BRATTON
PHYSICAL THERAPY

PATIENT INFORMATION FORM

Patient Information

Last Name_____ First Name _____ MI _____SSN_____

Address _____

City_____State _____ Zip_____

Home Phone_____ Cell Phone_____

Date of Birth_____Gender _____ Marital Status_____Email_____

Emergency Contact

Last Name_____ First Name_____

Relationship_____ Phone_____

Employer

Name_____ Phone_____

Address_____

City_____ State_____ Zip_____

Problem

Problem Description_____

When Did Symptoms Begin_____ Date of Surgery_____

Last Physician Visit_____Referred By_____

Primary Insurance

Insurance_____ Deductible_____

Member ID_____Max Benefit_____

Group #_____CoPay_____Coinsurance_____

Subscriber_____ Subscriber Date of Birth_____

Secondary Insurance

Insurance_____ Deductible_____

Member ID_____Max Benefit_____

Group #_____CoPay_____Coinsurance_____

Subscriber_____ Subscriber Date of Birth_____

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. I hereby acknowledge that I have received a copy of the Notice of Privacy Practices. (You have the right to refuse to sign this acknowledgement if you so choose.)

Signature_____ Date_____

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PHYSICAL THERAPY

NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

1) I hereby acknowledge that I received a copy of this clinic's **Notice of Privacy Practices.**
2) I would like to receive a copy of any amended Notice of Privacy Practices by email: YES or NO

Email Address:_____

Signature_____Date_____

LIMITATIONS AND RESTRICTIONS OF PROTECTED HEALTH INFORMATION

3) I authorize Bratton Physical Therapy to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them whenever this information changes (circle one):

Home Answering Machine/Voicemail	Yes	No
Work Answering Machine/Voicemail	Yes	No
Cell Phone/Voicemail	Yes	No
Spouse	Yes	No
Parent	Yes	No
Other Individuals Who May Answer Phone (such as fiancé, sister, brother, etc.)	Yes	No

List Specific Exclusions Here_____

Signature_____Date_____

Print Name_____

If Not Signed by Patient, Please Indicate Relationship_____

Patient Name_____ Witness_____

For Office Use Only

Signed Form Received by_____

Acknowledgement Refused Efforts to Obtain_____

Reason for Refusal_____

BRATTON
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MEDICAL HISTORY

Patient Name _____

List Any Medications You Are Currently Taking (If You Have A List, We Can Copy It)

_____

_____

_____

_____

List Any Medical Conditions (i.e. Hypertension, Diabetes, etc.)

_____

_____

_____

_____

List Any Past Surgical Procedures

_____

_____

_____

_____

BRATTON
PHYSICAL THERAPY

NEXT SCHEDULED DOCTOR APPOINTMENT NOTICE

We ask that you give us advance notice of your next scheduled appointment with the physician who prescribed you physical therapy. The therapist needs this notice in order to create an updated report of your progress.

If you are called in by your physician for an unexpected appointment, please give us notice if possible.

DATE OF NEXT SCHEDULED DOCTOR APPOINTMENT_____

Patient Signature_____Date_____

PHOTO AND PROMOTIONAL RELEASE

I hereby consent to be interviewed, recorded, photographed, videotaped or filmed by representatives of Bratton Physical Therapy for purposes of publication, display or broadcast (print, web, digital display, and all other forms of media). I agree that such interviews, recordings, articles, quotes, photographs, films, audio or video and/or reproductions of same in any form are the property of Bratton Physical Therapy and I relinquish any present or future claim for reimbursement for said photographic or film reproduction of my likeness or for said testimonials by me.

I hereby release Bratton Physical Therapy, its affiliates, employees, representatives, and agents from any and all claims, demands, costs, and liability that may from the use of these interviews, recordings, photographs, videotapes or films, and/or any reproductions of same in any form, as described above, arising out of being interviewed, recorded, photographed, videotaped, or filmed.

I acknowledge that I have read this consent form in its entirety, or it has been read (or translated) to me, and I have had the opportunity to ask questions about it and understand it.

Patient Name (Print)_____

Patient/Guardian Signature_____Date_____

Parent or Legal Guardian name and signature required for individuals under the age of 18

Bratton Physical Therapy Patient Attendance Policy

ATTENDANCE POLICY

1. As experts, we know that you will not get better if you do not attend your appointment. When you call to cancel an appointment, we expect that you will have other times available so we can reschedule you right away.
2. **We require that you cancel any appointment that you cannot make with no less than 24 hours' notice.**
3. We will reschedule you at that time to make sure you continue with your plan of care.
4. While we understand that illness can strike at any time, repeated cancellations for illness without 24 hours' notice will not be an accepted excuse for untimely notice.
5. For all appointments, we expect that you will arrive on time and ready to begin at your scheduled treatment time.
6. **Life happens and sometimes we all run late. We get it. If you are running late, we need you to call us immediately so we can be prepared for your late arrival.**
7. Please also be aware that if you are late for your appointment, you are missing the time that we have specifically scheduled for your care and we cannot guarantee that we will be able to provide you with your full treatment as we have reserved the appointment time following yours for someone else. Chronically late patients will be asked to change their appointment times or may be discharged.
8. **Please note, you will be charged a $50 fee for any no-shows and ALL cancellations that occur with less than 24 hours' notice. This amount is your responsibility as insurance will not cover this fee.** To avoid the $50 fee, you simply need to call the office and provide at least 24 hours' notice for any appointments you cannot attend. Calls the night before your appointment will not count as timely notice so please call during business hours. Calls for Monday's appointments must be made before the end of the business day on Friday. *Advanced notification allows us to help another patient by offering them your appointment slot.*
9. If you are Worker's Comp, we are required to notify your claims adjuster if you cancel or no-show.
10. You may be discharged from services if you do not show up for your appointment or cancel for 2 consecutive appointments or if attendance falls below 75%. We will notify your physician of your non-compliance.

Thank you for reviewing this policy. Please sign and return the signed copy and keep the second copy for your records. We look forward to working with you to meet your therapy goals.

Bratton Physical Therapy Staff

DISABILITIES OF THE ARM, SHOULDER AND HAND

Please rate your ability to do the following activities in the last week by circling the number below the appropriate response.

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. Open a tight or new jar.	1	2	3	4	5
2. Write.	1	2	3	4	5
3. Turn a key.	1	2	3	4	5
4. Prepare a meal.	1	2	3	4	5
5. Push open a heavy door.	1	2	3	4	5
6. Place an object on a shelf above your head.	1	2	3	4	5
7. Do heavy household chores (e.g., wash walls, wash floors).	1	2	3	4	5
8. Garden or do yard work.	1	2	3	4	5
9. Make a bed.	1	2	3	4	5
10. Carry a shopping bag or briefcase.	1	2	3	4	5
11. Carry a heavy object (over 10 lbs).	1	2	3	4	5
12. Change a lightbulb overhead.	1	2	3	4	5
13. Wash or blow dry your hair.	1	2	3	4	5
14. Wash your back.	1	2	3	4	5
15. Put on a pullover sweater.	1	2	3	4	5
16. Use a knife to cut food.	1	2	3	4	5
17. Recreational activities which require little effort (e.g., cardplaying, knitting, etc.).	1	2	3	4	5
18. Recreational activities in which you take some force or impact through your arm, shoulder or hand (e.g., golf, hammering, tennis, etc.).	1	2	3	4	5
19. Recreational activities in which you move your arm freely (e.g., playing frisbee, badminton, etc.).	1	2	3	4	5
20. Manage transportation needs (getting from one place to another).	1	2	3	4	5
21. Sexual activities.	1	2	3	4	5

DISABILITIES OF THE ARM, SHOULDER AND HAND

	NOT AT ALL	SLIGHTLY	MODERATELY	QUITE A BIT	EXTREMELY
22. During the past week, *to what extent* has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbours or groups? *(circle number)*	1	2	3	4	5

	NOT LIMITED AT ALL	SLIGHTLY LIMITED	MODERATELY LIMITED	VERY LIMITED	UNABLE
23. During the past week, were you limited in your work or other regular daily activities as a result of your arm, shoulder or hand problem? *(circle number)*	1	2	3	4	5

Please rate the severity of the following symptoms in the last week. *(circle number)*

	NONE	MILD	MODERATE	SEVERE	EXTREME
24. Arm, shoulder or hand pain.	1	2	3	4	5
25. Arm, shoulder or hand pain when you performed any specific activity.	1	2	3	4	5
26. Tingling (pins and needles) in your arm, shoulder or hand.	1	2	3	4	5
27. Weakness in your arm, shoulder or hand.	1	2	3	4	5
28. Stiffness in your arm, shoulder or hand.	1	2	3	4	5

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	SO MUCH DIFFICULTY THAT I CAN'T SLEEP
29. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand? *(circle number)*	1	2	3	4	5

	STRONGLY DISAGREE	DISAGREE	NEITHER AGREE NOR DISAGREE	AGREE	STRONGLY AGREE
30. I feel less capable, less confident or less useful because of my arm, shoulder or hand problem. *(circle number)*	1	2	3	4	5

DASH DISABILITY/SYMPTOM SCORE = _____ ([(sum of n responses / n) - 1] x 25, where n is the number of completed responses.)

A DASH score may <u>not</u> be calculated if there are greater than 3 missing items.

DISABILITIES OF THE ARM, SHOULDER AND HAND

WORK MODULE (OPTIONAL)

The following questions ask about the impact of your arm, shoulder or hand problem on your ability to work (including homemaking if that is your main work role).

Please indicate what your job/work is:_____

❒ I do not work. (You may skip this section.)

Please circle the number that best describes your physical ability in the past week. Did you have any difficulty:

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. using your usual technique for your work?	1	2	3	4	5
2. doing your usual work because of arm, shoulder or hand pain?	1	2	3	4	5
3. doing your work as well as you would like?	1	2	3	4	5
4. spending your usual amount of time doing your work?	1	2	3	4	5

SPORTS/PERFORMING ARTS MODULE (OPTIONAL)

The following questions relate to the impact of your arm, shoulder or hand problem on playing *your musical instrument or sport or both*.
If you play more than one sport or instrument (or play both), please answer with respect to that activity which is most important to you.

Please indicate the sport or instrument which is most important to you:_____

❒ I do not play a sport or an instrument. (You may skip this section.)

Please circle the number that best describes your physical ability in the past week. Did you have any difficulty:

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. using your usual technique for playing your instrument or sport?	1	2	3	4	5
2. playing your musical instrument or sport because of arm, shoulder or hand pain?	1	2	3	4	5
3. playing your musical instrument or sport as well as you would like?	1	2	3	4	5
4. spending your usual amount of time practising or playing your instrument or sport?	1	2	3	4	5

SCORING THE OPTIONAL MODULES: Add up assigned values for each response; divide by 4 (number of items); subtract 1; multiply by 25.
An optional module score may not be calculated if there are any missing items.