., Parkinson's, Muscular Dystrophy, Huntington's, CVA, Alzheimer's, TBI) <input type="checkbox"/> Obesity <input type="checkbox"/> Surgery for this Problem <input type="checkbox"/> Systemic Disorders (e.g., Lupus, Rheumatoid Arthritis, Fibromyalgia)
		ICD Code: _____