CARE CONNECTIONS

PATIENT WORKSHEET: NEUROMUSCULAR

NAME DATE

TIME AM/PM ❒ Initial Visit ❒ Discharge Visit

FORM COMPLETED BY: ❒ CAREGIVER ❒ PATIENT

FUNCTIONAL INDEX

Please mark the ONE answer in each section that best describes the general functional level of the patient during the last week. Answer questions 1–10 for PT ONLY or questions 1–14 for both PT and OT.

1. BED MOBILITY

- ❒ Independent in moving from lying down to sitting on edge of bed
- ❒ Independent in moving from lying down to sitting on edge of bed using a rail or adaptive equipment
- ❒ Moving from lying down to sitting on edge of bed requires minimal assistance of another person
- ❒ Moving from lying down to sitting on edge of bed requires moderate assistance of another person
- ❒ Moving from lying down to sitting on edge of bed requires maximum assistance of another person
- ❒ Dependent in all aspects of moving from lying down to sitting on edge of bed

2. TRANSFERS

- ❒ Independent in transfers to all surfaces
- ❒ Independent in transfers with assistive devices, set up or supervision
- ❒ Transfers with light or minimal assist from another person
- ❒ Transfers with moderate assist from another person
- ❒ Transfers with heavy/maximal assist from another person
- ❒ Dependent assist of one or two people necessary for transfers

3. WALKING

- ❒ Independent and safe walking on all types of terrain
- ❒ Independent walking with an assistive device (crutches, cane, walker) on all terrain
- ❒ Walking requires light to minimal manual assist with or without a device
- ❒ Walking requires moderate manual assist with or without a device
- ❒ Walking requires heavy maximum manual assist with or without a device
- ❒ Unable to walk

4. STAIRS

- ❒ Is able to negotiate stairs independently without any type of support or handrail
- ❒ Is able to negotiate stairs independently, with the handrail, crutch or cane.
- ❒ Is only able to negotiate stairs with minimal manual assist
- ❒ Is only able to negotiate stairs with moderate manual assist
- ❒ Is only able to negotiate stairs with maximum manual assist
- ❒ Is unable to negotiate stairs

5. BALANCE/STANDING

- ❒ Able to stand independently without support for all activities
- ❒ Able to stand independently with support or use of an assistive device for all activities
- ❒ Minimal or light support required to stand during an activity and/or has had occasional falls
- ❒ Moderate support required to stand during an activity and/or has had frequent falls
- ❒ Maximal support required to stand for even brief periods of time
- ❒ Unable to stand

6. CARRYING

- ❒ Able to carry any load independently
- ❒ Able to carry moderate loads independently
- ❒ Able to carry light loads independently
- ❒ Able to carry light loads with assistive equipment
- ❒ Able to carry light loads with assistance from another person
- ❒ Unable to carry anything

7. REACHING

- ❒ Able to reach to a high shelf to place an object with both the right and left arm
- ❒ Able to reach to a high shelf to place an object with either left or the right arm only
- ❒ Able to reach to a high shelf to place an object only if holding on for support
- ❒ Unable to reach to a high shelf but can place an object on a chest high shelf
- ❒ Able to reach to a counter height to place an object
- ❒ Unable to reach arm above waist level

8. ENDURANCE

- ❒ Endurance does not limit any activity.
- ❒ With planning, endurance does not limit activity
- ❒ Rest periods are necessary to complete community activities
- ❒ Rest periods are necessary to complete household activities
- ❒ Occasional rest periods are necessary to complete a single activity
- ❒ Frequent rest periods are necessary to complete a single activity

Please complete opposite side

9. WORK/HOMEMAKING

(Applies to work in home and outside)

- ❒ Able to work in the home or on the job independently
- ❒ Ability to work in the home or on the job is limited by endurance or physical condition
- ❒ Able to work in the home or on the job only with modification or adaptive equipment
- ❒ Able to work in the home with minimal assistance from others
- ❒ Able to work in the home with moderate assistance from others
- ❒ Unable to do any work in the home.

10. COMPREHENSION OF DIRECTIONS OR CONVERSATION

- ❒ Able to follow complex or abstract directions and conversation
- ❒ Able to consistently follow basic directions and conversation
- ❒ Able to follow directions and conversation but requires occasional verbal, visual, or physical cues
- ❒ Able to follow directions and conversation but requires verbal, visual, or physical cues most of the time
- ❒ Able to follow directions and conversation but requires verbal, visual, or physical cues all of the time
- ❒ Unable to follow directions or conversation even with cues

FOR OCCUPATIONAL THERAPY PATIENTS: PLEASE ALSO ANSWER QUESTIONS 11–14.

11. PERSONAL CARE (Bathing, grooming)

- ❒ Independent and safe in all personal care
- ❒ Independent in personal care with additional time
- ❒ Independent in personal care with set up or adaptive equipment
- ❒ Able to perform personal care tasks with minimal assistance from another person
- ❒ Able to perform personal care tasks with moderate assistance from another person
- ❒ Able to perform personal care tasks with maximum assistance from another person

12. DRESSING: UPPER BODY

- ❒ Able to dress and undress upper body independently
- ❒ Able to dress and undress upper body independently with additional time
- ❒ Able to dress and undress upper body independently with adaptive equipment or set up
- ❒ Able to dress and undress upper body with minimal assistance from another person
- ❒ Able to dress and undress upper body with moderate assistance from another person
- ❒ Able to dress and undress upper body with maximal assistance from another person

13. DRESSING: LOWER BODY

- ❒ Able to dress and undress lower body independently
- ❒ Able to dress and undress lower body independently with additional time
- ❒ Able to dress and undress lower body independently with adaptive equipment or set up
- ❒ Able to dress and undress lower body with minimal assistance from another person
- ❒ Able to dress and undress lower body with moderate assistance from another person
- ❒ Able to dress and undress lower body with maximal assistance from another person

14. EATING

- ❒ Able to feed self independently
- ❒ Able to feed self independently with extra time
- ❒ Able to feed self independently with set up or adaptive equipment
- ❒ Able to feed self with minimal assistance
- ❒ Able to feed self with moderate assistance
- ❒ Able to feed self with maximum assistance

ACUITY (*Answer on initial visit.*)

How many days ago did onset/injury occur? _____days

PAIN INDEX

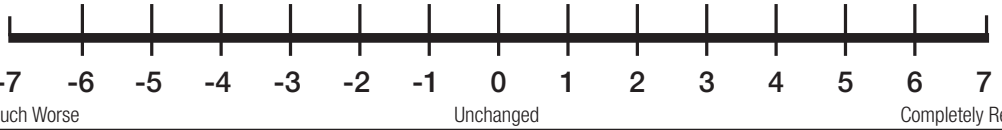
Please indicate the worst your pain has been in the last 24 hours on the scale below

No Pain ——————— Worst Pain Imaginable

PLEASE DO NOT COMPLETE THE FOLLOWING SECTIONS ON FIRST VISIT

GLOBAL RATING OF CHANGE

With respect to the reason you sought treatment, how would you describe yourself now compared to your first treatment at our clinic? (Circle one)



■ WORK STATUS *(check most appropriate)*

1. ❒ No lost work time
2. ❒ Return to work without restriction
3. ❒ Return to work with modification
4. ❒ Have not returned to work
5. ❒ Not employed outside the home

Work days lost due to condition:_____ days

I am aware that the information gathered on this form may be used anonymously for research or publication. Please initial: _____

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PHYSICAL THERAPY

PATIENT HISTORY QUESTIONNAIRE - PT

Date _____

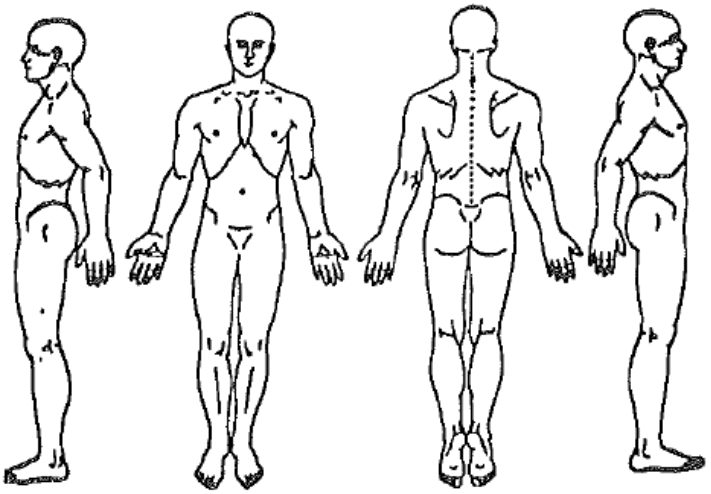
Name _____ DOB _____ Age _____ Height _____ Weight _____

Date of Next Visit with Referring Doctor _____ Family Doctor _____

Employer/Occupation _____ Leisure Activities _____

Describe the reason you are here _____

_____ Date Symptoms Began _____ Date of Surgery _____



Indicate on the diagrams, the area(s) or location(s) where you are currently experiencing symptoms, using the following key:

PPPPP = pins & needles
SSSSS = stabbing
XXXXX = burning
ZZZZZ = deep ache

Have you **EVER** been diagnosed as having any of the following conditions? Please circle.

Cancer	High Blood Pressure	Heart problems	Circulation problems	Blood Clots
Bleeding Disorder	Asthma	Hepatitis	Tuberculosis	Stomach Ulcers
Thyroid problems	Kidney problems	Depression	Diabetes	Multiple Sclerosis
Stroke	Seizures	Rheumatoid Arthritis	Chemical Dependency	
Osteoporosis	Osteoarthritis	COPD/Emphysema	Tobacco use: Y N Amt/day: _____	

Other _____

Please list any surgeries **or** other conditions for which you have been hospitalized, including the approximate date.

_____

Do you have allergies: Y N If yes, please specify _____

Please list any medications you are currently taking (prescription and over the counter). If you have a list, we would be happy to photocopy if for you.

_____

Please circle any of the following symptoms you are experiencing.

nausea/vomiting	fatigue	dizziness/lightheadedness	tremors
fever/chills/sweats	numbness or tingling	seizures	double vision
loss of vision	eye redness	skin rash	problems sleeping
sexual difficulties	hearing problems	joint/muscle swelling	easy bruising
excessive bleeding	difficulty breathing	regular cough	arm/leg swelling
heart racing in your chest	difficulty swallowing	heartburn/indigestion	post menopause
urinary incontinence	blood in urine	pregnant or think you might be	stress at home or work
weight loss/gain	bowel/bladder irregularities	abdominal pain/problems	
blood in stools	menstrual irregularities	night pain or night sweats	

If you circled any of the above, are you under a physician's care for this/these conditions? Y N

Patient Signature _____ *Thank you for taking time to complete this questionnaire.*

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PATIENT DEMOGRAPHIC INFORMATION

Date _____

First _____ **MI** _____ **Last** _____ **DOB** _____ **Age** _____

Male / Female **Married / Single / Widowed / Child** **Soc. Sec. #** _____

Home Address _____

City _____ **State** _____ **Zip** _____ **Email** _____

Home# _____ **Cell#** _____ **Work#** _____

Employer _____ **Occupation** _____

Emergency Contact _____ **Phone#** _____

How did you hear about our office? _____

IF PATIENT IS A MINOR:

Father: **Name** _____ **Phone#** _____

Mother: **Name** _____ **Phone#** _____

INSURANCE INFORMATION

Primary Insurance _____ Policy Holder Name _____

Policy Holder DOB _____ Relationship _____

Secondary Insurance _____ Policy Holder Name _____

Policy Holder DOB _____ Relationship _____

HOME ADDRESS OF POLICY HOLDER if different than patient's _____

_____

Is this a liability injury? **Yes** ☐ **No** ☐ If yes, please check one: **Worker's Comp** _____ **Auto** _____ **Other** _____

Claim#: _____ **Contact Person** _____ **Phone** _____

Are you being represented by an attorney? **Yes** ☐ **No** ☐

If yes:

Attorney Name _____ **Phone** _____

Address _____

I acknowledge that I have reviewed the information listed and confirm that there are no changes to my demographic and insurance information.

Initials _____ Date _____ Initials _____ Date _____ Initials _____ Date _____

Initials _____ Date _____ Initials _____ Date _____ Initials _____ Date _____

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PHYSICAL THERAPY

Welcome to Rock Valley Physical Therapy

Thank you for choosing Rock Valley and providing us the opportunity to work with you.
We hope to exceed your expectations and assist you in achieving your goals.

Notice of Privacy Practices:
I acknowledge being offered Rock Valley Physical Therapy's *Notice of Privacy Practices* pamphlet. I have initialed here to indicate that I understand my rights through HIPAA and that I am declining this pamphlet. (*Initial Here)* _____

Authorized Person(s):
I authorize you to speak to _____, _____, _____,

_____, _____, regarding my account and/or treatment.

By checking the box, I indicate that I do NOT want my Primary Care Physician (PCP) contacted regarding my care: ☐

Authorization to Release Information:
I authorize the release of any medical or any other information to the Centers for Medicare and Medicaid Services (CMS), my insurance carrier(s), or other entities necessary to determine insurance benefits or the benefits payable for related medical services and /or supplies provided to me by Rock Valley Physical Therapy.

Financial Responsibility:
I understand that insurance billing is a service provided as a courtesy and that I am, at all times, financially responsible to Rock Valley Physical Therapy. It is my responsibility to notify Rock Valley Physical Therapy of any changes in my health care insurance coverage. If the submitted charges or any part of them are denied for payment, I am responsible for the balance. I request that payment of my services be made on my behalf to Rock Valley Physical Therapy. I understand that by signing this form, I am accepting financial responsibility, as explained above, for payment of the balance of all medical services. I also understand that Rock Valley Physical Therapy collects for copayments at the time of service.

Supply Items:
I understand that Rock Valley Physical Therapy may, during the course of treatment, recommend purchase of a supply item. Supply items may or may not be covered under my insurance plan. I understand that it is my financial responsibility to pay for any item in full if it is not covered under my insurance plan.

This is to verify that I have read and agree with the above.

_____ _____
Patient or Responsible Party Date

Home Address of *Responsible Party* if different than the Patient:

_____

Non-Discrimination Policy:

Rock Valley Physical Therapy does not discriminate against any person on the basis of race, color, national origin, disability, or age in admission, treatment, or participation in its programs, services and activities, or in employment. For further information about this policy, contact the administrative assistant at (309)-743-2070. TDD/Relay Iowa.